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Review

Exploring the Increased Risk of Post-Traumatic Stress Following a Sexual Assault: Implications for Individuals Who Identify as a Sexual Minority

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Abstract: Decades of research have enhanced our understanding of the psychological impact of sexual victimization, including risk factors through which post-traumatic stress disorder (PTSD) manifests. Research on sexual assault and PTSD predominately reflects the experience of heterosexual women, yet sexual minorities are both at increased risk of sexual assault and suffer greater negative health outcomes from it. In these cases, PTSD is linked to a clearly identifiable cause, thereby making it possible to identify individuals at risk, enhance interventions immediately following the traumatic event, and offer services to mitigate further harm. This narrative review explores the potential risk factors for PTSS and PTSD among individuals who experience sexual assault and identify as a sexual minority. Knowledge of these compounding risk factors among service providers will assist in obtaining sexual assault disclosures in a sensitive and supportive manner, leading to the provision of early interventions to mitigate the risks of developing PTSD following sexual assault. The findings suggest that empirical investigation is urgently required to develop evidence-informed practices in providing targeted interventions for sexual and gender minorities following a sexual assault and mitigating further adverse health outcomes.

Keywords: sexual victimization; sexual orientation; LGBTQ; minority stress; mental health

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1. Introduction

Sexual assault is an interpersonal trauma that causes significant distress and often challenges the survivor's sense of control, safety, meaning, and perception of self and the world around them [1,2]. The physical, sexual, and psychological consequences of sexual victimization often have long-lasting effects on an individual's well-being and future functioning [1]. Post-assault, many sexual assault survivors experience health outcomes such as injuries, sexually transmitted diseases, gynecological problems, depression, anxiety, or post-traumatic stress disorder (PTSD) [2,3]. Most research on sexual assault and PTSD reflects the experience of heterosexual women despite the wealth of empirical evidence demonstrating that sexual minorities are both at increased risk of sexual assault [4–6] and suffer greater mental and physical health disparities compared to heterosexuals [7]. Established risk factors for PTSD include gender, level of education, history and number of trauma exposures, previous mental disorders, and a history of exposure to interpersonal violence [8]. Several of these risk factors occur at higher rates among sexual and gender minorities, thereby highlighting the need for an exploration of the prevailing risks of PTSD following sexual assault within this population. This narrative review explores the potential risk factors for PTSS and PTSD among individuals who identify as a sexual minority, as outlined by Shalev et al. [8], and addresses an urgent need for empirical exploration of these risks to mitigate further adverse health outcomes post-assault.

Sexual minorities are defined as individuals whose sexual orientation and sexual practices differ from heterosexuals, including lesbian, gay, bisexual, or pansexual people [9]. Individuals who identify as a sexual minority are at greater risk of sexual victimization than

individuals who identify as heterosexuals [10,11] in both childhood and adulthood [12]. According to the US-based National Intimate Partner and Sexual Violence Survey (NISVS) [13], while all lesbian, gay, and bisexual (LGB) individuals are at a greater risk of experiencing sexual assault than individuals who identify as heterosexuals, there are notable variances among subgroups. The NISVS reported that 46% of lesbians and 75% of bisexual women experienced sexual assault during their lifetime, while 40% of gay men and 47% of bisexual men were sexually victimized [13]. Sexual minority men are at greater risk of experiencing rape than heterosexual men [4]. Bisexual women were the highest risk group for sexual victimization by any type of perpetrator, including intimate partners [13]. These statistics provide insight into the increased risk of sexual violence among sexual minorities.

The rates at which LGB individuals experience sexual assault in Canada are less clear. The General Social Survey (GSS) on Canadians' Safety reports that LGB individuals are twice as likely to be sexually assaulted than heterosexual individuals, and bisexuals are nine times more likely to experience sexual assault than heterosexuals [6]. The GSS presents a homogeneous experience among sexual minorities, and its current categorization precludes understanding the problem's gendered scope. Its survey categories are represented as lesbian, gay, or bisexual, meaning that differences among male, female, and/or transgender bisexuals are unknown [6]. This is problematic as sexual assault remains a primarily gendered crime, with females being the most common victims [2]. While the prevalence of sexual assault perpetrated against unique sexual minority groups remains unclear, the research is consistent that sexual minorities experience significantly elevated rates of sexual victimization compared to the cis-gendered heterosexual population.

The occurrence of sexual assault among sexual minorities and the related outcomes may be associated with stigma and erroneous pathology historically associated with the sexual minority identity [7]. For decades, researchers have reported a critical need for methodologically rigorous data for female sexual minorities, including enhanced research on sexual victimization, unique risk factors, and adverse outcomes of victimization. However, the mechanisms used to research females identifying as a sexual minority are poorly established [14,15], given that many studies aggregate data into broad categories such as LGBTQ. This neglect has inhibited understanding of the unique mental and physical health risks among sexual minority survivors of sexual assault [14,15].

2. Post-Traumatic Stress Disorder and Sexual Assault

The Diagnostic and Statistical Manual V (DSM 5) characterizes PTSD by a range of criteria, beginning with exposure to or experiencing actual or threatened death, serious injury, or sexual victimization [16]. The effects of PTSD are persistent and long-lasting, and impact multiple areas of functioning [16]. PTSD is precipitated by various risk factors such as a "female sex, childhood trauma, fewer years of schooling, prior mental disorders, exposure to four or more traumatic events, and a history of exposure to interpersonal violence" [8]. The intensity of trauma exposure, and the lack of control and unpredictability of the event, are also believed to influence the development of PTSD [8], and the experience of sexual assault is a type of traumatic event that is characterized by an imbalance of power and control [1]. Furthermore, Ullman [17] explored factors associated with PTSD symptom severity among sexual assault survivors and found that a history of trauma, lack of social support, self-blame, perceived threat during the assault, and avoidance coping were associated with greater PTSD symptom severity among survivors.

Negative mental health outcomes are common among all survivors of sexual assault (regardless of sexual orientation), and psychopathology is present in various diagnostic categories [3]. Sexual assault is considered the highest predictive risk factor for PTSD [18,19], and PTSD is one of the most frequent diagnoses among survivors of sexual trauma [1,2,20]. In the first two weeks following a sexual assault, nearly all survivors (94%) experience PTSS, which includes nightmares, flashbacks, intrusive thoughts, dissociation, affect dysregulation, substance use, and suicidality [21]. These symptoms typically abate in approximately half of sexual assault survivors within a three-month period, while 47% will continue

to experience one or more symptoms of PTSD three months post-assault. The severity of symptoms fluctuates over time and may be influenced by additional stressors or life events [8]. Research suggests that approximately 31% of female sexual assault survivors meet the criteria for a diagnosis of PTSD compared to only 5–7% of the general female population who have never experienced sexual assault in their lifetimes [10,21].

Research exploring PTSD following sexual assault among sexual minorities is limited. However, Kerridge et al. [10] found that lesbian, gay, and bisexual (LGB) individuals are at a significantly greater risk of developing PTSD in their lifetime than heterosexuals. Specifically, female bisexuals were three times more likely to develop PTSD. Similarly, lesbian women (12.1%), gay men (7.8%), and male bisexuals (11.1%) were at increased risk [10]. These findings are consistent with Lehavot and Simpson [22], who explored the experience of trauma and PTSD in lesbian and bisexual (LB) veterans. They found that veterans who identified as lesbian or bisexual experienced high rates of PTSD and depression that were exacerbated by a sexist and discriminatory environment.

3. Minority Stress Theory

Minority stress theory is a useful framework to explore the unique compounding risk factors of PTSS and PTSD for sexual minorities following sexual assault. Minority stress theory hypothesizes that: (1) members of disadvantaged social groups are exposed to more stress than members of advantaged groups, and (2) as a result, they suffer from more mental health disorders [7,23]. For decades, minority stress theory has been widely utilized to account for the significant physical and mental health disparities of sexual minorities [11,24] and its central tenets continue to have relevance today [25]. Minority stress posits that the prejudice, stigma, and discrimination directed toward members of socially disadvantaged groups, such as sexual minorities, bring about unique stressors and that these stressors cause adverse health outcomes, including mental health disorders [7,25]. Individuals who identify as a sexual minority face considerable public scrutiny relative to their sexual identity, influencing an internalized self-perception as devalued and stigmatized [23]. Furthermore, the daily stressors of living in a heterosexist society compound existing stressors and erode coping mechanisms, ultimately negatively impacting health and well-being [26]. According to Frost and Meyer [25], stigma-related stress precipitates emotion dysregulation and interpersonal difficulties that may pose an increased risk for mental health disparities.

4. Risk of PTSS and PTSD for Sexual Minority Survivors of Sexual Assault

A History of Trauma

The risk of post-traumatic symptomatology is heightened with previous exposure to a traumatic event [27]. Sexual minorities experience elevated rates of childhood sexual abuse compared to individuals who are heterosexual [28–30]. Furthermore, adolescence is a time when sexual minorities are especially vulnerable to sexual violence [31]. Childhood sexual abuse is a particularly strong risk factor for sexual revictimization [32,33]. A meta-analysis examining the rate of sexual revictimization found that nearly half (47.9%) of all child sexual abuse survivors experience subsequent sexual assaults in their lifetime [32,33]. Sexual revictimization is inherently a second trauma for a sexual assault survivor and is a relatively common occurrence among heterosexual survivors [32,33]. Evidence suggests that child sexual abuse is associated with psychiatric symptoms [30], an established risk factor for PTSD [18,27,34]. Similarly, sexual revictimization increases symptoms of PTSD when compared with those who experience a single victimization [35,36].

Previous trauma experiences are associated with poor perceived health [37] and the development and severity of PTSS/PTSD [34,36]. The development of PTSD is associated with a dose-response, whereby increasing exposure to trauma increases the severity of symptoms [38]. Individuals who identify as LGBTQ+ have an elevated risk of trauma exposure and minority stress [39–41], largely based on increased rates of discrimination and victimization enacted in a heteronormative society [41,42]. Sexual and gender mi-

norities experience heightened traumatic exposure and stress throughout their lifespan, including physical and sexual violence [41,43], child maltreatment [41,44], harassment and discrimination [42,44], isolation, and rejection by family and friends [39]. Although not all traumatic events (discrimination) meet the narrow definition of PTSD in the DSM, these cumulative lifetime stressors have been associated with numerous adverse mental health outcomes, inclusive of PTSS and PTSD [39,41,43,44]. Furthermore, repeatedly experiencing interpersonal traumas throughout the lifespan is associated with the development and severity of PTSD [38], and much of the trauma experienced by sexual and gender minorities is interpersonal in nature. Thus, consideration should be given to assessing sexual and gender minorities who have been sexually assaulted for a history of trauma to explore a potential increased risk for PTSS or PTSD post-assault.

5. History of Mental Health Disorders

Prior mental health disorders are predictive of an increased risk of PTSS and PTSD [8,18,27,34]. Sexual minorities suffer from worse mental health outcomes than their heterosexual counterparts, including substance use disorders, affective disorders, and suicidal behavior [7,45,46]. For example, decades of research have established that LGB individuals are at much higher risk of substance use disorders than individuals who identify as heterosexuals [14,15,47]. Studies indicate that LGB youth are at 190% higher risk than individuals who identify as heterosexuals for substance use disorders, with subgroups such as bisexuals and females reflecting exceptionally elevated rates (340% and 400% respectively). Similarly, suicidal ideation and attempts are also elevated among sexual and gender minorities. Individuals who were rejected after *coming out* were eight times more likely to attempt suicide than the general population [48].

Compared to heterosexuals, sexual minorities face disproportionately higher rates of mental health disparities that are compounded by socially stigmatizing living conditions and minority stress [45]. Keating and Muller [42] posit that LGBTQ+ individuals who attribute their trauma to discrimination are more likely than individuals who experience non-discrimination-related traumas to experience PTSS. Furthermore, emerging evidence supports the conclusion that PTSD is the primary adverse mental health outcome following sexual assault for sexual minorities [49]. This is consistent with heterosexual assault survivors (3). Given the increased incidence of psychiatric histories among sexual and gender minorities, further empirical research is needed to explore psychiatric histories and PTSD among sexual assault survivors.

6. Lack of Support

Lack of social support following a traumatic event is a risk factor for PTSS and PTSD [27]. Following a sexual assault, many heterosexual survivors seek out family, friends, and intimate partners as instinctual safe zones. When these disclosures are responded to empathically, the survivor may choose to disclose their victimization to a variety of community responders, including healthcare providers, social services, and the criminal justice system [50]. Motivations for disclosure are often associated with seeking social support, professional treatment, or strengthening interpersonal bonds [51]. The importance of the disclosure experience cannot be understated, as the type of response survivors receive following a sexual assault disclosure can significantly impact their recovery trajectories, either supporting or inhibiting the healing process [52,53].

The lack of support that survivors experience due to negative responses to sexual assault disclosures (e.g., victim blaming, stigma) is strongly associated with PTSS following a sexual assault [54,55]. Disbelief, blame, or dismissiveness during sexual assault disclosures reinforces societal adherence to rape myths and may reinforce survivors' feelings of shame [55]. When sexual assault survivors report the assault and receive negative reactions or disbelief, they are unlikely to disclose subsequent sexual victimization [53] or seek out additional formal support services [56]. Since revictimization with sexual violence is common [57], and individuals who have been victimized on more than one occasion

report fewer positive responses from formal providers compared to those who have been singly victimized or non-victimized [57], the risk for PTSS may be heightened. Revictimized sexual assault survivors associate self-blame and psychological vulnerability with the negative responses they receive following disclosure [58]. Furthermore, Ullman and Relyea [59] have also found a bidirectional relationship between PTSS, maladaptive coping, and negative social reactions. For instance, individuals who receive negative feedback from their environment tend to engage in more maladaptive coping strategies, which, in turn, may facilitate further negative feedback from their environment. This feedback results in greater PTSS. Therefore, the quality of the disclosure experience for sexual assault survivors influences the level of support a survivor will receive.

Minority stress theory posits that sexual minorities experience significant discrimination, leading to heightened experiences of stress [7]. Furthermore, dominant sexual and gender scripts accepted in the general public view sexual assault through a heteronormative lens whereby men are perpetrators and women are victims [60]. This narrow perception of the occurrence of sexual assault poses challenges for sexual minority individuals to attain support. Expectations of negative disclosure experiences may place sexual minorities at greater risk of developing PTSS, as they are prone to anticipate and expect rejection from society and may refrain from seeking support post-assault [7].

In a study on hypervigilance among LGBTQ individuals, hypervigilance was ever-present as participants worried that their identities could solicit discrimination and rejection from others. Thus, many individuals who identified as LGBTQ were constantly assessing their environment for "unsafe" people, causing distrust in others [24]. This hypervigilance may be an important consideration for sexual and gender minority survivors of sexual assault as they may fear disclosing the assault to a potentially negative or discriminatory individual. Furthermore, sexual assault disclosure among sexual minority populations may have increased barriers due to concealment tactics, expectations of rejection, internalized stereotypes, and self-stigma [7]. According to Ullman and Filipas [55], stigmatized or blaming responses received following a sexual assault may influence survivors to internalize the trauma and suffer lifelong consequences, including increased severity of PTSS. As such, sexual assault survivors who identify as a sexual minority may lack the professional support they require to mitigate symptoms of PTSD, thereby precipitating psychological suffering in isolation.

Anderson et al. [49] found that sexual and gender minorities who were "out" or open about their identity were more likely to acknowledge their sexual assault, thereby fostering the ability to attain external support. However, individuals who minimized their sexual assault and did not identify it as a rape experienced increased PTSD. This supports the notion that minority stress and societal stigma may exacerbate PTSS or PTSD due to concealment strategies among the sexual minority population.

Moreover, in a qualitative study of sexual minority men who have experienced sexual assault, men consistently indicated that they expected to encounter discrimination and disbelief if they disclosed sexual assault. Their expectations led many male survivors to refrain from disclosing sexual assault and this contributed to an increase in their traumatic response [56]. Research indicates that anticipated social rejection in minority populations is a stronger predictor of negative psychological outcomes than the actual negative experience [7]. These expectations of rejection result in a chronic hyper-vigilance in the individual, which is not only used as a method of defensive coping but is also consistently present in his or her everyday life [7]. Sexual minorities may avoid disclosure of sexual assault and subsequent help-seeking strategies altogether due to this anticipation of rejection and feelings of shame [61]. Lack of disclosure inherently leads to a lack of social or professional support following the traumatic event. Fear of negative reactions to disclosure increases stress [47], decreases support, and may increase a survivor's risk of PTSS or PTSD.

7. Interpersonal Violence: Stigma and Internalized Homophobia

Interpersonal violence is a predictive risk factor for PTSD [8] and homophobia is a form of gender-based interpersonal violence [62]. Consistent with minority stress theory, sexual minorities are likely to experience the stress of compounding stigma following a sexual assault due to the victim-blaming messages they receive from society as a whole, as well as the internalization of socially sanctioned homophobia [7,15,63,64]. Defined as "a set of negative attitudes and affects toward homosexuality in other persons and toward homosexual features in oneself" [65], internalized homophobia occurs when the individual accepts and internalizes the negative stereotypes and myths about homosexuality that persist throughout mainstream culture [66]. This leads to intense feelings of shame, concealment of sexual orientation, and increased psychological distress [67]. Lehavot and Simoni [15] argue that there is a subgroup of sexual minorities who never fully accept their sexual orientation due to pervasive anti-gay socialization. These messages lead to devaluation and poor self-regard in the individual and have been linked to shame, psychological distress, loneliness, lower self-esteem, and greater substance use [15,66]. Gold et al., [66] found that internalized homophobia among gay men is a strong predictor of PTSS outcomes. High rates of internalized homonegativity have also been associated with adulthood PTSD among gay men with a history of childhood sexual abuse [66] and thus, further exploration of homophobia as a risk factor for PTSD following sexual violence is needed.

The stigma and discrimination that sexual minority individuals experience is compounded following a sexual assault. Research regarding bisexual women's vulnerabilities and consequences of sexual assault point to several ecological factors, including "a cultural milieu prone to hypersexualization, objectification, and dehumanization; . . . stereotypical understandings of bisexuality in women that may engender negative appraisals and resulting aggression toward this group" [14]. There is a growing body of research that suggests that bisexual women experience minority stress and more severe adverse health outcomes because they are doubly stigmatized and marginalized from both heterosexual and gay/lesbian communities due to strongly held stereotypes and societal perceptions [28]. For example, bisexual women are often stereotyped as hypersexual and as engaging in performative sexual acts for attention from a predominantly heterosexual male audience [14]. Research also demonstrates that both heterosexual and homosexual communities perceive bisexuals as greedy, addicted to sex, unable to commit to monogamy, and generally promiscuous [14]. In a study conducted by Brewster et al. [68], internalized biphobia was directly related to greater psychological distress and lower well-being among bisexual participants. Due to these socially condoned stigmas and stereotypes, it is plausible that bisexual individuals are at a high risk of experiencing victim-blaming messages and internalized homophobia upon disclosure of their sexual victimization, thereby potentially contributing to PTSS or PTSD.

Lesbian women are also at risk of experiencing compounding stigma and stereotyping post-assault [7,28]. This social stigma contributes to internalized homophobia. The experience of internalized homophobia is correlated with concealment strategies whereby the sexual minority individual does not disclose their sexual orientation as a survival strategy [67]. Lesbian women who have been victimized by another woman may experience compounding stress as disclosure of the assault may necessitate coming out or, conversely, further increasing their avoidance and concealment strategies [7]. This raises the question of lesbian women's unique experiences of stigma and gender stereotyping, particularly in their contact with community responders such as law enforcement, whose negative reactions remain heavily influenced by gender roles and perfect victim stereotypes (e.g., male perpetrators and female victims) [69]. As a result, stigma and internalized homophobia can become an insurmountable barrier for not only reporting the assault but also seeking support when symptoms of PTSD are present or emerging. The internal resources needed to cope with internalized homophobia add another compounding stress factor, depleting vital internal resources to cope with PTSS and PTSD.

8. Discussion

Minority stress experiences are important considerations for preventing, assessing, and treating sexual assault outcomes. This review identifies unique compounding stressors such as childhood sexual abuse and revictimization, prior trauma exposure, lack of support, unsupported disclosures, and internalized stigma and homophobia. These are experienced by sexual minorities as a result of minority stress. This review also identifies how these factors combine with the risk of PTSS and the development of PTSD following the experience of sexual assault. Moreover, these factors may compound among sexual and gender minorities to further increase the risk of negative mental health outcomes, namely, PTSD. For example, negative disclosure experiences may lead to maladaptive coping, and maladaptive coping is also associated with internalized homophobia.

These findings have important practical implications. Understanding the risks for PTSD and its prevalence among sexual and gender minorities is important for health and social service providers working within the LGBTQ+ community. Directly assessing risks among sexual and gender minorities may uncover opportunities to provide psychoeducation regarding associated risks, practical interventions such as harm reduction, enhanced protective factors, positive community supports, and mental health interventions to address psychiatric distress following sexual assault. Community service providers such as mental health workers, police, clergy, healthcare providers, and educators must be cognizant of the increased risk for PTSS and PTSD among sexual and gender minorities who experience sexual assault. Given that the risks for developing PTSD are well known and are also heightened among sexual and gender minorities, practitioners who are knowledgeable of these risks will be better equipped to respond to disclosures in a supportive manner and develop early interventions to mitigate PTSS and PTSD.

Much of the current research is based on cross-sectional studies, thereby limiting conclusions on causal factors for the risk of PTSS or PTSD [27]. Additional research is needed on sexual assault among sexual and gender minorities and its associated adverse mental health outcomes. Specifically, experimental and longitudinal designs to uncover predictive risk factors of PTSD among the LGBTQ+ population are needed. Additional research focusing on the unique risk factors of sexual minorities who have experienced sexual assault is necessary to design interventions to meet their unique needs. Furthermore, understanding how risk factors interact and influence PTSS is vital.

9. Conclusions

Sexual and gender minorities experience sexual assault at a higher rate than their heterosexual counterparts and PTSS and PTSD are common adverse health outcomes of sexual violence. Several risk factors have been associated with PTSS and PTSD, all of which are prevalent among individuals who identify as a sexual or gender minority. Thus, with an increased risk for PTSD, and heightened rates of sexual violence among the LGBTQ+ population, further research is needed to empirically explore the conferring risks for PTSD among sexual and gender minorities. Further, increased attention is needed on developing interventions to mitigate risks and increase protective factors for this marginalized group.

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