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Sexual Violence, Identity Centrality, And Mental Health Among Racial And Sexual Minoritized Individuals: An Application Of Cultural Betrayal Trauma Theory

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SEXUAL VIOLENCE, IDENTITY CENTRALITY, AND MENTAL HEALTH AMONG RACIAL AND SEXUAL MINORITIZED INDIVIDUALS: AN APPLICATION OF CULTURAL BETRAYAL TRAUMA THEORY

by

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Abstract

Sexual violence (SV) is a pressing concern in the United States. SV (i.e., unwanted sexual contact, coercion, and wanted or unwanted penetration of another). Individuals with minoritized sexual, racial/ethnic, and gender identities experience worse psychosocial outcomes than their majority counterparts. People with multiple marginalized identities have been shown to experience traumatic events at greater rates and with significantly different outcomes compared to those with one minoritized identity. Cultural betrayal trauma theory proposes that these differences in mental health outcomes may be explained in part by a shared cultural identity between a SV perpetrator and victim, which is posited to exacerbate mental health symptomology. This study's sample consisted of 276 participants who were over the age of 18 and identified with both minoritized sexual and racial/ethnic identities. Results of this study failed to support most of the study's hypotheses yet confirmed that increase in mental health symptomology is associated with SV experience. This study indicates that research of cultural betrayal trauma may necessitate a more nuanced approach among individuals with multiple marginalized identities.

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INTRODUCTION

Sexual Violence and Demographic Significance

Despite having received broad national attention, sexual violence (SV) continues to be a pressing concern in the United States. SV (i.e., unwanted sexual contact, coercion, and wanted or unwanted penetration of another) lifetime prevalence ranges from 10% - 25% among men and 30 - 40% among women (Fedina et al., 2018; Black et al., 2011; Smith et al., 2018). Some populations, such as college students, members of the LGBTQ+ community, and minoritized racial or ethnic groups, experience even greater rates (Fedina et al., 2018; Rusow et al., 2014; Kammer-Kerwick et al., 2021). In addition to physical injury, primary outcomes of SV include declines in mental well-being and increases in suicidal ideation (Black, et al., 2011; Campbell et al., 2009).

Notably, multiple studies have found anxiety, depression, and post-traumatic stress disorder (PTSD) to be strong correlates of SV among both men and women (Dworkin et al., 2021; Klump, 2006; Carey et al., 2018; Black et al., 2014; Campbell et al., 2009). A meta-analysis specifically noted lifetime symptomology prevalence of up to 65% for PTSD, 51% depression, and 40% anxiety (Campbell et al., 2009) following an experience of SV. Other outcomes include increased problem substance use, HIV/STI risk, interpersonal dysfunction, and lowered self-esteem, (Briere & Runtz, 1986; Bartholow et al., 1994; Hughes et al., 2019; Arreola et al., 2008; Rusow et al., 2014). In addition to this range of psychological, physical, and social health consequences, SV victims are also at a greater likelihood for re-victimization (Anderson et al., 2020). Although a primary goal for future research is to prevent SV from occurring, it is also important to identify risk and protective factors that may contribute to survivors' social and

psychological outcomes after SV. This holds particularly true among populations that may experience worse outcomes such as people of minoritized sexual orientations or racial/ethnic identities. Among these groups, past research has identified unique differences in the severity and frequency of SV outcomes.

People of color (POC) (i.e., individuals from minoritized racial/ethnic groups such as Black, Latino/a/x, Indigenous American, Asian, etc.) typically demonstrate worse outcomes following SV. Simultaneously, while minoritized racial/ethnic groups experience worse mental health symptomology following SV, socio-cultural factors further influence mental health. Compared to their white counterparts, POC experience greater symptoms of depression, PTSD, suicidal ideation, and substance use following SV (Slatton & Richard, 2020; Stockman et al., 2015; Bryant-Davis et al., 2009; Basile et al., 2015; Rape Network, 2016). Female African American college students were found to be more likely to blame themselves for rape events, have increased stress levels, and declines in self-esteem (Neville et al., 2004). In addition, Luo (2000) found Asian American females to report more symptoms of shame, helplessness, and embarrassment after victimization while another study found minority women in general to be more likely to engage in illicit drug use and heavy drinking compared to white counterparts (Kaukinen & DeMaris, 2005). Many POC live within cultures which stigmatize help seeking (Misra et al., 2021; Zinzow et al., 2021; Slatton & Richard, 2020; Cheng et al., 2015; Elkington et al., 2012; Satcher, 2001; Lund & Burgess, 2021). Pressures to conceal mental health problems from individuals within and outside of one's own racial/ethnic group are often coupled with unique structural barriers to treatment, including a lack of culturally informed treatment options, access to care (i.e., cost of care, insurance), a lack of knowledge about treatment options, and

discrimination among healthcare providers (Jones et al., 2015; Misra et al., 2021; Tyson et al., 2016; Murry et al., 2011; Cabassa et al., 2014). Notably, much of the research surrounding ethnic and racial minorities has traditionally centered around women, despite literature showing both heterosexual and gay or bisexual men also being susceptible to SV (Kammer-Kerwick et al., 2021).

Individuals with minoritized sexual orientations (i.e., bisexual, gay, lesbian, asexual) similarly experience worse mental health outcomes following SV and report a higher prevalence of SV than heterosexual survivors. Lifetime prevalence varies from 12% - 54% for gay or bisexual men and 16% - 85% for gay or bisexual women (Fedina et al., 2018; Rusow et al., 2014; Rothman et al., 2011) Compared to cisgendered, heterosexual male students, gender and sexual minority college students are 2.6 times more likely to experience SV (Kammer-Kerwick et al., 2021). In addition, people of minoritized sexual orientations experience decreases in community connectedness, more negative symptoms of post-traumatic stress, PTSD, depression, and higher suicide risk compared to heterosexual or cisgendered counterparts after experiencing SV (Newins, et al., 2021; Cogan et al., 2021; Ressel et al., 2018; Schwab-Reese et al., 2021; Lund & Burgess, 2021). One study found that a lack of social connectedness (i.e., social support) mediated the relationship between bisexual orientation and depressive symptoms, where bisexual women consistently experienced worse social reactions and less social support than heterosexual counterparts, subsequently resulting in greater depressive symptomatology (Sigurvinsdottir & Ullman., 2016).

Individuals with multiple minoritized identities (including sexual orientation and racial/ethnic group) who are victims of SV require further theoretical nuance. Minority stress

theory (Meyer, 2003) is one important framework that provides an explanation for the disparities in psychological outcomes (i.e., depression, PTSD, suicidal ideation) by proposing that minoritized groups uniquely experience discrimination and internalized prejudice. This then leads to a build-up of stress related to experience of discrimination or prejudice over time. Another useful theoretical perspective is Intersectionality Theory, a movement and theoretical framework, which posits that identifying with multiple marginalized identities involves complex interactions between said identities (Crenshaw 1989). These interactions result in unique psychological, social, environmental, and physical outcomes (Cho et al., 2013; Marecek, 2016). Under this framework, individuals with multiple identities (e.g., a gay, transgender Asian man) are seen to have compounding interactions with their environment. Applied to victimization research (e.g., physical violence, discrimination, verbal abuse, etc.), individuals with either single or multiple marginalized identities report greater mental distress, maladaptive coping mechanisms, worse mental health symptoms, experiences of discrimination, and disclosure of violence experiences (Mallory & Russel, 2021; Lehavot & Simoni, 2011; Balsam et al., 2015; Cyrus et al., 2017). Research involving sexual and racial/ethnic minorities' experiences following SV is limited. However, some studies address these frameworks. A community survey of LGBQ+ South Asian Americans demonstrated a disproportionate level of SV including rape and depression compared to heterosexual South-Asian Americans (Ali et al., 2022). In addition, researchers found that internalized homophobia in LGBQ+ identifying POC mediated sense of community and risk for SV (Murchison et al., 2017). Similarly, POC were more likely to experience more severe SV if their transgender status wasn't concealed, particularly compared to white transgendered identifying individuals (Staples et al., 2021).

Viewing the outcomes of SV among minoritized populations through these frameworks, minoritized individuals face unique issues with mental health and SV that majority group members (i.e., cisgendered, white, male) do not. However, while minority stress theory and intersectionality theory offer valuable frameworks for understanding socio-cultural influences on minoritized identities, they could benefit from a more nuanced approach regarding intra-group interactions. It is the goal of this study, then, to better understand mental health outcomes of SV through a culturally oriented framework in minoritized populations. Further, this study seeks to understand how the strength of one's cultural group identity is important and to explore the connections between SV, mental health, and identity centrality through the lens of Cultural Betrayal Trauma Theory (Gómez, 2011).

Cultural Betrayal Trauma Theory

Cultural Betrayal Trauma Theory (CBTT) (Gómez, 2011) is a culturally situated theory that extends the framework of Betrayal Trauma Theory (BTT) (Freyd, 1994). BTT posits that high-betrayal trauma, or experiences of violence perpetrated by a close individual (i.e., family member, friend, or other relationship), results in worse outcomes for the victim, compared to violence perpetrated by a non-close other. Betrayal by a close individual is hypothesized to result in maladaptive defense strategies, such as "dissociative blindness" where an individual unconsciously chooses to ignore or forget the betrayal of a close other (i.e., family member, friend, caretaker) in order to preserve the relationship. In the long-term this mechanism leads to difficulties, determining how much to trust others and in identifying signs of future betrayal among close individuals, which subsequently influences mental health outcomes (Gobin & Freyd, 2014). Studies have supported this theory and found that individuals with a close

relationship with an aggressor (i.e., high betrayal trauma) reported reduced trust in others, elevated symptoms of dissociation, trauma, anxiety, depression, anger, and higher suicide risk compared to individuals who were not close to the aggressor (Gobin & Freyd 2009; Edwards et al., 2012; Tang & Freyd, 2012; Gobin & Freyd 2014; Kelley et al., 2012; Goldberg & Freyd, 2006). Victims' struggles to appropriately allocate trust to others in the long-term has also been found to relate to a higher prevalence of revictimization, which subsequently negatively influences mental health issues (Tang & Freyd, 2012). CBTT, in turn, expands on this concept by extending betrayal trauma to incorporate marginalized identities.

CBTT is a framework that explores the relationship between individuals of the same cultural-group identity (i.e., people of the same race/ethnicity, gender, sexual orientation) betrayal trauma (e.g., discrimination, SV, microaggressions) and psycho-social outcomes (e.g., depression, anxiety, (intra)cultural trust) (Gómez, 2017). This relationship is called cultural betrayal trauma, where high cultural betrayal trauma is an instance in which people experience a betrayal trauma from someone of the same cultural-group identity while low cultural betrayal trauma occurs when betrayal comes from someone of an out-group identity. CBTT refines the ideas proposed in betrayal trauma theory through consideration of the unique experiences of a minoritized cultural identity, which is theorized to involve highly different standards, norms, and pressures. This is evident in the framework's inclusion of (intra)cultural pressure and (intra)cultural trust, where loss of trust with an important cultural identity (i.e., (intra)cultural trust) is coupled with pressure to not disclose trauma for the greater good of the group (i.e., (intra)cultural pressure). These values necessarily exist within all minoritized group identities,

such as the transgender or gay community, as they must battle negative stereotypes to garner a more positive public perception.

CBTT has been supported by the findings of several studies surrounding racial/ethnic identity. High cultural betrayal trauma has been linked to multiple symptoms of depression, internalized prejudice, post-traumatic stress, and anxiety following discriminatory or assault events (Gómez, 2018, 2019a, 2019b, 2019c, 2019d, 2021a, 2021b, 2022a, 2022b; Gómez & Gobin 2020). Gómez & Gobin (2022)'s qualitative study, for instance, applied CBTT to Black individuals with multiple minoritized identities. Results demonstrated difficulties in being accepted by peers in their racial/ethnic group due to maintaining simultaneous identities as a racial/ethnic and gender minority. Further, interviewee responses indicated that the exertion of (intra)cultural pressure, following a loss of (intra)cultural trust, seemed to worsen problems in their community by increasing hostilities, which were in turn linked to exacerbated mental health symptoms. Another study by Gómez (2019a) specifically viewed cultural outcomes associated with intraracial trauma and found that victims who experienced high cultural betrayal trauma saw greater feelings of internalized prejudice, more (intra)cultural pressure, and reductions in the strength of participants' ethnic identity. Ethnic identity centrality, or more broadly identity centrality, may be a very influential factor to consider in relationship to CBTT.

Ethnic identity centrality is the level of importance that an individual assigns to their racial/ethnic identity (Cross 1991). A person with high ethnic identity centrality may relate deeply to their ethnic/racial group, interacting with other group members or outwardly displaying cultural membership. Literature has thus far established the significance of ethnic identity centrality as a construct when evaluating mental health outcomes following prejudicial events

among minoritized groups. These studies determined ethnic identity centrality was associated with increases in well-being, reductions in drug use, and reductions in symptoms of depression or anxiety (Drolet & Lucas, 2020; Cobb et al., 2019; Oppedal et al., 2020). Though limited, research on individuals with multiple marginalized identities has had similar results (Tuthil, 2021; Szymanski & Lewis 2016). In addition, one novel study on Black and Latinx adults of minoritized sexual orientations showed complex interactions between race/ethnicity, sexual orientation, and mental wellbeing, indicating that the importance of one's sexual orientation in predicting mental wellbeing differed by the level of racial identity centrality (Tuthil, 2021).

In contrast to these important findings, some research has found inverse effects, where high ethnic identity centrality was associated with higher mental health symptoms following discrimination (Brook et al., 2008; Drolet & Lucas 2020; Fisher et al., 2017). Cultural betrayal trauma theory may explain these disparities, as the relationship between ethnic identity centrality and mental health outcomes could be influenced by betrayal from an individual of a shared group identity. In support, Durkee & Gómez (2022) addressed this by assessing the impact of racial insults on individuals with varying levels of racial/ethnic identity centrality. Increasing levels of racial/ethnic identity centrality were only protective against anxiety or depressive symptoms following exposure to low cultural betrayal trauma (i.e., insults from out-group members). Racial insults from in-group members resulted in more severe mental health outcomes irrespective of ethnic identity centrality. To my knowledge, no other study has examined the relationship between CBTT, ethnic identity centrality, and mental health symptoms. Further, no study has examined these relationships within the context of SV, or among individuals with multiple intersecting marginalized identities.

Current Study

Given the propensity for assaults to occur by a person known to the victim and of the same cultural group (Smith, 2018), it is important to understand associations between cultural betrayal trauma, mental health symptoms, and the extent to which this is moderated by ethnic identity centrality. Addressing this gap is necessary to continue to improve culturally informed treatment opportunities and quality for culturally diverse groups which are especially at risk of increased experiences of SV and worse psycho-social outcomes following victimization. To this end, this study proposes the following hypotheses based on the framework CBTT:

H1) Experiences of SV will be positively associated with mental health symptoms (i.e., depression, anxiety)

H2) Consistent with Betrayal Trauma Theory (BTT), experiencing (vs. not experiencing) SV victimization by close individuals (i.e., perpetrator known to the victim) will be more strongly associated with mental health symptoms than experiencing SV (vs. not experiencing) perpetrated by unclose individuals (i.e., perpetrator unknown to the victim)

H3) Consistent with Cultural Betrayal Trauma Theory (CBTT), experiencing (vs. not experiencing) SV by individuals of the same cultural identity will be more strongly associated with mental health symptoms than experiencing SV (vs. not experiencing) perpetrated by individuals of a different cultural identity.

H4) EIC will moderate the association between SV experiences (yes vs. no SV) and mental health symptoms. First, the association between SV perpetrated by individuals of the same cultural identity (vs. no SV perpetrated by individuals of the same cultural identity) and mental

health symptoms will be stronger when EIC is high. Second, the association between SV perpetrated by individuals of a different cultural identity (vs. no SV perpetrated by individuals of a different cultural identity) and mental health symptoms will be weaker when EIC is high.

METHODS

Participants and Procedures

Participants (n = 276) were recruited for this study via CloudResearch MTurk Toolkit, an online participant recruitment platform allowing researchers to target individuals based on demographic characteristics and integrate data quality tools (e.g., bot detection). To be eligible, participants must have been 18 years of age or older, and identify as both a POC (e.g., Black/African American, Asian, Native American or Alaska Native, Multiracial) and sexual minority (e.g., gay, lesbian, bisexual). Specifically, 49.6% of participants identified as Black/African American, 20.7% identified as Asian, 5.8% identified as Native American or Alaska Native, and 21% identified as multi-racial (including Latino/Latina ethnicity). 56.2% of the participants also identified as bisexual, 20.7% identified as gay or lesbian, 12.3% identified as pansexual, and 10.9% identified as some other sexual orientation. Further, 65.9% of participants identified as women, 23.2% as men, and 10.9% as another gender identity. Participants completed this self-paced survey online at a location of their choosing and $4 compensation was provided to all participants. Once they finished the survey, they were debriefed and offered information (websites, phone numbers) for mental-health resources should they desire them. Contact information for the primary investigator and institutional review board were also included. All procedures were conducted in accordance with university and institutional review board guidelines. Data collection was completed following a period of 4 months.

Measures

Cultural Betrayal Trauma

Cultural betrayal trauma was assessed with four items from the Brief Betrayal Trauma Survey (BBTS) (Goldberg & Freyd, 2006). Response options for these items included 1) never, 2) 1 time, 3) 2-5 times, 4) 6-20 times, 5) 21-100 times, and 6) more than 100 times. These items were selected because they directly addressed sexual victimization, while other portions of the scale addressed physical (non-sexual) violence. The BBTS survey has been modified to allow its use in minoritized samples (Gómez & Freyd, 2018), including questions about the ethnicity and specific relationship with the partner. However, only 4 items were selected due to their focus on SV-related trauma including: "You were made to have some form of sexual contact, such as touching or penetration, by someone of your same ethnicity with whom you were very close (such as a parent or lover)," "you were made to have some form of sexual contact, such as touching or penetration, by someone of your same ethnicity with whom you were not close," "you were made to have some form of sexual contact, such as touching or penetration, by someone of a different ethnicity with whom you were very close (such as a parent or lover)," and "you were made to have some form of sexual contact, such as touching or penetration by someone of a different ethnicity with whom you were not close." Scoring was recoded into binary variables for final analysis due to a low frequency of multiple SV events reported per participant. Items were coded as independent and grouped into 2 sets of 2. The first group included individuals by the racial/ethnic identity of their SV perpetrator in relation to their own racial/ethnic identity (i.e., same ethnicity or different ethnicity) and the second group included individuals by the closeness of their relationship with the perpetrator. Items were also coalesced

to create a general category of SV experience (yes/no). Though this measure has not undergone independent validation, the brief betrayal trauma survey does show re-test reliability (Gómez & Freyd, 2018).

Ethnic identity centrality

The Multigroup Ethnic Identity Measure (MEIM) (Phinney, 1992) is a 15-item measure which assess' three aspects of ethnic identity: positive attitudes and sense of belonging, ethnic identity achievement, and ethnic behaviors or practices. A short-form version was selected for this project utilizing items 1-6 including "I am happy that I am a member of the group I belong to," and were assessed on a 1-4 Likert scale (Strongly Disagree – Strongly Agree). Items were averaged to determine a composite score for one's ethnic identity centrality. The MEIM has produced good internal reliability ($\alpha = .9$).

Mental Health

Depression. Mental health was assessed across two domains: depression (Patient Health Questionnaire; PHQ-9) and hypervigilance. The PHQ-9 demonstrated very good validity and reliability (Kroenke et al., 2001). A 10-item measure, questions 1-9 offered the following response options: 0) not at all, 1) several days, 2) more than half the days, and 3) nearly everyday, while question 10 offered the response options: 0) not difficult at all, 1) somewhat difficult, 2) very difficult, and 3) extremely difficult. Analysis was conducted by aggregating the responses of all items. The PHQ-9 shows good internal reliability with a Cronbach's alpha of $\alpha = .89$.

Hypervigilance. Assessment of hypervigilance was conducted through a 5-item measure with a 1-5 scoring method (Not at all like me – very much like me) (Brief Hypervigilance Scale; BHS) (Bernstein et al., 2015). The BHS has shown very good internal reliability and validity, with a Cronbach's alpha of a = .81. Items included "I notice that when I am in public or new places, I need to scan the crowd or surroundings," and "I feel that if I don't stay alert and watchful, something bad will happen," and were averaged for analysis.

Analytic Plan

Prior to testing hypotheses, descriptive statistics were assessed. First, prevalence of SV for the total sample was determined and subsequently examined again across demographic groups and by type of SV. Due to small sample sizes gender, sexual orientation, and racial/ethnic identity were recoded, aggregating groups with less than 20 participants for analyses. Race was recoded into 3 groups (i.e., Black/African American, Asian, and multiracial or another identity), sexual orientation was recoded into 4 groups (i.e., bisexual, gay or lesbian, pansexual, and asexual, queer, or another identity), and gender was recoded into 3 groups (i.e., woman, man, and another gender identity). Cross-tabs were also assessed to determine the distributions of the types of SV that were experienced (i.e., the perpetrator was close or not-close to the victim, the perpetrator was of the same racial/ethnic identity or was not of the same racial/ethnic identity as the victim) across demographic groups (i.e., race, sexual orientation, and gender identity). Following this, given that a high number of individuals reported multiple types of SV, chi-square tests of independence were conducted to assess whether different SV types (i.e., close/not-close, same/different ethnicity perpetrator) are related. Bivariate correlations tests were then assessed to examine any linear associations between study variables.

A one-way ANOVA was conducted to assess Hypothesis 1, that mental health symptomology will be greater in individuals who experienced SV than those who did not. One-way ANOVAs were also conducted to assess Hypotheses 2 and 3. Hypothesis 2 posits that individuals who experience high betrayal trauma will have greater mental health symptomology than those who do not experience high betrayal trauma. Hypothesis 2 was tested by comparing mental health symptomology of individuals who reported SV perpetrated by someone who was close to them than to those who did not. Hypothesis 3 posits that individuals who experience SV perpetrated by someone of the same racial/ethnic identity will have greater mental health symptomology than those who do not experience SV perpetrated by someone of the same racial/ethnic identity. Hypothesis 3 was tested by comparing mental health symptomology in those who reported high cultural betrayal trauma to those who did not. Tukey HSD post hoc tests were also conducted where applicable to determine which groups differed. Finally, to test Hypothesis 4, that ethnic identity centrality will moderate the relationship between high cultural betrayal trauma and mental health symptomology, 2 moderation analyses were conducted using the PROCESS (Hayes, 2013) macro for SPSS. SV was modeled as a 4-group multi-categorical variable, where individuals who never experienced SV, experienced low cultural betrayal trauma only, or both low and high cultural betrayal trauma, were compared to a reference group composed of individuals who reported high cultural betrayal trauma only.

RESULTS

In this study, 63.4% (*n* = 175) of respondents reported having experienced SV of some kind irrespective of the perpetrator's ethnicity or closeness to the victim. Of the individuals who experienced SV, 62.2% (*n* = 109) experienced SV perpetrated by someone who was close and of the same racial/ethnic identity as the victim, 61.1% (*n* =107) experienced SV from someone who was close but not of the same racial/ethnic identity, 49.7% (*n* = 87) from someone who was not-close but of the same racial/ethnic identity, and 54.9% (n = 96) by someone who was not-close and not from the same racial/ethnic identity. Of women who completed the survey, 69.8% (*n* = 125) reported any experience of SV, while 67.7% (*n* = 21) of individuals of another gender identity who completed the survey reported SV and individuals who identified as men (n = 34) had a prevalence of 46%. Prevalence of SV among individuals who identified their sexual orientation as bisexual, pansexual, or their race as Black/African American, Asian, Latino/Latina, Multiracial or another racial identity can be seen in in *Table 1* below. The experience of SV perpetrated by someone of the same racial/ethnic identity was related to experiencing SV perpetrated by someone of a different ethnicity $\chi^2(3) = 24.87$, $p < .001$ and the experience of SV perpetrated by someone who was close to the victim was related to experiencing SV perpetrated by someone who was not-close to the victim $\chi^2(3) = 63.16$, $p < .001$. Chi square tests did not find significant relationships of racial/ethnic identity, $\chi^2(3) = 2.821$, $p = .244$, or sexual orientation, $\chi^2(3) = 6.86$, $p = .076$, with SV. However, a chi square test did find gender to be related to overall experience of SV, $\chi^2(3) = 11.67$, $p = .003$. Next, bivariate, point-biserial correlations, and descriptive statistics were assessed for all study variables.

Experience of any SV was positively associated with depression symptoms and hypervigilance. See *Table 2* for more descriptive statistics and bivariate correlations between study variables.

To test Hypothesis 1, two one-way ANOVA's were conducted to determine if individuals who experienced SV had higher depression symptoms and hypervigilance compared to individuals who did not experience SV. In support of Hypothesis 1, results indicated that depression symptoms were higher for individuals who experienced SV (n = 175, M = 10.96, SD = 6.92) than those who did not experience SV (n = 97, M = 9.21, SD = 6.55), $F(1, 270) = 4.16$, p = .042. Results also indicated that hypervigilance was higher among individuals who experienced SV (n = 175, M = 2.65, SD = 1.00) than those who did not experience SV (n = 97, M = 2.65, SD = 1.01), $F(1, 270) = 8.73$, p = .003.

Hypothesis 2, which states that individuals who experience SV perpetrated by someone they are close with will result in higher depression symptoms and hypervigilance compared to individuals who experienced SV perpetrated by someone they were not close to (i.e., a test of betrayal trauma), was tested by multiple one-way ANOVAs. First, a one-way ANOVA was conducted to assess differences in depression symptoms across four groups. Individuals who reported no SV had the lowest depression symptoms (n = 97, M = 9.21, SD = 6.55), while those who reported SV perpetrated by someone who they were not close (n = 48, M = 10.25, SD = 7.30) and those who reported SV perpetrated by someone they were close to (n = 24, M = 10.38, SD = 7.05) had reported less depressive symptomology than individuals who experienced SV perpetrated by close and not-close individuals (n = 103, M = 11.43, SD = 6.74). However, these differences across groups were not statistically significant $F(3, 268) = 1.78$, p = .152.

A one-way ANOVA conducted to assess differences in hypervigilance across these four groups was significant $F(3, 268) = 4.05$, $p = .008$. Specifically, individuals who experienced no SV reported the lowest hypervigilance ($n = 97$, $M = 2.28$, $SD = 1.01$) while those who experienced SV perpetrated by a not-close individual reported ($n = 48$, $M = 2.43$, $SD = .92$) and those who reported SV perpetrated by a close individual ($n = 103$, $M = 2.71$, $SD = 1.07$) were greater than those who reported no SV experience. However, these categories were slightly lower than hypervigilance scores of individuals who experienced SV perpetrated by separate individuals who were both close and who were not close to the victim ($n = 103$, $M = 2.75$, $SD = 1.02$). Tukey HSD post-hoc tests failed to support Hypothesis 2, finding that only the mean difference in hypervigilance scores between individuals who experienced no SV and those that experienced SV from someone who they were close with and another person who they were not close with was significant ($p = .006$, 95% CI (-.84, -.10)).

Next, to test Hypothesis 3 which states that individuals who experience SV perpetrated by someone of the same racial/ethnic identity will experience more depressive symptoms and hypervigilance (i.e., test of cultural betrayal trauma), additional one-way ANOVAs were conducted. Four groups were compared: no SV experience, SV perpetrated by someone with a different racial/ethnic identity than the victim, SV perpetrated by someone with the same racial/ethnic identity, and SV perpetrated by multiple individuals, one with a different racial/ethnic identity and someone else with the same racial/ethnic identity. Depression symptoms were lowest for individuals who reported no SV ($n = 97$, $M = 9.21$, $SD = 6.55$), followed by those who experienced SV perpetrated by someone with a different racial/ethnic identity ($n = 44$, $M = 8.95$, $SD = 6.24$), those who experienced SV perpetrated by someone with

the same racial/ethnic identity (n = 51, M = 11.02, SD = 7.34) and those who experienced SV perpetrated by individuals with both the same and different racial/ethnic identities (n = 80, M = 12.03, SD = 6.85). Results indicated that there were statistically significant differences in depression symptoms across groups, $F(3, 268) = 3.37$, p = .019. However, Tukey HSD post hoc analyses did not support Hypothesis 3 as it found that the only groups that differed significantly from each other were those who did not experience SV and those who experienced SV perpetrated by both same racial/ethnic identity and different racial/ethnic identity perpetrators (p = .031, 95% CI (-5.45, -.19)).

Next, differences across these four groups were assessed through hypervigilance. Individuals who experience no SV reported the lowest hypervigilance (n = 97, M = 2.28, SD = 1.01), those who experienced SV perpetrated by someone with a different racial/ethnic identity as second lowest (n = 44, M = 2.30, SD = .90), those who experienced SV perpetrated by someone of the same racial/ethnic identity (n = 51, M = 2.53, SD = .99) as the second highest, and individuals who experienced SV by perpetrators of the same and different racial/ethnic identities as the highest (n = 80, M = 2.93, SD = 1.00). Differences between groups were statistically significant, $F(3, 268) = 7.32$, p <. 001. However, again, Tukey HSD post-hoc tests failed to support Hypothesis 3 by finding significant differences only between no SV experience and experiences of SV form both the same and different racial/ethnic identities (p < .001, 95% CI (-1.04, -.27)) and between SV perpetrated by both the same and different racial/ethnic identities and SV perpetrated by someone of a different ethnicity (p = .004, 95% CI (-1.11, -.15)).

Finally, to test whether individuals' ethnic identity centrality moderates the relationship between the independent variable of SV type (i.e., victim/perpetrator ethnicity concordance) with

depressive symptoms and hypervigilance, respectively, two moderation analyses were conducted using the PROCESS macro for SPSS (Hayes, 2013). Specifically, these analyses were conducted to test Hypothesis 4, which states that ethnic identity centrality will have a stronger association with depressive symptoms and hypervigilance when SV is perpetrated by an individual of the same racial/ethnic identity as the victim, and that ethnic identity centrality will have a weaker association with depressive symptoms and hypervigilance when SV is perpetrated by an individual of a different racial/ethnic identity. The first moderation analysis assessed depressive symptoms. Racial/ethnic identity of the perpetrator with respect to the victim was coded as a multicategorical variable with 4 groups: no SV experience, different racial/ethnic identity, same racial/ethnic identity, and separate individuals where one has the same and the other has a different identity. SV experienced by an individual of the same racial/ethnic identity as the victim was used as the reference group against which all other groups were compared. Using ethnic identity centrality as a moderator, depressive symptoms as the outcome, and the racial/ethnic identity of the SV perpetrator with respect to the victim as a predictor variable, the overall model was found to be statistically significant $F(7, 264) = 2.41$, $p = .021$. However, no interactions between ethnic identity centrality and SV type were statistically significant. For full model results, see *Table 3.*

The second model assessed hypervigilance scores. With racial/ethnic identity as a multicategorical predictor and ethnic identity centrality as a moderator, the overall model was also found to be statistically significant $F(7, 265) = 4.07$, $p < .001$. However, none of the interactions between ethnic identity centrality and SV type were statistically significant. See

Table 4 below for full model results. Ultimately, results from both moderation analyses for depressive and hypervigilance symptoms failed to support Hypothesis 4.

DISCUSSION

The primary purpose of this study was to examine potential differences in mental health outcomes (i.e., depression symptoms and hypervigilance) among individuals with minoritized sexual and racial/ethnic identities based on their history of SV, including individuals' closeness with the perpetrator and concordance between the victim and perpetrator's racial/ethnic identity, and their ethnic identity centrality. In doing so, this study extends the current literature by applying cultural betrayal trauma theory and ethnic identity centrality to better understand the nuanced links between SV and mental health symptoms among individuals with multiple marginalized identities. Consistent with extant literature (Dworkin et al., 2017), results of this study showed that the experience of any SV was positively related to greater depression symptoms and hypervigilance, supporting the first hypothesis. However, contrary to hypotheses 2 and 3 and existing literature (Gómez, 2018; Gómez & Freyd, 2018), neither symptoms of depression nor hypervigilance scores differed significantly based on individuals' relationship with the perpetrator (close/not-close) or through racial/ethnic identity concordance between the victim and perpetrator (same/different). Further, analysis of ethnic identity centrality as a moderator of the associations between SV type with depression symptoms and hypervigilance did not support the hypothesis (H4) that, when ethnic identity centrality is high, experiencing SV by someone of the same racial/ethnic identity will relate to more depression symptoms and hypervigilance.

Prior studies have conceptualized betrayal trauma theory and cultural betrayal trauma theory as frameworks which explain the circumstances that lead traumatic events to be more

influential on mental health outcomes in minoritized populations (Gómez, 2017; Freyd, 1994; Gómez & Gobin, 2020). The breakage of trust held within important social and cultural bonds adds trauma to the experience of SV, which can be seen among differences in mental health outcomes between those who have and those who have not experienced high cultural betrayal trauma or high betrayal trauma (i.e., same racial/ethnic identity perpetrator or close relationship perpetrator). However, this study did not identify such differences in analysis. It should be noted that SV was coded as a binary "yes or no" response in this study; it is possible that betrayal trauma theory or cultural betrayal trauma theory could be better understood by examining the frequency or severity of SV experienced, as well as considering other factors such as the recency of the experience(s), situational factors like substance use, and coping and recovery processes that occurred post-victimization (Burns & Sinko, 2023; Fisher et al., 2017; Pegram & Abbey, 2019). The trust lost from a single experience of SV may be more easily repaired, while multiple experiences may reinforce the damage and subsequently exacerbate mental health symptomology (Gilroy & Carroll, 2009). Individuals who have experienced SV multiple times by a perpetrator of the same racial/ethnic identity or a close individual may result in more mental health symptoms compared to those who only experienced such an event once. As such, these frameworks may be better viewed as explaining the long-term circumstances that influence psychological outcomes in victims of SV. This may be particularly salient among minoritized communities, where individuals are likely to experience both cultural betrayal trauma and betrayal trauma simultaneously; SV is most likely to be perpetrated by an intimate partner or someone who is known to the victim (Basile et al., 2022).

Though ethnic identity centrality did not moderate the relationship between high cultural betrayal trauma and symptoms of depression or hypervigilance, it is worth noting that there was a negative correlation between symptoms of depression and ethnic identity centrality (i.e., strong ethnic identity centrality associated with lower depression symptoms). Although this association was not explicitly hypothesized, it does corroborate the findings of some literature which has shown that ethnic identity centrality can be protective (Cobb et al., 2019). Among minoritized groups, which experience greater stressors due to discrimination or prejudice, EIC may be positive. Strong EIC may be associated with greater social ties to a community of racial/ethnic peers, which offers a buffer against internalized thoughts or behavior (e.g., self-blame) that lead to mental health outcomes like depression. Though literature on this interaction is limited, some studies have indicated that internalizing behavior may be reduced while externalizing behaviors remained unaffected among individuals with minoritized identities who have strong identity centrality (Petruzzella et al., 2019; Meca et al., 2015; Blacklock et al., 2020).

Limitations and Future Research

It is important to note several methodological limitations of this study. A larger sample size should be prioritized in the future to adequately compare groups within each category (i.e., compare SV perpetrated by someone with the same ethnic/racial identity to those who experienced SV by someone with a different ethnic/racial identity). Future research could also use the full multigroup ethnic identity measure in place of the shortened version used for this study. Doing so would allow for analyses by subscales (i.e., ethnic affirmation/belonging, ethnic behaviors, ethnic identity achievement), which could be used to assess aspects of identity centrality that may differentially moderate the relationship between SV type and mental health

symptomologies. Similarly, future studies should evaluate the centrality of other identities, including those of sexual orientation and gender identity. Identification with a given group may have a separate meaning from identification with another group. Individuals may experience and react differently to betrayal among different group identities (e.g., Gilroy and Carroll, 2009). Individuals who have multiple marginalized identities must parse through the expectations and values within and between their identities as they cope with SV. It is likely then, that while (intra)cultural trust may be violated within one's racial/ethnic group, strong identification with another social group or identity could further influence psychological or social outcomes. These connections must be addressed in future research as considerations of intersectionality may improve cultural competency across methods of treatment (Garran & Rozas, 2013).

Another important limitation of this research is its limited information about individuals' experiences of SV. Though over 60% of the sample reported some form of SV, it is impossible to determine the recency of the event. As such, mental health outcomes may have been influenced by the time between the SV event and the participants' completion of the survey. It is possible that, given enough time or mental health treatment, mental health outcomes were reduced by the time of the study. Further, this study did not evaluate other forms of trauma, such as prejudice or discrimination. The experience of prejudice is theorized under cultural betrayal trauma theory to be a formative factor in the building of (intra)cultural trust, an adaptive response within minoritized communities to protect against societal traumas. The breakage of (intra)cultural betrayal is considered fundamental to cultural betrayal trauma, as the loss of the deep bonds formed with one's cultural group relates to negative outcomes (e.g., depression symptoms, dissociation, etc.) (Gómez, 2017; Gómez, 2022c). As such, discrimination

experiences could be influential in the development of (intra)cultural trust and, subsequently, outcomes following a traumatic event.

EIC may also be relevant to understanding the association between loss of (intra)cultural trust and negative outcomes. It is feasible that the level of one's EIC could influence the experience of societal traumas or the formation of (intra)cultural trust within minoritized groups. This interaction could be realized as an increased emphasis on the ties, values, beliefs, and expectations held within one's cultural group (Lee & Ahn, 2013). As such it is important that future research incorporate societal traumas, like prejudice, into analytical models to test their fit in the broader framework.

Implications

The experience of SV can be traumatic for many people. Cultural betrayal trauma theory attempts to conceptualize traumatic events within the cultural group they occur in and has commonly been explored through betrayals of a single identity. The theory posits that cultural betrayal trauma is triggered by the experience of SV by someone of the same identity (whether it be gender, racial/ethnic, sexual orientation) if they share (intra)cultural trust (Durkee & Gómez, 2022). Yet, the path form SV to mental health outcomes under this framework may be influenced by both individual and environmental factors. Thus, cultural betrayal trauma should be evaluated as a theory which considers the cumulative impact of traumatic experiences, as they apply to individuals with shared lived experiences, rather than a general, shared group identity.

Coupled with a minoritized status or multiple marginalized identities, the psychological effects of SV can be severe, which necessitates that research and treatment methods be informed

and respective to the unique needs of any specific group. The unique difficulties faced by people of minoritized identities – particularly those with multiple marginalized identities – include a lack of culturally competent treatments, social stigma, loss of social support, identity suppression (i.e., individuals who hide their identity from loved ones or other close relationships), discrimination, and more (Murchison et al., 2017; Misra et al., 2021; Marecek, 2016; Lehavot & Simoni, 2011; Sigurvinsdottir & Ullman, 2016). Though many of the hypotheses formed for this study were not supported, it remains important that future research focus on the pathways that link SV to mental health outcomes among minoritized populations. The necessity of such research is evident in the "real world," where these interactions may realize into mental health difficulties (Mallory & Russel, 2021; Ali et al., 2022; Fedina et al., 2018; Schwab-Reese et al., 2021) that co-occur with other health risk behaviors and outcomes such as problem substance use, risk-taking behavior, and suicidality (Lehavot & Simoni, 2011; Baiden et al., 2020; Nemoto et al., 2004). Examining these factors through frameworks such as intersectionality theory, cultural betrayal trauma theory, betrayal trauma theory, or minority stress theory, is needed as it allows specific address of the political, environmental, psychological, social, and cultural influences that lead to these outcomes in historically underrepresented groups (Rice et al., 2019). Such research can be used to inform treatment methods and help practitioners target the most salient areas of concern, better serving populations that often experience substantial barriers to treatment (Sue, 2006; Chu et al., 2016).

APPENDIX

Table I

Sexual Violence within Demographic Groups

Variable	%	N
Age (*M* = 30.79, *SD* = 7.84)		
Racial/ethnic identity		
Black/African American	63.0%	85
Latino/Latina	69.6%	39
Asian	57.5%	32
Pacific Islander	100%	2
Native American	78.6%	11
Multiracial	70.7%	41
Another identity	50.5%	4
Sexual Orientation		
Gay/Lesbian	54.5%	30
Bisexual	69.0%	107
Pansexual	69.7%	23
Asexual	43.8%	7
Another identity	66.7%	6
Gender Identity		
Questioning	50.0%	1
Nonbinary/Genderqueer/Genderfluid	67.9%	19
Woman	69.8%	125
Man	46.0%	29
Another identity	100.0%	1

Table 2

Descriptive Statistics and Simple Bivariate Correlations

Variable	Mean	SD	1	2	3	4	5	6	7	8
1) SV	--	--	-	.068	.61**	.51**	.60**	.55**	.123*	.177**
2) Ethnic Identity Centrality	2.80	.72		-	.13*	.11	.04	.11	-.134*	.114
3) Same racial/ethnic identity, close relationship SV	--	--			-	.60**	.34**	.29**	.054	.096
4) Same racial/ethnic identity, not-close relationship SV	--	--				-	.34**	.42**	.114	.222**
5) Other racial/ethnic identity, close relationship SV	--	--					-	.54**	.207**	.247**
6) Other racial/ethnic identity Not-close relationship SV	--	--						-	.202**	.246**
7) Depression Symptoms	10.33	6.83							-	.552**
8) Hypervigilance	2.52	1.02								-

Note. Same racial/ethnic identity and close relationship, Same racial/ethnic identity and not close relationship, Other racial/ethnic identity and close relationship, Other racial/ethnic identity and not-close relationship SV refer to the racial/ethnic identity of the sexual violence perpetrator with respect to the racial/ethnic identity of the victim (Same racial/ethnic identity, different racial/ethnic identity) and the closeness of the relationship of the perpetrator with the victim (Close relationship, Not close relationship)
* $p < .05$ ** $p < .01$

Table 3

Moderation Analysis: Influence of Sexual Violence Type and Ethnic Identity Centrality Predicting Depression Symptoms

Model Summary							
	R	R-Sq	MSE	F	Df1	Df2	p
	.25	.06	45.05	2.41	7.00	264.00	.021*

Model	Coeff	Se	t	p	LLCI	ULCI
Constant	16.72	3.68	4.55	.000**	9.48	23.96
SV type (reference = same racial/ethnic identity only)						
Other racial/ethnic identity	-.41	5.87	-.07	.945	-11.97	11.16
No SV experience	-5.02	4.46	-1.13	.261	-13.80	3.76
Both same racial/ethnic identity SV experience and other racial/ethnic identity SV experience	-2.87	4.92	-.58	.560	-12.55	6.81
Ethnic Identity Centrality	-2.14	1.33	-1.60	.110	-4.76	.49
SV type * ethnic identity centrality interaction (reference = same racial/ethnic identity only)						
Other racial/ethnic identity * Ethnic Identity Centrality	-.33	2.01	-.16	.869	-4.28	3.62
No SV experience * Ethnic Identity Centrality	1.22	1.60	.76	.446	-1.93	4.38
Both same racial/ethnic identity SV experience and other racial/ethnic identity SV experience * Ethnic Identity Centrality	1.50	1.74	.86	.389	-1.92	4.91

Note. The reference group for SV Type were individuals who experienced sexual violence perpetrated by someone of the same racial/ethnic identity as them.
* p < .05 *** p < .001

Table 4

Moderation Analysis: Interaction of Sexual Violence Type and Ethnic Identity Centrality Predicting Hypervigilance

Model Summary	R	R-Sq	MSE	F	Df1	Df2	p
	.31	.10	.97	4.07	7	264	.000***

Model	Coeff	Se	t	p	LLCI	ULCI
Constant	2.76	.54	5.12	.000***	1.70	3.82
SV type (reference = same racial/ethnic identity only)						
Different racial/ethnic identity only	-.43	.86	-.51	.614	-2.13	1.26
No SV experience	-1.20	.65	-1.83	.068	-2.48	.09
Both same and different Racial/ethnic identity	-.48	.72	-.67	.502	-1.90	.93
Ethnic Identity Centrality	-.09	.20	-.445	.66	-.47	.30
SV type * ethnic identity centrality interaction (reference = same racial/ethnic identity only)						
Different racial/ethnic identity * Ethnic Identity Centrality	.08	.29	.27	.787	-.50	.66
No SV experience * Ethnic Identity Centrality	.35	.23	1.49	.137	-.11	.81
Both same and different Racial/ethnic identity * Ethnic Identity Centrality	.32	.25	1.25	.213	-.18	.82

Note. The reference group for SV Type were individuals who experienced sexual violence perpetrated by someone of the same racial/ethnic identity as them.
*** $p < .001$

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