

Blurred Lines: Perceptions of Sexual Consent and the Role of Mental Illness

Mercedes Jahanzadeh

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### **Abstract**

Sexual activity can be a pleasurable and critical element of self-expression. However, research has found that mental illness is a condition that may affect the ability to sexually consent. Despite this fact, sexual consent remains under-studied and under-theorized when considering the various ways it can be influenced. Bipolar Disorder is especially concerning, as it is characterized by symptoms of thought disorder patterns, perception alterations, mood oscillations, and impulsivity. Consequently, individuals are particularly susceptible to bias when judging situations. The aim of this study, then, is to explore the relationship between mental illness and sexual behaviour. Specifically, perceptions of sexual consent and the role of Bipolar Disorder were examined among university students. The study is intended to determine if an individual's mental health status was related to perceptions of capacity to sexually consent. In other words, I sought to determine if individuals self-reporting a clinical diagnosis would be more likely to proceed with a sexual interaction knowing their partner had a mental illness, compared to individuals who had never experienced symptoms of a disorder who may be more fearful. Additionally, it was examined if students' sexual decision-making was influenced more by some disorders over others (e.g., Bipolar Disorder, Depression and Schizophrenia). The findings of this study demonstrates that there is a need for greater research examining people's understanding of sexual consent, and capacity to consent, especially in the context of mental illnesses such as Bipolar Disorder.

**Keywords:** mental illness, sexual consent, Bipolar Disorder.

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## CHAPTER I

### INTRODUCTION

Having the capacity to consent to sexual activity is important in any sexual interaction, but especially so for those people who suffer from a mental illness that may impair their capacity to make a decision in some way. To date, there is no consensus on how to define capacity for sexual consent, despite the major ethical and legal implications that exist from this lack of established criteria (Beres, 2007; Humphreys & Brousseau, 2010; Mandarelli, et al., 2011; Muehlenhard, 1995). In particular, concerns have been raised regarding individuals who have impairment in decision-making capabilities (Jollant et al., 2007; Mandarelli et al., 2011). Patients with severe psychiatric disorders, such as Bipolar Disorder, may be at greater risk due to mood elevation caused by manic episodes that can lead to cognitive impairment and loss of control over behaviour, exemplified by diminished impulse control and social judgment (Jollant et al., 2007; Mandarelli et al., 2011; Rock et al., 2013; Yechiam, Hayden, Bodkins O'Donnell, & Hetrick, 2008). Moreover, dimensions of mania related to increased sexual drive are associated with impaired impulse control and diminished social judgment (Adelson, 2010). These deficits, combined with the ambiguity surrounding the criteria for determining capability to sexually consent, become problematic as sexual situations unfold, as there is no shared understanding of how to interpret intentions. Understandably, this lack of discussion regarding consent may lead to misinterpretations of behavior during sexual interactions (Humphreys & Brousseau, 2010; Rubin, 2013).

It should be mentioned that, although one notable study done by Mandarelli and colleagues (2011) has looked at the relationship between Bipolar Disorder and sexual consent, research on this topic is limited. The current study builds on that past research with two significant differences. First, in this study, students attending university will be investigated in a lab setting, while the previous study targeted hospitalized patients in a psychiatric clinical setting. This is important, as most high-prevalence disorders, including mood disorders such as Bipolar Disorder, have symptoms that emerge during adolescence and early adulthood (Girolamo, Dagani, Purcell, Cocchi, & McGorry, 2007; Kessler, Amminger, Aguilar-Gaxiola, Alonso, & Lee, 2007; Merikangas et al., 2010). Thus, diagnoses and symptoms can be explored around the expected time of onset through use of university students as participants. Mandarelli and colleagues (2011) also only considered patients with Bipolar Disorder or Schizophrenia, while this study examined patterns from three groups: participants with any diagnosed mental illness, those who reported symptoms of Bipolar Disorder, and those with no diagnosis and no symptoms. Moreover, instead of administering a clinician oriented semi-structured interview, questionnaires and short-form responses were provided. Second, perceptions regarding sexual consent will be examined. Specifically, I explore which factors individuals deem important in determining full consent in a sexual scenario.

## CHAPTER II

### LITERATURE REVIEW

#### **Understanding Sexual Consent**

The limited attention given to understanding consent has contributed to the present difficulties in research in reaching an agreement on the definition. This shortcoming undermines the immense practical relevance of sexual consent in day-to-day sexual interactions, as it is both a form of sexual communication and a legal indicator of appropriate sexual activity (Humphreys & Brousseau, 2010). However, sexual consent remains under-studied and under-theorized when considering the various ways it can be influenced. Not only is there limited literature on this critical concept, but, even within the literature, there is no general consensus on what it is, how it should be defined, or how it is communicated (Beres, 2007; Muehlenhard, 1995). In fact, the only thing that has been widely agreed upon is that valid consent is necessary (Rubin, 2013). Moreover, there is minimal research that examines people's attitudes toward asking and giving consent (Humphreys & Brousseau, 2010; Primoratz, 2001; Rubin, 2013). Although there remains a need for greater clarification and an increased focus on this important topic, some researchers have made efforts in creating a foundation for defining consent.

In order to provide a solid understanding of the complexities of sexual consent, Muehlenhard (1995) set out to explore the foundation of what it means to consent to sexual activity. In his research, two themes emerged from the discussion of consent. First, consent requires knowledge (Muehlenhard, 1995). In other words, an individual needs to know exactly what it is that they are consenting to. This includes, but is not limited to, information regarding the sexual act, sexual meaning of the act, along with the risks and benefits associated with



sexuality. Second, consent is meaningless unless it is given freely (Muehlenhard, 1995). In other words, an individual must be free to say either “yes” or “no”. This freedom provides the opportunity to truly consider participation in the sexual activity, along with minimizing the possibility of coercion into it. However, the foundational criteria for consent become even murkier when we consider how to decide if someone has freely expressed their consent and whether they are truly ‘free’ in their capacity to do so.

One way to remove some of the ambiguity around how consent is expressed, especially from a legal perspective, is to ensure it is much more explicitly stated. This is reflected in a recent move away from a “No Means No”, and towards a “Yes Means Yes” mentality of sexual consent (La France, Loe, & Brown, 2012). Through the development of ‘Affirmative Sexual Consent’ in Canadian jurisprudence and legal theory, requirements of sexual consent have been explicitly proposed and recognized as an essential element of the common law and statutory definitions since 1994. As such, sexual consent has been defined as the unambiguous or express communication of “voluntary agreement” to sexual touching.

"Voluntariness" connotes that the agreement is not coerced, that the person who agrees is acting "freely" and has other options or other choices she could make without incurring harm or detrimental consequences. "Agreement" signals that there is specificity in what is agreed--the person agrees to something in particular. The agreement is to a specific sexual activity, at a specific time, with a specific person, and it is revocable. Finally, the agreement must be communicated or it will be legally ineffective to give the other person permission to engage in sexual touching. Communication may consist of either words or conduct but must be express, explicit, and unambiguous. (Vandervort, 2012, p. 402)

This concept of voluntary agreement was designed to protect certain populations deemed vulnerable. According to the Canadian legal literature, those considered especially vulnerable to non-consensual activity were those who are: 1) children and lack understanding of what is occurring; 2) asleep or unconscious; 3) physically, cognitively, or emotionally disabled for any reason; or 4) disempowered in one or more respects in relation to the assailant as a consequence of specific socioeconomic relationships or structures (Vandervort, 2012). Although individuals with mental illnesses are not clearly stated as a vulnerable population in the third category, it could be argued that this category captures their relevant impairments. However, some have questioned the current legislative provision's adequacy on meeting the needs of complainants with mental disabilities, and whether or not mental illnesses should be included in the model of disability (Benedet & Grant, 2007). This is not very surprising, as disability theorists have rarely included psychiatric disability in their work (Mulvany, 2007). Although this development of Affirmative Sexual Consent in Canadian law has made great strides in the area of defining consent, significant consideration has yet to be made in terms of those with mental illness.

#### **Ability to Give Sexual Consent (Mental Illness and Capacity)**

Trying to define the nature of sexual consent has brought to light the various factors that make it difficult for someone to freely give it. While some hold that verbal consent to sex is indeed enough to legitimize it, others maintain that more is required (Primoratz, 2001). This is because certain conditions, such as having a mental illness, may affect an individual's ability to provide their consent freely and with sufficient knowledge. Muelenhard (1996) intended to address this concern through the use of 'knowledge criteria', as an individual with a cognitive

impairment may not be sufficiently knowledgeable about the consequences of their behaviour or the risks involved.

Research has shown that, among the several significant factors that result in impaired decision-making, cognitive dysfunction and psychopathological symptoms are the most relevant in terms of sexual consent (Mandarelli et al., 2011). This is important to note, as Bipolar Disorder is characterized by symptoms of thought disorder patterns, perception alterations, mood oscillations, and impulsivity (Yechiam et al., 2008; Mandarelli et al, 2011). Consequently, individuals with psychiatric illnesses are particularly susceptible to bias when judging situations. However, as previously outlined, Bipolar Disorder is the most relevant disorder in terms of its potential impact in a sexual context due to its rare combination of multiple symptomatic impairments that no other clinical disorder (i.e., Borderline Personality Disorder, Histrionic Personality Disorder, Major Depression, and Schizophrenia) embodies.

### **Bipolar Disorder and Sexual Consent: Symptoms and Consequences**

Bipolar Disorder is a serious and recurrent illness, and is characterized by repeated cycles of depression and mania (Keck, McElroy, & Arnold, 2001; Lobban et al., 2011; Rock et al., 2001). The most common identified signs for depression are low motivation, low energy, and feeling tired, while the most commonly recognized for mania are feeling energetic, very active, and feeling emotionally high (Lobban et al., 2011). Due to the unique nature of the disorder cycling between ‘highs’ and ‘lows’ of emotion, it is important to examine its impact on decision-making, sexuality, and subsequent behaviors. This is because, regardless of whether or not certain manic episodes are positively experienced (as some people report) or frightening at the time, individuals have trouble confronting its aftermath, which has been described as “a sense of depersonalization such that one knows one behaved in particular ways but cannot reconcile that

behavior with one's personal sense of self or one's values" (Freedberg, 2011, p. 60). It is the experience post-mania of wanting to repair the damage done that is most challenging. Individuals with Bipolar Disorder face the repercussions of their decisions once their 'high' eventually comes down to a halting 'low'. This rollercoaster of emotions between mania and depression makes individuals with Bipolar Disorder more vulnerable to detrimental sexual consequences.

Patients with Bipolar Disorder are more likely to demonstrate bizarre and excessive sexual behavior compared to many other categories of psychiatric illness, and especially in comparison to healthy subjects (Bambole et al., 2013; Dell'Osso et al., 2009). Accordingly, these individuals warrant special consideration with regard to sexual health because of the potential negative consequences that may occur during personal sexual scenarios (Mazza et al., 2011). While there are a number of characteristics of Bipolar Disorder that could alter a person's ability to make well-reasoned and informed decisions, two specific symptoms are pertinent to consent issues: impulsivity and hypersexuality.

Impulsivity, a key feature of several mental disorders that exhibit mania, has been shown to be significantly higher in individuals with Bipolar Disorder (Christodoulou, Lewis, Ploubidis, & Frangou, 2006; Moeller, Barratt, Dougherty, Schmitz, & Swann, 2001). Moeller and colleagues (2001) define impulsivity as swift action without conscious judgment, or behavior without adequate thought. This is manifested specifically as a lack of behavioral inhibition during the manic phase (Keck, McElroy, Arnold, 2001; Moeller et al., 2001). Mania, the core and defining psychopathology of Bipolar Disorder (Quilty, Selbom, Tackett, & Bagby, 2009), is the reason behind this increased level of impulsiveness (Mandarelli, 2012).

While many core symptoms of this type of episode may be considered positive, such as increased confidence and sociability, mania is associated with negative high-risk behaviour

(Chandler, Wakeley, Goodwin, Rogers, 2009; Yechiam et al., 2008). Although mania (and related impulsivity) may be observed in other populations, the mania bipolar individuals experience greatly differs from that of their non-diagnosed counterparts (Chandler, Wakeley, Goodwin, Rogers, 2009; Yechiam et al., 2008). In fact, research on youth populations has consistently found manic experiences to be a common occurrence among the general population (Rock et al., 2013). This could account for some of the behaviour commonly observed in adolescents and young adults in which they fail to consider the consequences of their actions. However, it often does not lead to extreme risk-taking the way it does with individuals diagnosed with Bipolar Disorder. Manic behavior in Bipolar Disorder often entails a substantial lack of consideration for consequences of actions, which results in extreme and dangerous risk-taking (Mandarelli et al., 2011; Yechiam et al., 2008). For example, in a qualitative study done by Freedberg (2011) investigating the lived experience of people with Bipolar Disorder, a participant named Bailey, age 22 at the time and diagnosed at 20, highlights some of the impulsive behavior associated with mania in the following way:

“It's very, very hard to be manic. But after those, like collecting all the damage that you've done... when I was manic I spent loads of money. I racked up huge credit card debt. I did ridiculous things and now you are like... oh, I didn't want to do that. You have to go and like pick it up.. after that [it] is really hard. How do I explain to my grandparents who came to visit me that I'm not... I was sick. I was rude to them!! It was like out of control. And you don't want to, like, hurt people like that and you wouldn't on a regular basis but you're not yourself. With mental illness you don't have any... I'm not missing a limb or don't have bipolar on my head so... it's hard” (p. 60).

Hypersexuality is another common symptom of mania in diagnosed Bipolar Disorder (Adelson, 2010; Dell’Osso et al., 2009; Mazza et al., 2011; Rock et al., 2013). The concept has been defined as “sexual behavior characterized by increased sexual drive, interest, or preoccupation relative to developmental norms... [and] may be precocious, socially inappropriate, or associated with lack of impulse control” (Basco & Hoyo, 2012, p. 42). Several case series/studies have found evidence of increased sexuality in bipolar patients, including increased sexual feelings and intensity, frequent nudity and sexual exposure, and episodic or unexplained promiscuity or extramarital affairs (Adelson, 2010). Although this symptom overlaps with many other psychiatric disorders, patients diagnosed with Bipolar Disorder were more likely to demonstrate bizarre and excessive sexual behavior compared to those with other disorders, such as Schizophrenia (Bambole et al., 2013).

Impulsivity and hypersexuality, as seen in Bipolar Disorder, should be key elements within the conversation of sexual consent, because the sexual behaviours of an individual may be the result of symptoms of mania rather than being consistent with their personal values and judgment. As a result, it is usually only when the individual is no longer in a manic episode that the impaired decision-making is recognized. This lack of forethought in sexual behavior places these individuals in danger of victimization and a number of other negative consequences (Chandler, Wakeley, Goodwin, Rogers, 2009; Mandarelli et al., 2011; Yechiam et al., 2008).

Even though it can be argued that a number of other disorders also have characteristics that might also impact capacity to consent (e.g., Borderline Personality Disorder, Histrionic Personality Disorder, Major Depression, and Schizophrenia), Bipolar Disorder is especially concerning. Bipolar Disorder is characterized by mood cyclicity, impulsivity, hypersexuality, and cognitive impairment, all of which are of concern in the discussion of sexual consent.

Borderline Personality Disorder has symptoms of impulsivity (Baryshnikov et al., 2015; Boen et al., 2015) and hypersexuality, but lacks mood cyclicity between depression and elation (Henry et al., 2001). Histrionic Personality Disorder has symptoms of hypersexuality and impulsivity (Ferguson & Negy, 2014), but is not characterized by cognitive impairment (American Psychiatric Association, 2013). Major Depression has symptoms of cognitive impairments, but lacks the hypersexuality symptoms. Schizophrenia has symptoms of mood cyclicity, along with cognitive impairments (Diwadkhar et al., 2011; Keck, McElroy, Arnold, 2001), but also lacks the hypersexuality. Thus, in light of Bipolar Disorder's unique symptom combination, the focus of this thesis will be on individuals diagnosed with this illness in terms of how this relates to capacity to consent.

### **Bipolar Disorder and Sexual Consent: Increased Risk of Victimization**

The vulnerability to victimization in mentally ill individuals occurs in a number of ways. People with mental illness are two to eight times more likely than the general population to be victims of violent crime (Desmairis et al., 2014). In fact, they are at a substantially increased risk of being a victim of sexual violence, with a recent study showing 40% of women with a mental illness suffering sexual assault, compared to 7% of their non-disordered counterparts (Khalifeh et al., 2015). Over the past three decades, multiple studies have shown that individuals with Schizophrenia and Bipolar Disorder are more likely to be victimized than others (Darves-Bornoz, Lemperiere, Degiovanni, & Gaillard, 1995; Eckert, Sugar, & Fine, 2002; Garcia-Moreno & Riecher-Rossler, 2013; Goodman et al., 2001; Goodman, Dutton, & Harris, 1995; Hiday, Swartz, Swanson, Borum, & Wagner, 1999; White, Chafetz, Collins-Bride, & Nickens, 2006).

Mandarelli and colleagues (2011) suggest two likely explanations for this high occurrence of sexual victimization. First, psychopathological symptoms such as thought and

mood alterations might endanger the interpersonal communications that are necessary for understanding consent in sexual scenarios. Second, and equally relevant, an individual's evaluation of his or her own consent level can be influenced by the presence of mood elevation from a manic episode. This lack of awareness of sexual risk taking can result in the possible transmission of STD's, unwanted or unplanned pregnancies, sexual abuse or violence, or susceptibility to sexual coercion (Mandarelli et al., 2011). In the short-term, these various consequences require interventions that are specifically able to address the immediate threat to health (McCandless & Sladen, 2003).

In addition, there are further consequences that can affect individuals in the long-term that are more difficult to deal with. In a study by McCandless and Sladen (2003) on the sexual health of women with Bipolar Disorder, sexual impulsivity was shown to have the potential to negatively impact the individual's overall self-esteem and self-image. Acting on sexual impulses and their associated behaviors could conflict with the individual's cultural or religious background, or may be inconsistent with their own personal standards for sexual behavior. Moreover, interpersonal conflict may arise in relationships as a result of sexual indiscretions. In fact, several studies on the hypersexuality of bipolar patients have found increased episodic promiscuity that lead to extramarital affairs (Adelson, 2010). Thus, in the post-manic period, where an individual may reflect on behavior, the realization of these consequences can add to the stress that is already being experienced by this vulnerable population as a result of the disorder itself (Freedberg, 2011; McCandless & Sladen, 2003).

Research on patients with mood disorders has also found an association between hypersexuality and suicidality. Dell'Osso and colleagues (2009) found the emergence of a significant relationship between hypersexuality and feeling that life was not worth living. This



suggests higher lifetime suicidality in patients with a history of sexual manic symptoms (Dell’Osso et al., 2009). This data is consistent with other studies that have reported an association between individuals with mental disorders who reported multiple partners and infrequent condom use in the past year to depression and suicidal ideation (Boden & Horwood, 2006). This research demonstrates that the impulsive sexual behavior that manifests as part of mania in Bipolar Disorder can cause devastating effects on the physical and emotional well-being of the individuals (Adelson, 2010; Boden & Horwood, 2006; Dell’Osso et al., 2009; Mandarelli et al., 2011; McCandless & Sladen, 2003).

To further complicate matters, individuals with Bipolar Disorder, as with any psychiatric illness, are not homogenous. While some patients may show impaired decision-making abilities, others display a wide-range of competencies in their everyday lives (Freedberg, 2011; Howe, Foister, Jenkins, Skene, Copolov, and Keks, 2005; Michalak, Yatham, Kolesar, & Yam, 2006) and has resulted in recent debate on how to reach a balance between protection and autonomy. It is necessary, therefore, to find a balance between protecting individuals who do have impairments in decision-making, while ensuring autonomy for individuals who are capable of making informed decisions (Mandarelli et al., 2011). This critical need, though, weighs heavily on perception of capability. Thus, in the context of sexual behaviors, the explicit mention of mental illness is something that might impact perceptions of consent when a bipolar individual is involved. The importance of developing a better understanding of how to strike this balance highlights the need for research examining people’s understanding of sexual consent, and capacity to consent, especially in the context of mental illnesses such as Bipolar Disorder.

### **Current Study**

The current study was designed to explore the relationship between mental illness and

sexual behaviour. The objective of this research was to analyze university students' perceptions of capacity to sexually consent when different mental health groups are considered. Participants were asked about how they give and receive consent to ascertain what factors they think are important in making this determination. Mental health status was identified using a demographics questionnaire with a self-report history of clinical diagnoses, and the use of the General Behaviour Inventory (GBI) that screens for characteristics of both depressive and manic conditions. This study is intended to determine if an individual's mental health status was related to perceptions of capacity to sexually consent. More specifically, this study examined whether individuals self-reporting a clinical diagnosis, or symptoms of an affective condition, were more likely to proceed with sexual interaction knowing their partner had a mental illness, compared to individuals who had never experienced symptoms of a disorder before. Additionally, this study sought to determine if students' sexual decision-making was influenced more by disorders such as Bipolar Disorder compared to Depression and Schizophrenia. Depression was selected for comparison because it is also a mood disorder—and a component of Bipolar Disorder—which allowed the comparison of participants' responses to other mood disorders. Schizophrenia was selected as it is a disorder with similar cognitive impairments but also considered to be the highest ranking type of disabling mental illnesses in terms of severity (Rossler, Salize, Os, & Richer-Rossler, 2005), which allowed for a comparison of responses related to Bipolar Disorder to responses of a disorder that may be perceived to be more 'serious'. Thus, while the primary interest is in people's responses to Bipolar Disorder, these comparisons ensured that any significant results that are found are not merely a response to mental disorders in general, but is specific to the one being studied.

## Research Questions

- 1) What factors are important in determining full consent or unwillingness to engage in sexual activity?
- 2) Would participants who have either self-reported a clinical diagnosis or exhibited symptoms of a disorder be more willing to proceed with sexual intercourse knowing their partner has a mental illness, compared to participants who have never experienced any type of mental illness?
- 3) Would participants who have never experienced any type of mental illness be more fearful of sexual interactions with a partner who has a mental illness, compared to participants who have either been clinically diagnosed with a disorder or exhibited symptoms of a disorder?
- 4) Does willingness to proceed with sexual activity differ depending on the type of disorder (i.e. Bipolar Disorder, Major Depression, Schizophrenia) the partner has been diagnosed with?

## CHAPTER III

### METHODOLOGY

#### **Participants**

The participants of this study were 254 undergraduate students at the University of Ontario Institute of Technology. Participants were recruited from students enrolled in psychology courses that offered the opportunity to participate in the Participant Pool for which they could receive extra credit in their courses.

Subjects ranged in age from 17 to 39, 92% being 23 years of age or younger. Participants were 58% female and 42% male. In terms of ethnicity, 38% identified as White, while 26.5% were Asian/Pacific Islander, 8.3% Black/African American, 1.6% Hispanic/Latino, 1.2% Native American/American Indian, and 24.5% identified with an ethnicity other than the options offered. Approximately 9% (N= 24) of respondents self-reported as having been clinically diagnosed with a mental disorder. The most frequently reported diagnoses were Depression (46%) and Anxiety (31%), with no individuals reporting a diagnosis of Bipolar Disorder or Schizophrenia. Within the entire group of self-reported diagnoses, only eight participants stated that they were currently on medication for their illness. All participants, regardless of reporting being diagnosed with a clinical disorder or not, were asked to complete the GBI to assess the prevalence of symptoms of the bipolar spectrum. While both depressive and manic symptoms were measured, only those who scored high on mania would be categorized in a category, as it is the impulsivity and hypersexuality in mania that research has found to potentially negatively affect decision-making in sexual contexts.

Depending on the results of the GBI, participants were divided into one of three Mental Health Status groups: participants reporting being diagnosed with any mental illness (N= 24), those who scored high on the GBI for mania (N= 20), and those who reported no diagnosis and scored low on the GBI for symptoms of Bipolar Disorder (N=215). These groups will be stated as ‘self-report clinical diagnosis’, ‘high mania symptoms’, and ‘no lifetime experience of any disorder’, respectively.

### **Materials**

The Informed Consent Form (Appendix A) was emailed to each participant within 24 hours of signing up for the study to give a brief overview of the research to allow them time to consider if they were willing to take part in the study given the potential for this to be a sensitive topic for some people. The Debriefing Form (Appendix B) was given to all participants individually after completing the study to thank them for their participation and provide contact information for mental health services at UOIT and in Durham Region.

Participants began the study by answering a Demographics survey (Appendix C), to provide general knowledge and information regarding age, gender, ethnicity, sexual orientation, and relationship status. They were also asked if they had been clinically diagnosed with a mental disorder, and if so, to specify the illness (if they did not wish to answer, they were instructed to move on to the next page). For those participants who did answer, they were asked if they were currently on any medication for their illness, and if they believed their behaviour varied depending on whether or not they take medication.

The study then utilized the General Behavior Inventory (Appendix D) to identify both depressive and manic conditions in participants. The revised GBI is a 73-item, self-report,

screening tool to assess all symptomatic behaviours associated with depression and mania.

The scale has comprehensive coverage of all symptomatic behaviour, with equal weighting on six different areas: somatic, vegetative (e.g., *“Have you had periods of several days or more when it was difficult or almost impossible to think and your mind felt sluggish, stagnant, or ‘dead’?”*), psychomotor (e.g., *“Have you experienced periods of several days or more when you were feeling down and depressed, and you also were physically restless, unable to sit still, and had to keep moving or jumping from one activity to another”*), affective (e.g., *“Have you found that your feelings or energy are generally up or down, but rarely in the middle”*), mood (e.g., *“Has your mood or energy shifted rapidly back and forth from happy to sad or high to low?”*), and cognitive (e.g., *“Have there been periods of several days or more when you could not keep your attention on any one thing for more than a few seconds, and your mind jumped rapidly from one thought to another or to things around you?”*). Depue and colleagues (1989) administered this test in a nonclinical university population with results showing the scale to have high predictive power, adequate sensitivity, high specificity, and adequate selection ratios for sampling of affective and non-affective subjects from nonclinical populations for research purposes. The GBI (Cronbach’s Alpha= .967) has performed well in both nonclinical and clinical populations in many studies (Youngstrom et al., 2005; Youngstrom, Choukas-Bradley, Calhoun, & Jensen-Doss, 2015).

Participants answered a questionnaire regarding sexual consent and mental illness (Appendix E). They were also asked a series of Yes/ No questions, including if they always have conversations regarding consent before sexual activities (*“Do you always have conversations regarding consent before engaging in sexual activities?”*), if it is necessary to obtain consent every time (*“Would you try to obtain consent every time? If yes, how would you try to obtain*

*consent every time?* Response: Fill-in explanation. *If having sex with someone more than once, would the first time obtaining consent be enough?*”), if the length of a relationship changes how consent would be ensured (*“Do you believe the length of time of a relationship changes how you would ensure consent?”*), if they believe it is important to understand a partner’s diagnosis or necessary to speak with their guardian first (*“Do you think it is important to understand any diagnoses a person may have before getting involved with them sexually? Do you believe it would be necessary to speak with a potential partner’s guardian to obtain consent if they suffered from a mental illness?”*). They were also given a set of behaviours illustrating Bipolar Disorder symptoms, and were asked to answer questions about the likelihood of proceeding with sexual activity if their partner were exhibiting certain behaviours (*“Would any of the following behaviours seen in a partner change your decision to engage in sexual activities? [check those that apply]: Elevated/Euphoric Mood, Irritability/Aggressiveness, Flight of Ideas/Racing Thoughts, Decreased Need for Sleep, Delusions/Hallucinations”*). Response values: Yes, it would make it more likely I would engage in sexual activity / Yes, it would make it less likely I would engage in sexual activity / No.)

Finally, a set of 10 different Vignettes were provided (Appendix F). Students were asked to read through multiple scenarios and decide how they would personally react to a sexual situation involving partners in the different situations (Cronbach’s Alpha= 0.716). This included partners with a clinical diagnosis (*“Imagine you are about to engage in sexual activity with someone, and you learn they are diagnosed with Bipolar Disorder / Imagine you are about to engage in sexual activity with someone, and you learn they are diagnosed with Depression / Imagine you are about to engage in sexual activity with someone, and you learn they are diagnosed with Schizophrenia”*), partners exhibiting symptoms of a mental illness (*“Imagine you*

*are about to engage in sexual activity with someone who is exhibiting the following behaviours: [hallucinations, delusions, and disorganized speech and behaviour / elevated/euphoric mood, irritability/aggressiveness, flight of ideas/racing thoughts, and/or disordered thinking / sadness, pessimism, guilt, and/or indecisiveness]”),* partners dealing with life crises (*“Imagine you are about to engage in sexual activity with someone, and you learn they [are drunk / have had a recent death in the family/ are stressed with exams]”*), along with one control measure of being with a partner who has no clinical diagnosis, no life crisis, and exhibiting no mental illness symptoms (*“Imagine you are about to engage in sexual activity with someone who is exhibiting characteristics of a typical healthy adult”*). For each scenario, participants then answered how four different types of emotions would be affected (*“In considering moving forward with the sexual activity...”*). Responses included likelihood to proceed with sexual intercourse, their confidence in proceeding, their hesitancy, and whether they would be fearful about proceeding. So, to summarize, the situations included three labeled disorders (Bipolar Disorder, Schizophrenia, and Major Depression), three life situations (stress from exams, death in the family, being drunk), three exhibitions of symptoms (no labels, but referring to Bipolar Disorder, Schizophrenia, and Major Depression), and the one control measure, of a ‘healthy’ individual. For this thesis, I chose to focus analyses on a comparison of participant responses to explicitly labeled mental illnesses.

The study concluded with four questions with fill-in responses to explain the participant’s stance on how they personally show consent and non-consent in sexual scenarios (*“Please specify what indicators of consent are important in order to determine full participation in a sexual activity—what YOU do to indicate consent and willingness. Please specify what indicators of consent are important in order to determine that consent is not being given for a*



*sexual activity—what YOU do to indicate you are not giving consent and are unwilling”), and how participants understand consent and non-consent of potential partners in sexual scenarios (“Please specify what indicators of consent are important in order to determine full participation in a sexual activity—what you look for in YOUR PARTNER to indicate that they are giving consent and willingness. Please specify what indicators of consent are important in order to determine that consent is not being given for a sexual activity—what you what you look for in YOUR PARTNER indicate they are not giving consent and are unwilling”).*

### **Procedures**

Upon signing up for the study on SONA systems, participants were emailed the Informed Consent Form (Appendix A) through the website so they could have the opportunity to read about the study and withdraw their participation if they thought they might find the material distressing. The study was administered in a UOIT psychology lab. Once in the lab, each study session began with a maximum of six participants completing and signing an Informed Consent Form (Appendix A) to ensure they were fully aware of what they were consenting to, and so that the collected data could be used for analyses. Next, they completed the Demographics survey, the GBI, the questions regarding mental illness and sexual consent, and lastly, ten different Vignettes. All ten vignettes were counterbalanced for each participant to control for order effects. Once the materials were all completed, participants were debriefed (Appendix B), and given the opportunity to discuss the study or ask questions, and then were free to leave.

The first research question was examined using open responses to the question “Please specify what indicators of consent are important in order to determine full participation in a sexual activity—what YOU do to indicate consent and willingness”. I analyzed the responses manually, using a thematic analysis approach. This means, data was analyzed and coded, then

categorized based on themes. Since the resulting categories emerged from the data analysis, as opposed to being imposed on the data, grounded theory was used (Glaser & Strauss, 1967). It is an approach for developing theory that is "grounded in data systematically gathered and analyzed" (Strauss & Corbin, 1994). The particular version of Grounded Theory used was Constant Comparative Method, which involves the researcher constantly going from looking at the data and doing data analysis. First, a brief overview of the entire data was conducted to get a sense of what participants said in their responses. The words that were repeated most frequently were: "asking", "discussing", "flirting", and "interest". This was duly noted to use as the foundation for broader categories that would be later created. Then, a more in-depth review of the responses was undertaken, to formally code repeated statements (e.g., "saying yes", "body language showing comfort", "that there is no impairment from alcohol or drugs"). I created a tally chart of frequently repeated statements, and when it was recognized that multiple codes represented a common idea, a theme was created (e.g., "verbal consent", "body language", "no impairment", etc). Every time a new theme was created, the data was examined again start-to-finish to begin counting the number of participants who used the frequent phrases in their response. During this process, statements that were less often mentioned (e.g., "unsure because I've ever had sex", "having medical conditions") were placed in an independent section of the tally chart. Once the themes were identified, a final scan of the responses was done to determine the size of each category. This was also in effort to make sure no codes were unmentioned or themes unlabelled.

The remaining research questions were analyzed using one-way analysis of variance (ANOVA), which is an inference-based statistical measure, meant to compare mean scores of two or more different groups. Chi-Square Test and Levene's Test were run to assess if a

significant association between variables existed, and if the groups had equal variances, respectively.

## CHAPTER IV

### RESULTS

The sample consisted of 254 respondents, with five to seven missing responses depending on the question. Of these, the majority (215) had no lifetime experience with any disorder, while several had symptoms of high mania (24), based on a cutoff of 12 on the GBI ( $M= .08$ ;  $SD= .28$ ), and self-reported clinical diagnosis (20). Qualitative (for research question 1) and quantitative analyses (for research questions 2-4) were conducted on the participant's responses. These results are outlined below.

#### **Research Question 1) What factors are deemed important in determining full consent or unwillingness to sexual activity?**

Qualitative thematic analysis was used to examine the responses on one self-report short-answer question measuring factors thought to be important in understanding sexual consent. A content analysis of the responses produced distinct themes determined to be important in identifying either full consent or unwillingness to engage in sexual activity from one's partner. From the 254 participants who responded, seven themes emerged (see Table 1): Verbal Consent (asking if this is what they want, discussing what it is they are comfortable with, telling that they are on the same page, approval for the sexual activities to continue, and permission to proceed), Body Language (engaging mutually in the sexual behaviour, flirting, facial expression of seeming willing and wanting, eye-contact during the interacting, showing comfort throughout the entire sexual scenario, openness to what is occurring, consistent interest in the partner, confidence), No Impairment (being fully conscious and awake during the sexual interaction, not

being drunk from excessive drinking, no use of illegal drugs, ability to understand what is going on, awareness of what is occurring), Non-Resistance (not physically stopping it), Positive Mood (being happy and in general good spirits—as to ensure the interaction is not a result of reacting from an upsetting event), Unsure/ Never Had Sex (stating they cannot explain the ability to consent as they have never been in a sexual situation), and Medical Conditions/Disorders (seemingly not being in the midst of an episode from a prior-known mental illness).

Table 1.

*Summary of qualitative analysis of responses to the statement “Please specify what indicators of consent are important in order to determine full participation in sexual activity- what you do to indicate consent and willingness”.*

Theme	Description	Sample (N)	Illustrative Quote
Verbal Consent	Asking, discussion, telling, approval, permission	156 (61%)	-“Asking the person, under most circumstances, is enough consent as far as I’m concerned”. -“Consent is verbally needed in my opinion, actually asking for the consent, and hearing the person say yes”.
Body Language	Engaging, flirting, facial expression, eye-contact, comfort, openness, interest, confidence	75 (29%)	-“Engaging in sexual behaviour (i.e. flirting, kissing) and make it aware to the [partner] that I am ‘interested’”. -“Having open body language, reciprocating behaviour, showing willingness of wanting to participate”.

No Impairment	Consciousness, not being drunk, no use of drugs, ability to understand, awareness, appropriate mental state	19 (7%)	-“Consider the person’s mental state- if they are intoxicated or if their judgment may be otherwise impaired or compromised, hold off. Saying ‘yes’ voluntarily is important, but they also need to be aware of the situation they are putting themselves in”.  -“Are conscious, say yes and are completely ok to participate. Make sure individual’s judgment is not impaired in any way”.
Non-Resistance	Not physically stopping it	7 (3%)	-“For me, my way of giving consent is by not stopping and continuing with the mood of the room”.  -“If they go along with whatever’s happening”.
Stable Mood	Happy, good spirits	5 (2%)	-“Happy, non-irritable, in a good mood”  -“Stable, healthy mental mind”.
Unsure/ Never had sex	Virginity, N/A	5 (2%)	-“I never had sexual activity before”.  -“I never had to gain the consent of a partner, as I’ve never been in an intimate relationship before. Therefore, I cannot answer any of these questions with absolute confidence in their correctness”.
Medical Conditions/ Disorders		3 (1%)	-“Whether I have any medical conditions or disorders, and whether or not I have any anxiety or depression issues”.

Combination	Verbal consent, body language, no impairment.	<p>-“Being of sound capable mind, who can clearly articulate consent”.</p> <p>-“I think there may be many indicators of sexual consent to be given such as: the nodding of the head. Saying things like, ‘yes’ and ‘I like that or this’, encouragement to keep going. CONSCIOUSNESS, being engaged in the activity, etc.”</p> <p>-“The person must be conscious and sober in order to be able to give complete consent. People should be enjoying themselves and show a willingness to proceed with the sexual act. I would actually say ‘yes, I want this to happen’ as an indicator of consent”.</p>
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**Research Question 2) Would participants who have either been clinically diagnosed with a disorder or exhibited symptoms of a disorder be more willing to proceed with sexual intercourse knowing their partner has a mental illness?**

To begin, chi-square analysis was conducted to determine whether participants’ responses differed depending on the type of disorder they were told their partner had. These results showed that there was a significant association between the likelihood to proceed to sexual intercourse based on the type of disorder their partner had  $\chi^2(8) = 119.2, p < 0.001$ . The frequency of responses can be seen in Table 2. The effect size for this finding, Cramer’s V, was

moderate, 0.28. When responding to which disorder they were ‘Not at all likely to proceed’ to intercourse with, 20% of the participants stated Schizophrenia, compared to 8.9% for Bipolar Disorder and 6.7% for Depression. When responding to which disorder they were ‘Completely likely to proceed’ to intercourse with, most participants stated (2.6%) stated Depression, while 1.3% for Bipolar Disorder and only 0.7% stated Schizophrenia.

Table 2.

*Comparing frequency of responses to ‘likelihood to proceed with sexual intercourse’ depending on the partner’s disorder.*

Likelihood		Bipolar Disorder	Depression	Schizophrenia	Total
	N	66	50	149	265
Not at all likely	%	8.9%	6.7%	20.0%	35.6%
Completely likely	N	10	19	5	34
	%	1.3%	2.6%	0.7%	4.6%
Total	N	247	249	249	745
	%	33.2%	33.4%	33.4%	100.0%



Given that participants differed significantly in their responses depending on the type of disorder, their responses for each separate disorder were examined. For each dependent variable (i.e., willingness to proceed to intercourse if their partner was diagnosed with a) Bipolar Disorder, b) Depression, or c) Schizophrenia), a one-way ANOVA was conducted with mental health status (self-report diagnosis vs. no self-report diagnosis but symptoms of high mania through GBI score vs. neither self-report nor symptoms) as the between-participant variable. Because the sample sizes between groups are different, report homogeneity of variance tests was conducted each time to ensure that the assumption of equal variances is not violated. So, although the sample sizes between groups were quite different, Levene's Test of Homogeneity of Variances indicated that the variances for the groups did not significantly differ. Depending on whether the ANOVA was significant, the Bonferroni Post Hoc Test was then run at a significance level of 0.05 each time for the particular mental illness.

#### **A. Bipolar Disorder.**

An ANOVA was conducted to determine whether participants with a clinical diagnosis differed in their willingness to proceed with sexual intercourse knowing their partner has Bipolar Disorder compared to those with symptoms of mental disorder and those with no diagnoses or symptoms. Levene's test of homogeneity of variances was not statistically significant ( $p=.15$ ). Thus, equality of variances can be assumed. A significant main effect was found for willingness to have intercourse with someone with Bipolar Disorder,  $F(2, 244) = 7.347, p=.001$ . Participants with a clinical diagnosis ( $M=3.11, SD =0.99$ ) reported more willingness to proceed to intercourse with a participant with Bipolar Disorder than participants with manic symptoms but no diagnosis ( $M=2.55, SD=1.27$ ) and those with neither a diagnosis

nor symptoms ( $M=2.19$ ,  $SD =1.03$ ). Refer to Table 3 for an ANOVA visual of where exactly the means do and do not differ when participants considered Bipolar Disorder.

Table 3.

Multiple comparisons of response mean (SD) for willingness towards bipolar disorder depending on mental health status

Mental Health Status	Multiple Comparisons
None (2.19)	High Mania (2.55) <sub>b</sub>
	Self-Report Diagnosis (3.11) <sub>a</sub>
High Mania (2.55)	None (2.19) <sub>b</sub>
	Self-Report Diagnosis (3.11) <sub>b</sub>
Self-Report Diagnosis (3.11)	None (2.19) <sub>a</sub>
	High Mania (2.55) <sub>b</sub>

<sub>a</sub> Means differ significantly using Bonferroni post-hoc t-tests at  $p < .05$

<sub>b</sub> Means do not differ significantly using Bonferroni post-hoc t-tests at  $p < .05$

Based on the Bonferroni post hoc test, significant differences were identified in likelihood of sexual activity with someone with Bipolar Disorder between those with ‘no lifetime experience with any disorder’ and ‘self-report diagnosis’ ( $p=.001$ ). Those with symptoms of ‘high mania’ and those with a ‘self-report diagnosis’ ( $p=.299$ ) did not differ significantly in their likelihood of engaging in sexual activity with someone with Bipolar Disorder. Both of these groups were more likely to engage in sexual activity with someone with Bipolar Disorder than those who had no lifetime experience with a mental disorder.

## **B. Depression.**

An ANOVA was conducted to determine whether participants with a clinical diagnosis differed in their willingness to proceed with sexual intercourse knowing their partner has Depression compared to those with symptoms of mental disorder and those with no diagnoses or symptoms. The Levene's test of homogeneity of variances was not statistically significant ( $p=.08$ ). Thus, equality of variances can be assumed. A significant main effect was found for willingness to have intercourse with someone with Depression,  $F(2, 246) = 3.34$ ,  $p=.04$ . Participants with a clinical diagnosis ( $M= 3.16$ ,  $SD= 0.83$ ) reported more willingness to proceed to intercourse with a participant with Depression than participants with manic symptoms but no diagnosis ( $M= 2.85$ ,  $SD =1.18$ ) and those with neither a diagnosis nor symptoms ( $M= 2.51$ ,  $SD= 1.17$ ).

However, based on the Bonferroni post hoc test, it can be seen that no significant differences in likelihood of sexual activity with someone with Depression are found between any of the mental health categories.

## **C. Schizophrenia**

An ANOVA was conducted to determine whether participants with a clinical diagnosis differed in their willingness to proceed with sexual intercourse knowing their partner has Schizophrenia compared to those with symptoms of mental disorder and those with no diagnoses or symptoms. The Levene's test of homogeneity of variances was not statistically significant ( $p=.10$ ). Thus, equality of variances can be assumed. A significant main effect was found for willingness to have intercourse with someone with Schizophrenia,  $F(2, 246) = 4.179$ ,  $p=.02$ . Participants with a clinical diagnosis ( $M= 2.05$ ,  $SD= 0.83$ ) reported more willingness to proceed

to intercourse with a partner with Schizophrenia than participants with manic symptoms but no diagnosis ( $M= 1.90$ ,  $SD= 1.12$ ) and those with neither a diagnosis nor symptoms ( $M= 1.54$ ,  $SD= 0.83$ ). Refer to Table 4 for an ANOVA visual of where exactly the means do and do not differ when participants considered Schizophrenia.

Table 4.

Multiple comparisons of response mean for willingness towards schizophrenia depending on mental health status

Mental Health Status	Multiple Comparisons
None (1.54)	High Mania (1.90) <sub>b</sub>
	Self-Report Diagnosis (2.05) <sub>a</sub>
High Mania (1.90)	None (1.54) <sub>b</sub>
	Self-Report Diagnosis (2.05) <sub>b</sub>
Self-Report Diagnosis (2.05)	None (1.54) <sub>a</sub>
	High Mania (1.90) <sub>b</sub>

<sub>a</sub> Means differ significantly using Bonferroni post-hoc t-tests at  $p < .05$

<sub>b</sub> Means do not differ significantly using Bonferroni post-hoc t-tests at  $p < .05$

Based on the Bonferroni post hoc test, significant differences were identified in likelihood of sexual activity with someone with Schizophrenia between those with ‘no lifetime experience with any disorder’ and ‘self-report diagnosis’ ( $p=.04$ ). Those with symptoms of ‘high mania’ and those with a ‘self-report diagnosis’ ( $p=1.000$ ) did not differ significantly in their likelihood of engaging in sexual activity with someone with Schizophrenia. Both of these groups were more likely to engage in sexual activity with someone with Schizophrenia than those who had no lifetime experience with a mental disorder.

**Research Question 3) Would participants who have never experienced any type of mental illness be more fearful of sexual interactions with a partner who has a mental illness?**

A chi-square analyses was conducted to determine whether participant's responses differed depending on the type of disorder they were told their partner had. These results showed that there was a significant association between fearfulness to proceed to sexual intercourse based on the type of disorder their partner had  $\chi^2(8) = 73.1, p < 0.001$ . The frequency of responses can be seen in Table 5. The effect size for this finding, Cramer's V, was moderate, 0.27. When responding to which disorder they were 'Not at all fearful' to proceed, most participants (10.3%) stated Depression, compared to 5.4% for Bipolar Disorder and 3.4% for Schizophrenia. When responding to which disorder they were 'Completely fearful' to proceed, 9.7% stated Schizophrenia, along with 5.5% for Bipolar Disorder and only 2.7% for Depression.

Table 5.

*Comparing responses to fearfulness to proceed with sexual intercourse.*

Fearfulness		Bipolar Disorder	Depression	Schizophrenia	Total
	N	40	77	25	142
Not at all fearful	%	5.4%	10.3%	3.4%	19.0%
Completely	N	41	20	72	133

fearful	%	5.5%	2.7%	9.7%	17.8%
Total	N	247	249	250	746
	%	33.1%	33.4%	33.5%	100.0%

Given that participants differed significantly in their responses depending on the type of disorder, their responses for each separate disorder were examined. An ANOVA was conducted to determine whether participants with a clinical diagnosis differed in their fearfulness to proceed with sexual intercourse knowing their partner has Bipolar Disorder compared to those with symptoms of mental disorder and those with no diagnoses or symptoms. The Levene's test of homogeneity of variances a not statistically significant ( $p=.57$ ). Thus, equality of variances can be assumed. A significant main effect was found for fearfulness to have intercourse with someone with Bipolar Disorder,  $F(2, 244) = 3.389, p = .04$ . Participants with a clinical diagnosis ( $M = 2.26, SD = 1.15$ ) reported less fearfulness to proceed to intercourse with a participant with Bipolar Disorder than participants with neither a diagnosis nor symptoms ( $M = 3.03, SD = 1.33$ ) and those with manic symptoms but no diagnosis ( $M = 3.25, SD = 1.25$ ).

Based on the Bonferroni post hoc test, significant differences were identified in fearfulness of sexual activity with someone with Bipolar Disorder between those with 'no lifetime experience with any disorder' and 'self-report diagnosis' ( $p=.04$ ). Those with symptoms of 'high mania' and those with a 'self-report diagnosis' ( $p=.60$ ) did not differ significantly in their fearfulness of engaging in sexual activity with someone with Bipolar Disorder. Those who had no lifetime experience with a mental disorder and high mania groups were more fearful to

engage in sexual activity with someone with Bipolar Disorder than those who had a self-report diagnosis.

While ANOVA was also conducted to determine whether participants with a clinical diagnosis differed in their fearfulness to proceed with sexual intercourse knowing their partner has Depression or Schizophrenia, compared to those with symptoms of mental disorder and those with no diagnoses or symptoms, analyses found that they were not significant.

**Research Question 4) Does willingness to proceed with sexual activity differ depending on the type of disorder (i.e., Bipolar Disorder, Major Depression, Schizophrenia) the partner has been diagnosed with?**

Chi-square tests were run to compare differences in responses related to willingness to proceed across three different disorders (Bipolar Disorder, Depression, and Schizophrenia).

**A. How confident would you feel?**

There was a significant association between confidence to proceed to sexual intercourse based on the type of disorder their partner had  $\chi^2(8) = 104.1, p < 0.001$ . The frequency of responses can be seen in Table 6. The effect size for this finding, Cramer's V, was moderate, 0.27. When responding which disorder they were 'Not at all confident' to proceed, most participants (18.8%) stated Schizophrenia, compared to 8.5% for Bipolar Disorder and 5.7% for Depression. When responding to which disorder they were 'Completely confident' to proceed, 1.8% stated Depression, along with 1.5% for Schizophrenia and only 1.2% for Bipolar Disorder.

Table 6.

*Comparing responses to 'confidence to proceed with sexual intercourse' depending on partner's disorder.*

Confidence		Bipolar Disorder	Depression	Schizophrenia	Total
	N	63	42	139	244
Not at all confident	%	8.5%	5.7%	18.8%	32.9%
Completely confident	N	9	13	11	33
	%	1.2%	1.8%	1.5%	4.5%
Total	N	245	248	248	741
	%	33.1%	33.5%	33.5%	100.0%

### **B. How hesitant would you feel?**

There was a significant association between the hesitancy to proceed to sexual intercourse based on the type of disorder their partner had  $\chi^2(8) = 87.1, p < 0.001$ . The frequency of responses can be seen in Table 7. The effect size for this finding, Cramer's V, was moderate, 0.24. When responding which disorder they were 'Not at all hesitant' to proceed, most participants (3.2%) stated Depression, compared to 2.5% for Bipolar Disorder and 2.3% for Schizophrenia. When responding to which disorder they were 'Completely hesitant' to proceed, 13.5% stated Schizophrenia, along with 5.2% for Bipolar Disorder and 3.5% for Depression.



Table 7.

*Comparing responses to 'hesitancy to proceed with sexual intercourse' depending on partner's disorder.*

Hesitancy		Bipolar Disorder	Depression	Schizophrenia	Total
	N	19	24	17	60
Not at all hesitant	%	2.5%	3.2%	2.3%	8.0%
Completely hesitant	N	39	26	101	166
	%	5.2%	3.5%	13.5%	22.2%
Total	N	248	249	250	747
	%	33.2%	33.3%	33.5%	100.0%

## CHAPTER V

### DISCUSSION

The aim of this study was to explore the relationship between mental illness and sexual behaviour. Specifically, perceptions of sexual consent and the role of Bipolar Disorder, in comparison to two other disorders (i.e., Depression and Schizophrenia) were examined among undergraduate university students. Analysis of the data produced four major findings. First, individuals often do not consider mental illness when reflecting on factors important for consent to sex. Second, mental health status, specifically ‘no lifetime experience with any disorder’ and ‘clinical diagnosis’, affects willingness to proceed sexually with a partner was diagnosed with either Bipolar Disorder or Schizophrenia. Students who have experience with mental illness were more accepting of and open to relationships with someone else with a mental illness compared to students who have never experienced symptoms of or been diagnosed with mental illness. Third, mental health status, specifically ‘no lifetime experience with any disorder’ and ‘clinical diagnosis’, affects fearfulness to proceed sexually with a partner diagnosed with Bipolar Disorder. Students with no experience of mental illness were wearier of an individual with this disorder compared to students who have been clinically diagnosed with a mental illness. Fourth, when comparing the three disorders, individuals are more confident with a partner who has Depression, while more hesitant with a partner who has Schizophrenia, with feelings towards Bipolar Disorder falling in the middle of these two diagnoses. Students saw some disorders as more concerning than others, which made them more hesitant to pursue a sexual relationship with an individual who had these disorders.

Qualitative analysis was conducted to determine important factors in identifying sexual consent. Participants identified three main factors as being important: verbal consent, body language, and that their partner demonstrates no impairment. The majority of respondents stated that verbal consent (e.g., saying “yes”) and body language (e.g., flirting) were the most important factors to determine sexual consent. Only three of the 254 participants mentioned mental illness in their response at all. This is problematic, as research has shown a wide-range of decision-making impairments for individuals with various mental illnesses (Tait, Chibnall, Iltis, Wall, & Deshields, 2011; Misra, Socherman, Hauser, & Ganzini, 2008; Roy-Byrne, 2001). These studies looking at informed consent to treatment and participation in clinical research support the notion that mania-induced behavior has the ability to undermine the ability to understand and appreciate information, and the ability to resist pressures from others. As such, if research has shown support for the impairment of consent for non-sexual contexts, it may also manifest similar impairments in other consent domains (Mandarelli et al., 2011). In fact, recent research has found that mental illness does have the potential to influence sexual behaviour in terms of cognitive impairment and sexual dysfunction (Adelson, 2010; Bambole et al., 2013; Dell’Osso et al., 2009; Mandarelli et al., 2011; Mazza et al., 2011). Even though psychiatric patients have a high prevalence of impaired decision-making in sexual contexts, the issue of determining sexual consent for mentally ill populations is rarely considered. It is encouraging that so many of the participants are aware of the necessity for a clear message indicating consent, but the lack of consideration for mental health issues is shown through the qualitative data analysis of the students’ personal perception of what they regard as full or unwilling sexual consent. This is especially telling as when the informed consent (Appendix A) was obtained prior to participants coming into the lab, they were specifically informed that the study was about mental illness. In

other words, even these three participants who noted concern for mental illness may not have identified mental illness as a factor in obtaining consent if they were not aware that the study was about issues related to mental illness. However, it could be argued that, even though participants did not consciously think about mental illness at the start of the study, when presented with the scenarios at the end, they demonstrated an awareness that true consent may not have been given because of the symptoms of mental illness. So, students stating that they would be hesitant to accept consent from someone displaying characteristics of a mental illness did show an awareness of the potential for diminished capacity to consent.

When analyzing the data comparing willingness to proceed with sexual activity depending on mental health status, there was a significant difference in the responses by those with ‘no lifetime experience with any disorder’ and ‘self-report clinical diagnosis’ for two of the mental illness categories (Bipolar Disorder and Schizophrenia). Specifically, those who reported having a mental illness were much more willing to engage in sexual relations after finding out their partner had a mental illness, compared to those who had never experienced a mental illness. It is likely that individuals who have been clinically diagnosed with a disorder are more aware, and thus more comfortable, with a partner who is living with their own mental illness. This also explains why those with ‘symptoms of high mania’ and ‘self-report diagnosis’ showed no significant difference between their responses. This finding is related to research done by Pratt (2015) on the experiences of individuals living with a mentally ill parent, and which found that the majority of participants described themselves as becoming more empathetic, sensitive, and accepting towards individuals with mental illnesses. This finding can be deemed positive, as those with experience with mental illness are more accepting of others with mental illness and

more willing to engage in a relationship. However, it remains true that mania can influence decision-making, thus those with clinical diagnoses appear to be downplaying the importance of cognitive distortions by not considering the impairment in sexual consent, perhaps because they do not believe their own distortions to be of concern. Of course, it is not to say that the other mental health status groups are considering the cognitive distortions of mentally ill individuals, but rather are likely reacting from fear and stigma. However, this greater level of comfort felt by those who have personal experience with mental illness may result in negative consequences in the sexual arena when disregarding the possibility for affected decision-making.

Data on fearfulness to proceed with sexual activity showed that only the situation of a partner having Bipolar Disorder (compared to Major Depression or Schizophrenia) created significant differences in responses between mental health status groups. Specifically, those who reported never experiencing a mental illness were much more fearful in engaging in sexual relations with a partner who had Bipolar Disorder, compared to individuals who reported having a mental illness. Scholars argue that this fear may be due to negative representation of the mentally ill perpetuated by mass media (Diefenbach & West, 2007; Shon & Arrigo, 2006). Because media is a significant aspect of modern society, notions that are repeatedly presented to us eventually become legitimized as true (Shon & Arrigo, 2006). According to a study done by Diefenbach and West (2007) on media and attitudes, a common target of negative portrayal in television has been mentally-ill individuals. A content analysis of network, prime-time television found a generally consistent demonstration of these individuals portrayed as violent, unpredictable, and to be feared (Diefenbach & West, 2007; Shon & Arrigo, 2006). It is unclear, then, why all participants in the current study were not equally fearful of engaging in sex with a partner who had Depression or Schizophrenia, irrespective of their mental health status. It is

possible that this is because Depression is more commonly experienced and well-understood, while Schizophrenia is more rarely experienced and less-understood due to its less-common characteristic of psychosis. From this view, then, there would be more widespread comfort with Depression and equally widespread alarm of those with Schizophrenia. However, future research should attempt to tease apart these differing attitudes to different mental disorders.

When comparing different disorders, participants had much greater reservations towards a partner diagnosed with Bipolar Disorder or Schizophrenia than they did for Major Depression. This finding is in line with research that has suggested there is more negative stigma related to some mental illnesses than others (Oliveira, Esteves, and Carvalho, 2015); indeed, individuals with psychotic disorders such as Schizophrenia report more rejection experiences (Lundenberg, Hansson, Wentz, and Bjorkman, 2008; Michalak et al., 2006) compared to those with depressive disorders (Holzinger, Beck, Munk, Weithaas, and Angermeyer, 2003). It is clear that there is a hierarchy of stigma within mental illness categories. Even though research shows that mental illnesses have the potential to influence sexual behaviour, this research demonstrates that it is certain mental illnesses that are of greater concern regarding perceptions of sexual consent.

### **Limitations**

Of course, there are limitations to any research endeavor. First, to fulfill the ethical requirements of the university's Research Ethics Board, a selection bias may have impacted the findings. Students were sent the consent form before they arrived to participate in the study, so there is a possibility that certain types of individuals chose to participate, namely those already interested in mental health issues, or interested because of their own personal knowledge and experience. Moreover, the sample was limited to students enrolled in psychology courses. Only

sampling these individuals may make results less generalizable to the wider population, as these participants had more in-depth knowledge regarding psychology than the average person, which may have helped in making sense of the relationship between consent and mental illness. Their greater understanding of psychology could possibly make them more accepting of mental illness in their sexual partners. However, as many of the students are in their first year and come from programs other than Psychology (e.g., business, nursing), they are still likely to have only a fairly rudimentary understanding of psychology, and thus can still provide valuable information of how people generally make sense of the relationship between consent and mental health.

Second, because the data came from questionnaires, the richness of data that could have come from other methodologies, such as in-depth interviews, was not available in this study. By only allowing specific set responses, this restricted the answers people could provide. However, this also meant a much greater number of individuals were able to participate, allowing examination of a greater breadth of responses and increasing the generalizability of the results. Furthermore, the closed-ended data analysis was complemented by a cursory analysis of open-ended data on the factors important in determining sexual consent.

Third, the GBI had a cut-off score for individuals considered to have bipolar affective tendencies. In other words, in order to categorize individuals as having either relevant manic or depressive symptoms, their overall test score needed to be at least 22 points. For this study, the score was then divided in half, for identifying “high/low” potential for having bipolar symptoms, and only those placed in the ‘high’ category were examined. And so, it is very possible that those participants who had an overall result close in proximity to the cut-off score were incorrectly classified. Moreover, the use of a ‘high/low’ split may have put more individuals in the category

of relevant manic symptoms through a minimum score of 12 when they would not have been when using the original cut-off score of 22. Lastly, self-report measures may not be completely reliable, as individuals may reflect on their own behaviours differently due to personal bias on a situation.

Fourth, a fairly small sample of the individuals who chose to participate in the study suffered from mental illness. Only 9.3% of the participants self-reported being clinically diagnosed with a mental disorder, and only 7.7% scored high on mania from the GBI. Because of the limited number of individuals with a clinical diagnosis or who scored high on mania, the results from comparing responses between mental health status groups may not be completely representative of the population. Future research examining a greater percentage of individuals dealing with mental illness (from a clinical diagnosis or experiencing symptoms of a disorder) would help overcome this limitation.

Fifth, there were vastly unequal sample sizes between mental health status groups. One of the criteria for conducting ANOVAs is that the groups should be roughly equal in size (Ho, 2006). Although this is not ideal, it is a natural consequence of being unable to experimentally manipulate which of the various mental health categories a person is in, and individuals were categorized based on their Demographics questionnaire and GBI results. However, it is important to note that ANOVA can be run with unequal groups if the groups have equal variance (Zar, 1996).

### **Practical Implications**

The effects of mental illness cannot necessarily be generalized from one person to the next. While it remains true that, for a small but significant number of individuals living with a



mental disorder, there are severe restrictions placed on their social, psychological, and physical wellbeing (Mulvany, 2000), it is equally important to recognize that many are still competent to provide consent in various circumstances and display a wide-range of competencies in their everyday lives (Howe, Foister, Jenkins, Skene, Copolov, and Keks, 2005). In relation to the current study, although it may be good in some ways that participants veered on the safe side in terms of not being fully confident regarding sexual intercourse with an individual who has a mental illness, the findings may actually be due to societal stigma of this group, and the reported feeling of fear speaks to a lack of understanding regarding individual capability. In order to ensure the balance between protection and autonomy of those with mental illness, it is important to implement educational programs geared towards encouraging the recognition of vulnerabilities that some individuals may have while also raising awareness to the negative and stigmatizing notions that may be representative of others reality.

This ambiguity surrounding capacity to consent influences the way legal proceedings are handled. According to a study done by Benedet and Grant (2007) examining sexual assault cases involving mentally disabled women, not only is capacity to consent rarely ever argued, even when it is mentioned, it is rarely anything more than a passing reference. The authors suggest that Crown counsel may be reluctant to raise the issue of incapacity unless it is a clear-cut case. Therefore, the only way to work against this reluctance to discuss capacity is to remove the ambiguity surrounding consent.

Thus, future research examining the effects of mental illness on sexual consent needs to develop a capacity threshold for mentally ill populations who are most vulnerable to issues of consent. This legal threshold would need to be high enough to protect individuals lacking the

ability to fully understand the sexual situation, but not too high that individuals will be stripped of their right to a sexual life. According to Benedet and Grant (2007), using the social model of disability would be helpful for inquiry into capacity.

The capacity threshold is, in essence, a normative assessment of the level of understanding that society requires before one can give consent to sexual activity. Where the law draws that line reveals much about society's attitudes toward disability, and about the potential for women with disabilities to live a full social and sexual life. We need to acknowledge this explicitly, rather than pretending that there is an objective threshold of capacity to consent that can be scientifically measured, such as, for example, through an IQ test (p. 287).

As the issue of the ability of mentally ill individuals to give sexual consent becomes increasingly acknowledged, there remains a debate surrounding concerns of protection versus infringement. When impairments interfere with an individual's capacity to make informed decisions, there is a struggle to decide who needs protection from harm and avoiding infringing on sexual freedom (Kennedy & Niederbuhl, 2001). This is because mental illnesses are heterogeneous and there is great diversity in the decision-making abilities of individuals with disorders, just as there is in the general population.

### **Conclusions**

Sexual activity can be a pleasurable and critical element of self-expression. However, mental illness is a condition that may affect the ability to sexually consent. Diagnostic criteria for Bipolar Disorder has highlighted that individuals experiencing a manic episode are inclined to engage in pleasurable activities, even though there is a high potential for painful consequences.

This is because mood elevation is related to risk-taking, impulsivity, and poor cognitive control, which can cause hypersexuality and lead to unsafe sexual behavior. It is this intrusiveness of illness that significantly impacts the lives of bipolar patients by compromising psychosocial wellbeing (Mazza et al., 2008). This study contributes to improved understanding of the intrusiveness of mental illness because the findings suggest that the sexual lives of both those who are mentally ill and those who are not are significantly impacted by perceptions of consent depending on an individual's mental health status. The uncertainty and fear felt by those who have never personally experienced mental illness ultimately creates barriers for the development of healthy, sexual relationships with potential partners who have diagnosed disorders. Thus, there is a need for greater research examining people's understanding of sexual consent and capacity to consent, especially in the context of mental illnesses such as Bipolar Disorder. By shedding light on the various obstacles that mentally ill individuals face, the complexities of sexual consent can be better understood, along with ensuring both the autonomy and protection of individuals with mental illness.

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## Appendices

### Appendix A: Informed Consent

#### **Mental Illness and Sexual Behaviour**

You are invited to participate in a research study entitled Mental Illness and Sexual Behaviour. This study (REB# 15-011) has been reviewed by the University of Ontario Institute of Technology's Research Ethics Board and has been approved as of XXX. Please read this form carefully, and feel free to ask any questions you might have. If you have any questions about your rights as a participant in this study, please contact the Compliance Officer at (905) 721-8668 ext 3693 or [compliance@uoit.ca](mailto:compliance@uoit.ca).

#### **Researcher(s):**

This research is being carried out by Mersedeh Jahanzadeh under the supervision of Dr. Leigh Harkins.

#### **Purpose and Procedure:**

This study aims to investigate student views on sexual consent and mental illness. Some of the questions will be quite personal and will ask you about your own sexual experiences and interests, and some of the questions/ situations might be upsetting to some people as they depict different disorders. If you decide to take part in this study, you will be asked to fill out 9 questionnaires that assess a number of characteristics, including general demographics, any diagnoses for mental disorders you may have received, as well as your opinion about sexual consent. Following this, you will be debriefed. The entire process will take approximately 60 minutes.

#### **Potential Benefits:**

You will receive course credit for participation and it may help you develop a better understanding of how research works.

#### **Potential Risk or Discomforts:**

Questionnaires in this study will ask about your experience with mental illness, your sexual attitudes and asks for your views on sexual situations. As you complete the materials involved in this study, you may feel uncomfortable revealing your diagnoses, past activities/ interests or find it upsetting to answer such questions if you have characteristics of a disorder or have been a victim of sexual crime. If so, please know you can stop the study at any time, leave questions blank, or contact the support service provided on the debriefing form. Please be assured that all of your responses will be anonymous, and your responses will not be connected to you in any way. Furthermore, we are aware that many people have engaged different types of antisocial and illegal activities in the past. There will be no repercussions for answering the questionnaires

honestly. Any information you will provide will be used anonymously, and aggregated with the data of the complete pool of participants. If at any point in time during the study you have any questions or concerns, please do not hesitate to inform the experimenter. At any point in time during the study, you also have the right to discontinue the study without any penalty.

**Storage of Data:**

Data will only be stored on one personal laptop, and one USB key for emergency backup. The personal laptop will be password protected, and the USB will only include encrypted zipped files to ensure data cannot be opened by any other individual. No identifying information is included in the data set anyway. No identifying information, such as your name or student ID, will appear in the database. All the data will be aggregated to further protect the confidentiality of your responses. The data will be kept indefinitely and aggregated / grouped data may be shared with other researchers as required by the ethics and professional guidelines around publication. If this is the case, none of your identifying information will be included.

**Confidentiality:**

It is entirely up to you if you want to take part. You will be asked to provide a memorable word at the end of the study, which will be linked with your responses to protect the anonymity of your data. This will mean your responses will remain anonymous, but will allow us to withdraw your data if you decide you no longer want it to be included. All data will remain anonymous by the investigator.

Confidentiality will be provided to the fullest extent possible by law, professional practice and ethical codes of conduct. Your privacy shall be respected. No information about your identity will be shared or published without your permission, unless required by law. There are some situations in which confidentiality may need to be breached - if you report the intention to harm yourself or someone else, or if you report committing a specific previous crime with a victim that can be identified. We also may have a duty to report any abuse to children under the age of 16 to the Children's Aid Society (i.e. if you provide unsolicited information about an identifiable victim). Please note that we have designed the questionnaires in a way that *should not* result in the situations described above, so please feel free to answer the yes or no questions honestly. We do ask, however, that you not provide any extra detail regarding past offences so your confidentiality can be maintained.

**Right to Withdraw:**

Your participation is voluntary, and you can choose to answer only those questions that you are comfortable with. The information that is shared will be held in strict confidence and discussed only with the principal investigator and supervisor. You may withdraw from the study at any time without affecting entitlement to research credit. If you withdraw from the research project at any time, any data that you have contributed will be removed from the study, up until March 2016, at which point the data will be analyzed and it will no longer be possible to identify your individual responses. As a participant, you are not waiving any rights to legal recourse in the event of research-related harm. To withdraw during the course of the study, verbally indicate to

the experimenter you would like to stop and withdraw, and all of your data will be discarded without having been viewed.

The process for withdrawing from the study after completion is as follows:

1. At the end of the study, you will be prompted to provide a memorable word. This word should be something that you will be able to remember, but that does not provide us with any identifiable information.
2. We recommend that you make note of your memorable word on your debrief form, or another location you can easily access (ex. Cell phone)
3. If you wish to withdraw your data, you can contact Dr. Leigh Harkins using the emails provided on your debrief form, in person, or by phone at 905-721-8668 ex.5991
4. When contacting Dr. Leigh Harkins, please clearly state your intent to withdraw your data, and provide your memorable word.
5. Providing your memorable word will allow for all data collected from you to be identified and destroyed. You *do not* have to provide a reason for withdrawal. Once you have stated your intent for your data to be withdrawn, it will not be viewed again, even in the process of withdrawal. You will be contacted to confirm your data has been withdrawn from the study

### **Participant Concerns and Reporting:**

This research project has been approved by the University of Ontario Institute of Technology's Research Ethics Board on XXX. If you have any questions, concerns, or complaints, you may contact Dr. Harkins (leigh.harkins@uoit.ca; 905-721-8668 ext. 5991). Any questions regarding your rights as a participant, complaints or adverse events may be addressed to Research Ethics Board through the Compliance Office (905 721 8668 ext. 3693).

### **Risk Assessment to Participants:**

**Social Risk:** This is no social risk applicable. There is limited opportunity to experience risk as responses are anonymous, meaning individual responses will be unknown to the researchers.

**Greater than everyday risk:** Answering questions about mental health might raise concerns about mental health for some participants. If this is the case, you will be directed towards appropriate resources to deal with these issues with qualified professionals. We encourage participants to seek help from qualified professionals using the resources provided in the Debriefing Form (Appendix B).

### **Debriefing and Dissemination of Results:**

As a participant, you are entitled to be informed of the results of this study if interested. The results may be published in an academic journal and/or presented at an academic conference. Even in this form, all data will be aggregated and remain anonymous. If participants are interested in the results of this study please contact the academic supervisor at leigh.harkins@uoit.net.

**Consent to Participate:**

1. I have read the consent form and understand the study being described
2. I have had an opportunity to ask questions and my questions have been answered. I am free to ask questions about the study in the future.
3. I freely consent to participate in the research study, understanding that I may discontinue participation at any time without penalty. A copy of this Consent Form has been given to me for my records.

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(Name or identifier of Participant)

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(Date)

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(Signature of Participant)

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(Signature of Researcher)

## Appendix B: Debriefing Form

Firstly, thank you for participating in this study, it is a huge help!

In this study you answered a series of questionnaires on diagnosed mental illnesses, past depressive and manic experiences, your sexual attitudes, your views on sexual situations, and other personal characteristics such as your perceptions of sexual scenarios in regard to consent. The purpose of this research is to determine any relationships that may exist between mental illness and capacity to give sexual consent, and how these relate to attitudes, experiences, and personal characteristics. All responses you gave over the course of this study will remain confidential in agreement with the confidentiality agreements the research team has signed. In order to ensure you can withdraw your data at any time during data collection, please make a note of your memorable word on your copy of the debrief form, or somewhere else where you can easily access it. It is important to note you will need to remember your memorable word in order to withdraw your data. If at any point in time you would like to withdraw your data, you can contact Dr. Harkins (leigh.harkins@uoit.ca; 905-721-8668 ext. 5991) and provide your memorable word. After doing so, your data will be removed from the study.

This research will hopefully increase our understanding of the impact of mental illness on consent. Although we recognize that people have a variety of sexual interests and experiences, it is important to note that any sexual contact in which the other person does not clearly provide consent is illegal. For more information on this, please see <http://www.consented.ca>.

It would be greatly appreciated if you would keep the details of this study confidential until the end of the academic year in order to help us maintain the study's integrity. We do recognize, however, that due to the sensitive nature of the topics discussed in this study, you may feel upset or distressed. If you do feel upset as a result of this study, and feel the need to discuss the study content with a counsellor, please feel free to do so. Your personal health is of the utmost importance! As a research team, we want to ensure you feel supported following study completion. If you should feel distressed, upset, or simply would like to speak to a counsellor about this study, please feel free to contact the Distress Centre. The Distress Centre is a 24-hour confidential support service, and can be contacted anonymously at the number below:

Distress Centre Durham  
1.800 452 0688

If you have any concerns about your mental health and are interested in seeking professional support, please contact UOIT's Student Mental Health Services. The university is able to offer short-term counselling and therapy services to students. Students in crisis will also be provided support and counselling as needed. There is no cost and services are confidential.

**Contact information**

Student Lifeline

905.721.3392

studentlifeline@uoit.ca

**Location**

UOIT Student Life

-North Oshawa location: U5 Building

-Downtown Oshawa location: 61 Charles Street Building, Room 225 (by appointment only)

**Hours**

Monday to Friday, 8:30 a.m. to 4:30 p.m.

You can also contact Durham's Mental Health Services (DMHS), a charitable not-for-profit agency providing services and supports to individuals and families who are living with mental health concerns.

**Main Office**

519 Brock Street South

Whitby, Ontario L1N 4K8

Phone (905) 666-0831

Toll Free: 1-855-888-DMHS (3647)

Fax (905) 666-2976



Do you have any questions about the study you would like to ask now?

If you have any further questions, concerns, or complaints about this study, you may contact Dr. Harkins ([leigh.harkins@uoit.ca](mailto:leigh.harkins@uoit.ca); 905-721-8668 ext. 5991). Any questions about your rights as a participant, complaints, or adverse events that occurred during the study can be addressed by the Research Ethics Board through the Compliance Office (905-721-8668 ext. 3693).

Once again, THANK YOU for your participation in this study!

**Appendix C: Demographics Questionnaire**

\*Please answer the following questions by checking off the appropriate answer

**1) What is your age? \_\_\_\_\_**

**2) What is your gender?**

- Female
- Male
- Other

**3) What is your ethnicity?**

- White
- Hispanic or Latino
- Black or African American
- Native American or American Indian
- Asian / Pacific Islander
- Other

**4) What is your sexual orientation?**

- Heterosexual
- Homosexual
- Bisexual

**5) What is your current relationship status?**

- Single, Never Married
- Married / Domestic Partnership
- Divorced
- Widowed

**6) Have you been clinically diagnosed with a mental disorder?**

- Yes

No

-If your answer is NO, please skip to Questionnaire D.

-If YES, could you please specify, and answer questions 7 & 8.

*(Note: If you do not wish to answer questions 6-8, you may skip to Questionnaire D).*

**Diagnosis:**

- Anxiety
- Depression
- Bipolar Disorder
- Obsessive-Compulsive Disorder
- Schizophrenia
- Post-Traumatic Stress Disorder
- Eating Disorder
- Other
- Rather not say

**7) Are you currently on any medication for the mental illness?**

- Yes
- No

**8) Do you believe your behaviour varies depending on whether or not you are on medication?**

- Yes
- No

### Appendix D: The GBI

Below are questions about behaviors that occur in the general population. Using the scale below, select the number that best describes how often you experience these behaviors:

---

1	2	3	4
never	sometimes	often	very often
or hardly ever			or almost constantly

---

#### **Keep the following points in mind:**

**Frequency:** You may have noticed a behavior as far back as the early teens, or you may have experienced it more recently. In either case, estimate how frequently the behavior has occurred since you first noticed it.

*For example: If you first noticed a behavior when you were 14, and you have experienced it repeatedly since then, mark your answer "often" or "very often – almost constantly".*

*However, if you have experienced a behavior during only one isolated period in your life, but not outside that period, mark your answer "never – hardly ever" or "sometimes".*

**Duration:** Many questions require that a behavior occur for an approximate duration of time (for example, "several days or more"). The duration given is a minimum duration. If you usually experience a behavior for shorter durations, mark the question "never - hardly ever" or "sometimes".

**Changeability:** What matters is not whether you can get rid of certain behaviours if you have them, but whether they have occurred at all. So even if you can get rid of these behaviors, you should mark your answer according to how frequently you experience them.

*(c) 1987 Richard A. Depue, Laboratory of Neurobiology of Personality, Department of Human Development, G22 MVR Hall, Cornell University, Ithaca, New York 14853.*

E-mail: [rad5@cornell.edu](mailto:rad5@cornell.edu)1234

1. Have there been periods in your life when it was almost impossible to make even small decisions, even though this may not be generally true of you?

1    2    3    4

2. Have you found your enjoyment in being with people changes – from times when you enjoy them immensely and want to be with them all the time, to times when you don't want to see them at all?

1    2    3    4

3. Have you become sad, depressed or irritable for several days or more without really understanding why?

1    2    3    4

4. Have you experienced periods of several days or more when, although you were feeling unusually happy and intensely energetic (clearly more than your usual self), you also were physically restless, unable to sit still, and had to keep moving or jumping from one activity to another?

1    2    3    4

5. Have there been periods of several days or more when you felt you needed more sleep, even though you slept longer at night or napped more during the day (not including times of exercise, physical illness, or heavy work schedules)?

1    2    3    4

6. Have people said that you looked sad or lonely?

1    2    3    4

7. Have there been periods of several days or more when you were almost constantly active

such that others told you they couldn't keep up with you or that you wore them out?

**1    2    3    4**

8. Have there been periods of several days or more when you could not keep your attention on any one thing for more than a few seconds, and your mind jumped rapidly from one thought to another or to things around you?

**1    2    3    4**

9. Have there been periods lasting several days or more when you lost almost all interest in people close to you and spent long times by yourself?

**1    2    3    4**

10. Have you had periods of several days or more when food seemed rather flavourless and you didn't enjoy eating at all?

**1    2    3    4**

11. Have there been periods of several days or more when your friends or family told you that you seemed unusually happy or high – clearly different from your usual self or from a typical good mood?

**1    2    3    4**

12. Have there been times when your memory or concentration seemed especially poor and you found it difficult, for example, to read or follow a TV program, even though you tried?

**1    2    3    4**

13. Have there been periods of time when you lost almost all interest in the things that you usually like to do (such as hobbies, school, work, entertainment)?

**1    2    3    4**

14. Have you had periods of sadness and depression when almost everything gets on your nerves

and makes you irritable or angry (other than related to the menstrual cycle)?

1 2 3 4

15. Have there been times of several days or more when you did not feel the need for sleep and were able to stay awake and alert for much longer than usual because you were full of energy?

1 2 3 4

16. Have you had long periods in which you felt you couldn't enjoy life as easily as other people?

1 2 3 4

17. Have you had periods of several days or more when you wanted to be with people so much of the time that they asked you to leave them alone for a while?

1 2 3 4

18. Have there been times of several days or more when you were so tired and worn out that it was very difficult or even impossible to do your normal everyday activities (not including times of intense exercise, physical illness, or heavy work schedules)?

1 2 3 4

19. Has your mood or energy shifted rapidly back and forth from happy to sad or high to low?

1 2 3 4

20. Have there been periods lasting several days or more when you spent much of your time brooding about unpleasant things that have happened?

1 2 3 4

21. Have there been times when you felt that you were physically cut off from other people or from yourself, or felt as if you were in a dream, or felt that the world looked different or had changed in some way?

1 2 3 4

22. Have you had periods of extreme happiness and intense energy lasting several days or more when you also felt much more anxious or tense (jittery, nervous, uptight) than usual (other than related to the menstrual cycle)?

1 2 3 4

23. Have there been times of several days or more when you were so sad that it was quite painful or you felt that you couldn't stand it?

1 2 3 4

24. Have you found that your enjoyment in eating changes – from periods of two or more days when food tastes exceptionally good, clearly better than usual, to other periods of several days or more when food seems rather flavourless and you don't enjoy eating?

1 2 3 4

25. Have there been times of several days or more when you wake up much too early in the morning and have problems getting back to sleep?

1 2 3 4

26. Have you had periods when you were so down that you found it hard to start talking or that talking took too much energy?

1 2 3 4

27. Have there been times of several days or more when, although you were feeling unusually happy and intensely energetic (clearly more than your usual self), you also had to struggle very hard to control inner feelings of rage or an urge to smash or destroy things?

1 2 3 4

28. Have there been periods other than when you were physically ill that you had more than one



of the following: (a) headaches or feelings of tightness, pressure, or "wooziness" in your head; (b) dizziness; (c) constipation or diarrhea; (d) aches and pains; (e) nausea, vomiting, or stomach aches; (f) blurred vision; (g) trembling or shaking hands; or (h) feeling too hot or too cold?

**1    2    3    4**

29. Have you experienced periods of several days or more when you were feeling down and depressed, and you also were physically restless, unable to sit still, and had to keep moving or jumping from one activity to another?

**1    2    3    4**

30. Have there been times lasting several days or more when you felt you must have lots of excitement, and you actually did a lot of new or different things?

**1    2    3    4**

31. Have you had periods of extreme happiness and intense energy (clearly more than your usual self) when, for several days or more, it took you over an hour to get to sleep at night?

**1    2    3    4**

32. Have there been times when you looked back over your life and could see only failures or hardships?

**1    2    3    4**

33. Have you experienced times of several days or more when you felt as if you were moving in slow motion?

**1    2    3    4**

34. Have there been long periods in your life when you felt sad, depressed, or irritable most of the time?

**1    2    3    4**

35. Has it seemed that you experience both pleasurable and painful emotions more intensely than others?

1    2    3    4

36. Have there been periods of several days or more when you felt guilty and thought you deserved to be punished for something you had or had not done?

1    2    3    4

37. Have you had times of several days or more when you woke up frequently or had trouble staying asleep during the middle of the night?

1    2    3    4

38. Have you had periods of extreme happiness and high energy lasting several days or more when what you saw, heard, smelled, tasted, or touched seemed vivid or intense?

1    2    3    4

39. Have there been times when you were feeling low and depressed, and you also had to struggle very hard to control inner feelings of rage or an urge to smash or destroy things?

1    2    3    4

40. Have you found that your feelings or energy are generally up or down, but rarely in the middle?

1    2    3    4

41. Have you had periods of several days or more when it was difficult or almost impossible to think and your mind felt sluggish, stagnant, or "dead"?

1    2    3    4

42. Have there been times when you had a strong urge to do something mischievous, destructive,

risky, or shocking?

1 2 3 4

43. Have there been periods of several days or more when your thinking was so clear and quick that it was much better than most other people's?

1 2 3 4

44. Have there been times when you exploded at others and afterwards felt bad about yourself?

1 2 3 4

45. Have there been times of several days or more when you were so down that nothing (not even friends or good news) could cheer you up?

1 2 3 4

46. Have there been times of a couple days or more when you felt that you were a very important person or that your abilities or talents were better than that of most other people?

1 2 3 4

47. Have there been times when you hated yourself or felt that you were stupid, ugly, unlovable, or useless?

1 2 3 4

48. Have you found that your thinking changes greatly – that there are periods of several days or more when you think better than most people, and other periods when your mind doesn't work well at all?

1 2 3 4

49. Have there been times of a day or more when you had no feelings and seemed cut off from other people?

1 2 3 4

50. Have you had sad and depressed periods lasting several days or more when you also felt much more anxious or tense (jittery, nervous, uptight) than usual (other than related to the menstrual cycle)?

**1    2    3    4**

51. Have there been times when you have done things – like perhaps driving recklessly, taking a trip on the spur of the moment, creating a public disturbance, being more sexually active than usual, getting into fights, destroying property, or getting into trouble with the law – which you later thought showed poor judgment?

**1    2    3    4**

52. Have you had periods of sadness and depression when, for several days or more, it took you over an hour to get to sleep at night, even though you were very tired?

**1    2    3    4**

53. Have you had periods lasting several days or more when you felt depressed or irritable, and then other periods of several days or more when you felt extremely high, elated, and overflowing with energy?

**1    2    3    4**

54. Have there been periods when, although you were feeling unusually happy and intensely energetic, almost everything got on your nerves and made you irritable or angry (other than the menstrual cycle)?

**1    2    3    4**

55. Have there been times when upsetting or bad thoughts kept going through your mind and you couldn't stop them?

**1    2    3    4**

56. Have there been times of several days or more when you really got down on yourself and felt worthless?
- 1    2    3    4
57. Have there been times when you had blank spells in which your activities were interrupted, and you did not know what was going on around you?
- 1    2    3    4
58. Have you had sad and depressed periods of several days or more, interrupted by periods lasting between an hour to a day when you felt extremely happy and intensely energetic?
- 1    2    3    4
59. Have there been periods of several days or more when you were slowed down and couldn't move as quickly as usual?
- 1    2    3    4
60. Have you experienced weight changes (increases, decreases, or both) of five (5) pounds or more in short periods of time (three weeks or less), not including changes due to physical illness, menstruation, exercise, or dieting?
- 1    2    3    4
61. Have there been periods of a couple days or more when sexual feelings and thoughts were almost constant, and you couldn't think about anything else?
- 1    2    3    4
62. Have you had periods when it seemed that the future was hopeless and things could not improve?
- 1    2    3    4
63. Have there been periods lasting several days or more when you were so down in the dumps

that you thought you might never snap out of it?

1 2 3 4

64. Have you had times when your thoughts and ideas came so fast that you couldn't get them all out, or they came so quickly others complained that they couldn't keep up with your ideas?

1 2 3 4

65. Have there been times of several days or more when you felt very down and depressed during the early part of the day, but then less so during the evening?

1 2 3 4

66. Have there been times when you began many new activities with lots of enthusiasm and then found yourself quickly losing interest in them?

1 2 3 4

67. Have you found that your mood consistently follows the seasons, where you have long periods of depression during the winter but mostly happy during the summer?

1 2 3 4

68. Have you had long periods when you were down and depressed, interrupted by brief periods when your mood was normal or slightly happy?

1 2 3 4

69. Have there been times of several days or more when you have struggled to control an urge to cry, have had frequent crying spells, or found yourself crying without really understanding why (other than related to the menstrual cycle)?

1 2 3 4

70. Have there been times of several days or more when almost all sexual interest was lost?

1 2 3 4

71. Have you found yourself at times feeling fearful or suspicious of your environment or other people?

**1    2    3    4**

72. Have there been periods of time when you felt a persistent sense of gloom?

**1    2    3    4**

73. Have there been times when you have felt that you would be better off dead?

**1    2    3    4**

**Appendix E: Consent & Illness**

\*Please answer the following questions by checking off Yes or No.

1. Do you always have conversations regarding consent before engaging in sexual activities?

Yes

No

2. Would you try to obtain consent every time?

Yes

No

2 A. If yes, how would you try to obtain consent every time?

Explanation:

3. If having sex with someone more than once, would the first time obtaining consent be enough?

Yes

No

4. Do you believe the length of time of a relationship changes how you would ensure consent?

Yes

No

5. Would any of the following behaviours seen in a partner change your decision to engage in sexual activities? [check those that apply]:

- A. Elevated/Euphoric Mood



- Yes, it would make it *more likely* I would engage in sexual activity
- Yes, it would make it *less likely* I would engage in sexual activity
- No
- B. Irritability/Aggressiveness
  - Yes, it would make it *more likely* I would engage in sexual activity
  - Yes, it would make it *less likely* I would engage in sexual activity
  - No
- C. Flight of Ideas/Racing Thoughts
  - Yes, it would make it *more likely* I would engage in sexual activity
  - Yes, it would make it *less likely* I would engage in sexual activity
  - No
- D. Decreased Need for Sleep
  - Yes, it would make it *more likely* I would engage in sexual activity
  - Yes, it would make it *less likely* I would engage in sexual activity
  - No
- E. Delusions/Hallucinations
  - Yes, it would make it *more likely* I would engage in sexual activity
  - Yes, it would make it *less likely* I would engage in sexual activity
  - No

6. Do you believe it would be necessary to speak with a potential partner's guardian to obtain consent if they suffered from a mental illness?

- Yes
- No

7. Do you think it is important to understand any diagnoses a person may have before getting involved with them sexually?

- Yes
- No

**Appendix F: Scenario Vignettes**

\*Please answer the following questions by checking off the appropriate answer.

**1) Imagine you are about to engage in sexual activity with someone, and you learn they are diagnosed with Bipolar Disorder. In considering moving forward with the sexual activity...**

*A. How likely would you be to proceed to sexual intercourse?*

- 1: Not at all likely
- 2: Somewhat likely
- 3: Moderately likely
- 4: Very likely
- 5: Completely likely

*B. How confident would you feel?*

- 1: Not at all confident
- 2: Somewhat confident
- 3: Moderately confident
- 4: Very confident
- 5: Completely confident

*C. How hesitant would you feel?*

- 1: Not at all hesitant
- 2: Somewhat hesitant
- 3: Moderately hesitant
- 4: Very hesitant
- 5: Completely hesitant

*D. How fearful would you feel?*

- 1: Not at all fearful
- 2: Somewhat fearful
- 3: Moderately fearful
- 4: Very fearful
- 5: Completely fearful

**2) Imagine you are about to engage in sexual activity with someone, and you learn they are drunk. In considering moving forward with the sexual activity...**

*A. How likely would you be to proceed to sexual intercourse?*

- 1: Not at all likely
- 2: Somewhat likely
- 3: Moderately likely
- 4: Very likely
- 5: Completely likely

*B. How confident would you feel?*

- 1: Not at all confident
- 2: Somewhat confident
- 3: Moderately confident
- 4: Very confident
- 5: Completely confident

*C. How hesitant would you feel?*

- 1: Not at all hesitant
- 2: Somewhat hesitant
- 3: Moderately hesitant
- 4: Very hesitant
- 5: Completely hesitant

*D. How fearful would you feel?*

- 1: Not at all fearful
- 2: Somewhat fearful
- 3: Moderately fearful
- 4: Very fearful
- 5: Completely fearful

**3) Imagine you are about to engage in sexual activity with someone who is exhibiting the following behaviours: hallucinations, delusions, and disorganized speech and behaviour. In considering moving forward with the sexual activity...**

*A. How likely would you be to proceed to sexual intercourse?*

- 1: Not at all likely
- 2: Somewhat likely
- 3: Moderately likely
- 4: Very likely
- 5: Completely likely

*B. How confident would you feel?*

- 1: Not at all confident
- 2: Somewhat confident
- 3: Moderately confident
- 4: Very confident
- 5: Completely confident

*C. How hesitant would you feel?*

- 1: Not at all hesitant
- 2: Somewhat hesitant
- 3: Moderately hesitant
- 4: Very hesitant
- 5: Completely hesitant

*D. How fearful would you feel?*

- 1: Not at all fearful
- 2: Somewhat fearful
- 3: Moderately fearful
- 4: Very fearful
- 5: Completely fearful

**4) Imagine you are about to engage in sexual activity with someone, and you learn they are diagnosed with Depression. In considering moving forward with the sexual activity...**

*A. How likely would you be to proceed to sexual intercourse?*

- 1: Not at all likely
- 2: Somewhat likely
- 3: Moderately likely
- 4: Very likely
- 5: Completely likely

*B. How confident would you feel?*

- 1: Not at all confident
- 2: Somewhat confident
- 3: Moderately confident
- 4: Very confident
- 5: Completely confident

*C. How hesitant would you feel?*

- 1: Not at all hesitant
- 2: Somewhat hesitant
- 3: Moderately hesitant
- 4: Very hesitant
- 5: Completely hesitant

*D. How fearful would you feel?*

- 1: Not at all fearful
- 2: Somewhat fearful
- 3: Moderately fearful
- 4: Very fearful
- 5: Completely fearful

**5) Imagine you are about to engage in sexual activity with someone, and you learn they have had a recent death in the family. In considering moving forward with the sexual activity...**

*A. How likely would you be to proceed to sexual intercourse?*

- 1: Not at all likely
- 2: Somewhat likely
- 3: Moderately likely
- 4: Very likely
- 5: Completely likely

*B. How confident would you feel?*

- 1: Not at all confident
- 2: Somewhat confident
- 3: Moderately confident
- 4: Very confident
- 5: Completely confident

*C. How hesitant would you feel?*

- 1: Not at all hesitant
- 2: Somewhat hesitant
- 3: Moderately hesitant
- 4: Very hesitant
- 5: Completely hesitant

*D. How fearful would you feel?*

- 1: Not at all fearful
- 2: Somewhat fearful
- 3: Moderately fearful
- 4: Very fearful
- 5: Completely fearful

**6) Imagine you are about to engage in sexual activity with someone who is exhibiting the following behaviours: elevated/euphoric mood, irritability/aggressiveness, flight of ideas/racing thoughts, and/or disordered thinking. In considering moving forward with the sexual activity...**

*A. How likely would you be to proceed to sexual intercourse?*

- 1: Not at all likely
- 2: Somewhat likely
- 3: Moderately likely
- 4: Very likely
- 5: Completely likely

*B. How confident would you feel?*

- 1: Not at all confident
- 2: Somewhat confident
- 3: Moderately confident
- 4: Very confident
- 5: Completely confident

*C. How hesitant would you feel?*

- 1: Not at all hesitant
- 2: Somewhat hesitant
- 3: Moderately hesitant
- 4: Very hesitant
- 5: Completely hesitant

*D. How fearful would you feel?*

- 1: Not at all fearful
- 2: Somewhat fearful
- 3: Moderately fearful
- 4: Very fearful

- 5: Completely fearful

**7) Imagine you are about to engage in sexual activity with someone, and you learn they are diagnosed with Schizophrenia. In considering moving forward with the sexual activity...**

*A. How likely would you be to proceed to sexual intercourse?*

- 1: Not at all likely  
 2: Somewhat likely  
 3: Moderately likely  
 4: Very likely  
 5: Completely likely

*B. How confident would you feel?*

- 1: Not at all confident  
 2: Somewhat confident  
 3: Moderately confident  
 4: Very confident  
 5: Completely confident

*C. How hesitant would you feel?*

- 1: Not at all hesitant  
 2: Somewhat hesitant  
 3: Moderately hesitant  
 4: Very hesitant  
 5: Completely hesitant

*D. How fearful would you feel?*

- 1: Not at all fearful  
 2: Somewhat fearful  
 3: Moderately fearful  
 4: Very fearful  
 5: Completely fearful

**8) Imagine you are about to engage in sexual activity with someone, and you learn they are stressed about exams. In considering moving forward with the sexual activity...**

*A. How likely would you be to proceed to sexual intercourse?*

- 1: Not at all likely
- 2: Somewhat likely
- 3: Moderately likely
- 4: Very likely
- 5: Completely likely

*B. How confident would you feel?*

- 1: Not at all confident
- 2: Somewhat confident
- 3: Moderately confident
- 4: Very confident
- 5: Completely confident

*C. How hesitant would you feel?*

- 1: Not at all hesitant
- 2: Somewhat hesitant
- 3: Moderately hesitant
- 4: Very hesitant
- 5: Completely hesitant

*D. How fearful would you feel?*

- 1: Not at all fearful
- 2: Somewhat fearful
- 3: Moderately fearful
- 4: Very fearful
- 5: Completely fearful

**9) Imagine you are about to engage in sexual activity with someone who is exhibiting the following behaviours: sadness, pessimism, guilt, and/or indecisiveness. In considering moving forward with the sexual activity...**

*A. How likely would you be to proceed to sexual intercourse?*

- 1: Not at all likely
- 2: Somewhat likely
- 3: Moderately likely
- 4: Very likely
- 5: Completely likely

*B. How confident would you feel?*



- 1: Not at all confident
- 2: Somewhat confident
- 3: Moderately confident
- 4: Very confident
- 5: Completely confident

*C. How hesitant would you feel?*

- 1: Not at all hesitant
- 2: Somewhat hesitant
- 3: Moderately hesitant
- 4: Very hesitant
- 5: Completely hesitant

*D. How fearful would you feel?*

- 1: Not at all fearful
- 2: Somewhat fearful
- 3: Moderately fearful
- 4: Very fearful
- 5: Completely fearful

**10) Imagine you are about to engage in sexual activity with someone who is exhibiting characteristics of a typical healthy adult. In considering moving forward with the sexual activity...**

*A. How likely would you be to proceed to sexual intercourse?*

- 1: Not at all likely
- 2: Somewhat likely
- 3: Moderately likely
- 4: Very likely
- 5: Completely likely

*B. How confident would you feel?*

- 1: Not at all confident
- 2: Somewhat confident
- 3: Moderately confident
- 4: Very confident
- 5: Completely confident

*C. How hesitant would you feel?*

- 1: Not at all hesitant
- 2: Somewhat hesitant
- 3: Moderately hesitant
- 4: Very hesitant
- 5: Completely hesitant

*D. How fearful would you feel?*

- 1: Not at all fearful
- 2: Somewhat fearful
- 3: Moderately fearful
- 4: Very fearful
- 5: Completely fearful

***Open-ended/Fill-in questions:***

11. Please specify what indicators of consent are important in order to determine full participation in a sexual activity—what YOU do to indicate ***consent and willingness***.

12. Please specify what indicators of consent are important in order to determine that consent is not being given for a sexual activity—what YOU do to indicate ***you are not giving consent and are unwilling***.

13. Please specify what indicators of consent are important in order to determine full participation in a sexual activity—what you look for in YOUR PARTNER to indicate that ***they are giving consent and willingness***.

14. Please specify what indicators of consent are important in order to determine that consent is not being given for a sexual activity—what you what you look for in YOUR PARTNER indicate ***they are not giving consent and are unwilling***.

