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ORIGINAL PAPER

# Psychological Outcomes of Within-Group Sexual Violence: Evidence of Cultural Betrayal

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**Abstract**
Cultural betrayal trauma theory is a new framework for understanding trauma-related mental health outcomes in immigrant and minority populations. The purpose of the current study is to empirically test cultural betrayal trauma theory. We hypothesized that the association between within-group sexual violence and mental health outcomes would be stronger for minorities. Participants ($N=368$) were minority and majority college students, who completed online measures of sexual violence victimization and mental health outcomes. A MANOVA revealed that the link between within-group sexual violence and total trauma symptoms, depression, sexual abuse sequelae, sleep disturbance, and sexual problems was stronger for minorities. This study provides evidence for cultural betrayal trauma theory, as the findings suggest that outcomes from the same experience—within-group sexual violence—is affected by minority status. This work has implications for how mental health is understood, investigated, and treated in immigrant and minority populations.

**Keywords** Cultural betrayal trauma theory · Rape · Dissociation · Trauma symptom checklist · College students

## Background

Interpersonal violence is prevalent, with some minority populations being at increased risk for victimization based on race/ethnicity [multiracial; African American; Latino/a American; Native American], sexual orientation [lesbian; gay; bisexual], and disability [physically disabled or mentally handicapped] (National Center for Victims of Crime [50], National Coalition Against Domestic Violence [51], Rape, Abuse, and Incest National Network [54]). Interpersonal violence victimization is linked with many outcomes, including posttraumatic stress disorder (PTSD; Kelley et al. [40]), depression, anxiety (e.g., Goldsmith et al. [24]), dissociation, hallucinations [30, 32], non-suicidal self injury, and suicidality [20, Gomez and Freyd [30]. Though the majority of trauma work has been focused on White American samples [3, 58], contextual factors, such as societal trauma (e.g., [5]), societal status [41], and cultural values (e.g., [20]), may impact outcomes of violence victimization [4, 5, 8, 37].

## Theoretical Framework

Cultural betrayal trauma theory (CBTT; [29]) is a new theoretical framework that is derived from the literatures that document the harm of violence victimization (e.g., [14, 22, 35]) and stress the importance of contextual factors in trauma sequelae (e.g., [4]). According to CBTT (e.g., [29]), societal trauma (e.g., oppression; discrimination) creates the context for violence perpetrated by a perceived fellow minority to be a harmful contributor to posttraumatic distress (Fig. 1).

Similar to how interpersonal relationships are conceptualized in betrayal trauma theory (e.g., [15, 21]), some individuals in minority populations may feel attachment towards other in-group minority members. This bond, termed *(intra) cultural trust*, is similar to racial loyalty [1, 56] and may serve as a protective factor against the effects of discrimination. Given that CBTT (e.g., [29]) contextualizes relationships within larger sociocultural dynamics, *(intra)cultural* trust creates a vulnerability for cultural betrayal to be harmful. In immigrant and minority populations, within-group

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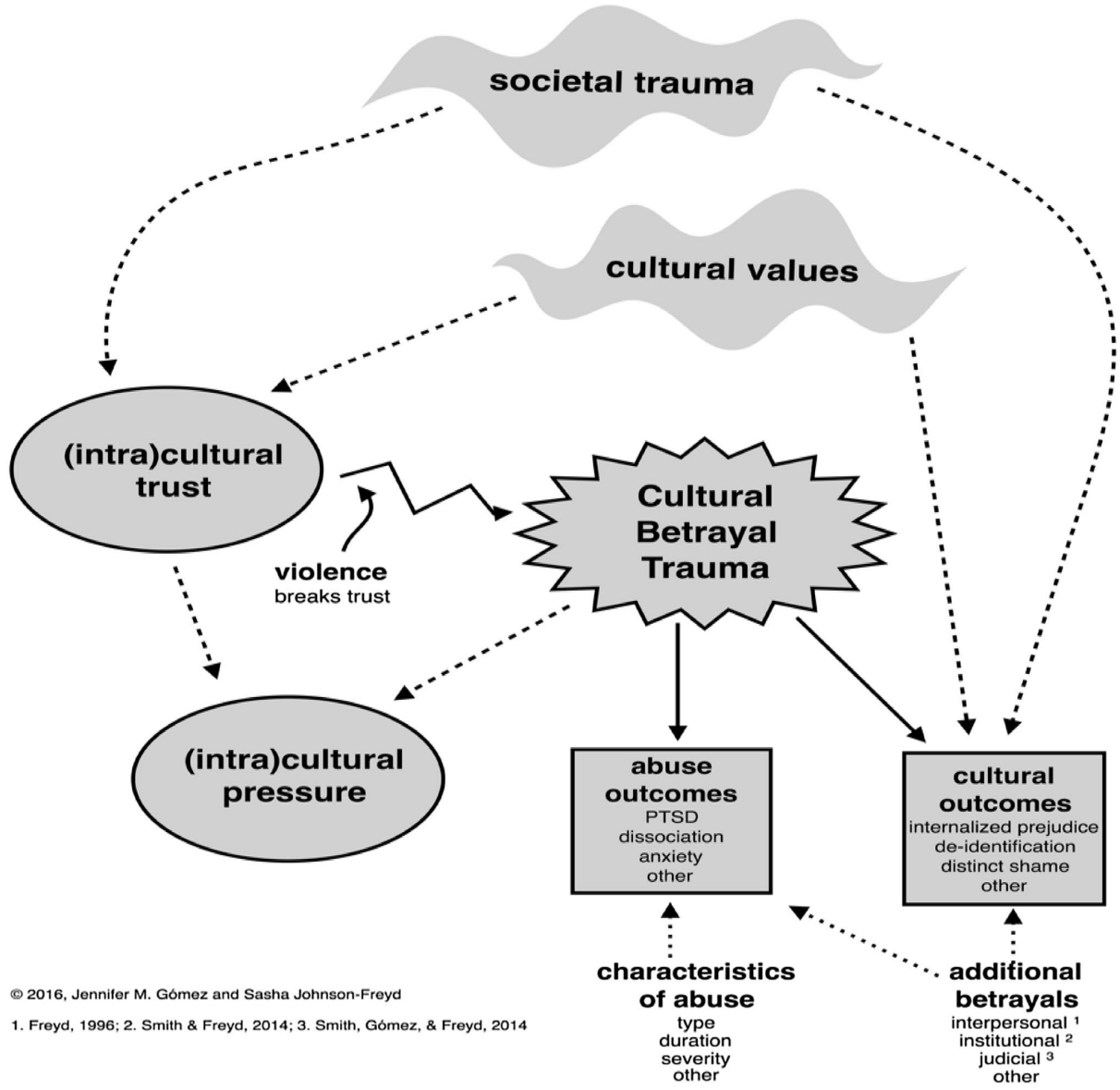


**Fig. 1** Cultural Betrayal Trauma Theory, *reprinted with permission*

violence is conceptualized as a *cultural betrayal trauma* and predicts diverse outcomes (Fig. 2). Though within-group violence happens across all groups, according to CBTT [e.g., 26], the cultural betrayal would be present only in violence perpetrated within cultural minorities; within-group violence between majority members (e.g., White and otherwise societally privileged Americans in the U.S.) would not be conceptualized as a cultural betrayal and therefore, would not be presumed to have the same deleterious effects.

While the tenets of CBTT are promising in understanding immigrant and minority mental health outcomes, there has been little empirical work to test the theory. Given the high rates of sexual assault on college campuses (e.g., [34, 53]), the purpose of the current study was to use a diverse sample of minority and majority college students to test cultural betrayal trauma theory. Specifically, within-group sexual violence victimization will be assessed to determine if there is evidence for this type of violence being a "cultural betrayal trauma" in immigrant and minority populations. In doing so, this study has implications for understanding how violence victimization may differentially affect immigrant and minority mental health. We hypothesized that:

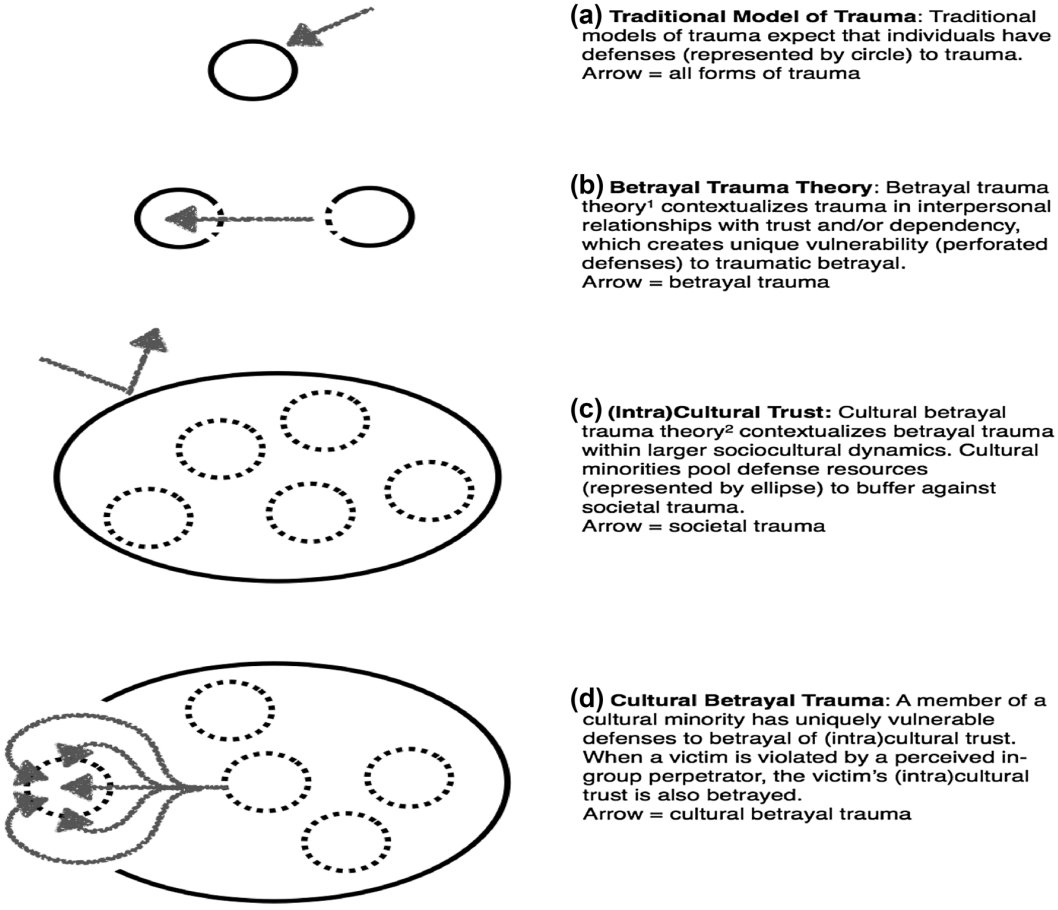


**Fig. 2** Impact of societal trauma on within-group violence, *reprinted with permission*

(1) Minorities would have experienced higher rates of sexual violence compared with their majority member counterparts.
(2) In the entire sample, within-group sexual violence victimization would impact outcomes from the Trauma Symptoms Checklist [17]: trauma symptoms (total), dissociation, anxiety, depression, sexual abuse sequelae, sleep disturbance, and sexual problems.
(3) Minority status would not independently impact the aforementioned outcomes: trauma symptoms (total), dissociation, anxiety, depression, sexual abuse sequelae, sleep disturbance, and sexual problems.
(4) Minority status would moderate the association between within-group sexual violence victimization and trauma outcomes, with the associations being stronger for minority members.

## Methods

### Participants

Participants ($N = 368$) were students at a large, public Northwestern university. The university institutional review board (IRB) reviewed and approved the current study. Participants were coded as 'minority' ($N = 179$) and 'majority' ($N = 189$). Minority participants (coded as '1') were those who self-identified as an ethnic minority, Muslim, foreign national, and/or non-heterosexual by answering affirmatively to: "I identify as a racial/ethnic minority, a Muslim, a foreign national (e.g., born and raised outside of the U.S.), or a non-heterosexual (e.g., gay, lesbian, bisexual)." Majority participants (coded as

'0') self-identified as *not* having any of those minority identities: "I do not identify as a racial/ethnic minority, a Muslim, a foreign national (e.g., born and raised outside of the U.S.), or a non-heterosexual (e.g., gay, lesbian, bisexual)." Participants wrote in their age, gender, and ethnicity. Minorities were slightly older than majority members (minority: $M = 20.12$ years, $SD = 2.58$; majority: $M = 19.49$ years, $SD = 2.00$; $t\,(332.798) = 2.60$, $p = .010$), but similar in gender distribution (minority: 65% female, 34% male, 1% transgender, 1% gender queer; majority: 66% female, 33% male, 1% gender queer).The majority members were 87% White/Caucasian (13% other ethnicities; all participants in this group self-identified as not being a minority), whereas the minority participants were ethnically diverse, with 35% Asian/Asian American/Pacific Islander, 21% White/Caucasian, 14% Hispanic/Latino, 12% Mixed Race or Other, 8% Black/African American, 7% Arab/Middle Eastern, 1.1% Jewish, and 0.5% Native American.

## Data Collection

Students in the university human subjects pool chose to participate in research or complete an alternate assignment for class credit. Students who elect to be participants select studies based on time availability without prior knowledge of the study content. Participants gave informed consent and completed the 30-min online study at a location of their own choosing. Participants could decline to answer any question and could withdraw from the study at any time without penalty.

## Measures

These data are part of a larger study (*author citation*), therefore only some of the measures are listed here.

### Sexual Experiences Survey—Modified for Cultural Betrayal [SES-CB]

The authors modified the Sexual Experiences Survey [44], a 14-item questionnaire, to retrospectively assess for sexual violence victimization perpetrated by in-group member(s). Participants responded on a Likert scale, *1*- never to *4*- often. The modified instructions define an in-group member as "someone who holds the same Group Identity." The instructions further provide the primary group identity that the participant reported in the previous section and indicate that questions should be answered based on this group identity. A sample item is: "A trusted or depended upon in-group member obtained sexual acts with you such as anal or oral intercourse when you didn't want to by using threats or physical force (twisting your arm, holding you down, etc.)." An alpha score is not appropriate to calculate for this measure because the SES-CB assesses incidents of abusive events, not an underlying construct. An original SES version has reported stable responses in test re-test reliability [43]. Though the adapted measures has not been independently validated, the original victimization items of the SES have been shown to be a valid measure of sexual violence victimization [43]. Items from the SES-CB, along with the items from the BBTS-CB (see below Goldberg and Freyd [23]) were averaged to create a mean score of within-group sexual violence.

### Brief Betrayal Trauma Survey—Modified for Cultural Betrayal [BBTS-CB]

The authors modified two items from the 12-item BBTS [23] to retrospectively assess for sexual violence victimization perpetrated by in-group member(s). The instructions and Likert scale were the same as those for the SES-CB [44]. A sample item is: "You were made to have some form of sexual contact, such as touching or penetration, by an in-group member with whom you were not close." Like the SES-CB, a measure of internal consistency is not appropriate for the BBTS-CB, as it is not a measure of an underlying construct. Though the adapted measure has not been independently validated, the original BBTS demonstrated good test re-test reliability and is considered a valid measure of victimization [23]. As mentioned, the BBTS-CB items were added to the SES-CB items to calculate a single variable that is the mean score of within-group sexual violence.

### Trauma Symptom Checklist (TSC-40; Elliott and Briere [17])

The TSC-40 [17] is a 40-item measure that assesses trauma symptoms with the following scale and subscales: trauma symptoms (total scale; 40 items), dissociation (6 items), anxiety (9 items), depression (9 items), sexual abuse trauma index (for clarity, hereafter labeled *sexual abuse sequelae*; 7 items), sleep disturbance (6 items), and sexual problems (8 items). Some items are present in more than one subscale, thus, the number of items from all subscales exceeds the total number of items for the scale. Response choices are on a Likert scale from *1*- never to *4*- very often. A sample item is: *How often have you experienced each of the following in the last two months? Flashbacks (sudden, vivid, distracting memories)*. The TSC-40 has good predictive validity of post-traumatic states [2]. In our sample, internal consistency ranged from good to excellent: total TSC ($\alpha = 0.96$), dissociation ($\alpha = 0.77$), anxiety ($\alpha = 0.82$), depression ($\alpha = 0.85$), sexual abuse sequelae ($\alpha = .76$), sleep disturbance ($\alpha = 0.81$), and sexual problems ($\alpha = 0.86$). Items from each subscale were averaged to create mean variables for trauma symptoms [total], dissociation, anxiety, depression, sexual abuse sequelae, sleep disturbance, and sexual problems, respectively.

## Analysis

Descriptive statistics were run to assess means, standard deviations, and proportions for sexual violence victimization, trauma symptoms [total], dissociation, anxiety, depression, sexual abuse sequelae, sleep disturbance, and sexual problems. T-tests and Chi square analyses were run to assess group differences between minority and majority members. A multivariate analysis of variance (MANOVA) was run with trauma symptoms [total], dissociation, anxiety, depression, sexual abuse sequelae, sleep disturbance, and sexual problems as the dependent variables and within-group sexual violence, minority status, and the interaction between within-group violence and minority status as the independent variables. Finally, two separate MANOVAs with the aforementioned variables were run for minorities and majority members, respectively.

**Table 1** Percentages of within-group sexual violence and mental health outcomes in minorities and majority members

| | Minorities[a] (%) | Majority members[b] (%) | $\chi^2$ (df = 1) |
|---|---|---|---|
| Within-group sexual violence [1–4] | 18 | 14 | 0.77 |
| Trauma symptom checklist [1–4] | 90 | 88 | 0.62 |
| Dissociation | 78 | 66 | 8.74** |
| Anxiety | 83 | 78 | 1.64 |
| Depression | 86 | 83 | 0.71 |
| Sexual abuse sequelae | 89 | 82 | 6.23* |
| Sleep disturbance | 84 | 77 | 3.54 |
| Sexual problems | 89 | 84 | 3.62 |

*$p < .05$

**$p < .01$

[a]In U.S.: identify as racial/ethnic minority, Muslim, foreign national, non-heterosexual (e.g., gay, lesbian, bisexual)

[b]In U.S.: do not identify as racial/ethnic minority, Muslim, foreign national, non-heterosexual (e.g., gay, lesbian, bisexual)

## Results

The greater proportion of minorities and majority members reported experiencing any within-group violence and psychological distress, with significantly more minorities experiencing dissociation and sexual abuse sequelae (Table 1). Contrary to Hypothesis 1, minorities did not experience more sexual violence victimization than their majority member counterparts (Table 2). A MANOVA revealed that within-group sexual violence was associated with all outcomes in the entire sample (Hypothesis 2). Contrary to Hypothesis 3, minority status was indeed associated with

**Table 2** Means and standard deviations of within-group sexual violence and posttraumatic distress for minorities and majority members

| Variable [range] | Minorities[a] | Majority members[b] | T test |
|---|---|---|---|
| Within-group sexual violence [1–4][c] | 1.05 (0.16) [1.00–2.06] | 1.07 (0.29) [1.00–4.00] | −0.58 |
| Trauma symptom checklist [1–4][d] | 1.60 (0.50) [1.00–3.85] | 1.52 (0.50) [1.00–3.70] | 1.42 |
| Dissociation | 1.47 (0.50) [1.00–4.00] | 1.39 (0.48) [1.00–3.67] | 1.60 |
| Anxiety | 1.53 (0.49) [1.00–3.67] | 1.46 (0.51) [1.00–3.78] | 1.29 |
| Depression | 1.66 (0.55) [1.00–3.78] | 1.60 (0.57) [1.00–3.78] | 1.05 |
| Sexual abuse sequelae | 1.59 (0.47) [1.00–4.00] | 1.53 (0.47) [1.00–3.43] | 1.34 |
| Sleep disturbance | 1.68 (0.57) [1.00–4.00] | 1.61 (0.58) [1.00–3.50] | 1.09 |
| Sexual problems | 1.77 (0.59) [1.00–3.88] | 1.66 (0.58) [1.00–3.63] | 1.69 |

Mean (Standard Deviation)

[Range]

[a]In U.S.: identify as racial/ethnic minority, Muslim, foreign national, non-heterosexual (e.g., gay, lesbian, bisexual)

[b] In U.S.: do not identify as racial/ethnic minority, Muslim, foreign national, non-heterosexual (e.g., gay, lesbian, bisexual)

[c]Degrees of freedom = 355

[d]Degrees of freedom = 346

some outcomes, specifically trauma symptoms [total], depression, sexual abuse sequelae, and sexual problems.

Hypothesis 4 examined the moderating role of minority status on outcomes. Partially supporting Hypothesis 4, the interaction between within-group sexual violence and minority status was associated with trauma symptoms [total], depression, sexual abuse sequelae, sleep disturbance and sexual problems, but not dissociation or anxiety (Table 3). Furthermore, the strength of the associations of within-group sexual violence with trauma symptoms [total], depression, sexual abuse sequelae, sleep disturbance, and sexual problems—but not dissociation and anxiety—were stronger for minorities (Table 4). Meaning, compared to majority members, within-group violence explained more of the variance in the aforementioned mental health outcomes among minorities. Taken together, these results suggest that minorities may be at increased risk for some trauma-related mental health problems, even when victimization rates are comparable between minorities and majority members. This provides evidence for CBTT, as it suggests that cultural betrayal may be a contributing factor to trauma-related mental health in minorities, but not majority members.

**Table 4** Within-group sexual violence: multivariate analysis of variance assessing main effects separately for minorities and majority members

| | Minorities[a] $F$ (1, 166) [$R^2$] | Majority members[b] $F$ (1, 175) [$R^2$] |
|---|---|---|
| Trauma symptoms [total] | 16.99*** [0.09] | 6.81* [0.03] |
| Dissociation | 10.07** [0.05] | 11.73** [0.06] |
| Anxiety | 10.29** [0.05] | 9.68** [0.05] |
| Depression | 15.99*** [0.08] | 4.17* [0.02] |
| Sexual abuse sequelae | 16.11*** [0.08] | 6.26* [0.03] |
| Sleep disturbance | 12.75*** [0.07] | 6.44* [0.03] |
| Sexual problems | 13.23*** [0.07] | 2.12 [0.01] |

*$p < .05$

**$p < .01$

***$p < .001$

[a]In U.S.: identify as racial/ethnic minority, Muslim, foreign national, non-heterosexual (e.g., gay, lesbian, bisexual)

[b]In U.S.: do not identify as racial/ethnic minority, Muslim, foreign national, non-heterosexual (e.g., gay, lesbian, bisexual)

## Discussion

The current study provided support for CBTT as a new framework for examining trauma-related mental health in immigrant and minority populations. Contrary to Hypothesis 1 and national statistics (e.g., Rape, Abuse, and Incest National Network [54]), minorities did not report higher rates of sexual violence victimization. Our findings may be explained by our college student, as opposed to community, sample. In support of Hypothesis 2 and prior literature (e.g., [32]), in the entire sample, within-group sexual violence was linked with all outcomes: trauma symptoms (total), dissociation, anxiety, depression, sexual abuse sequelae, sleep disturbance, and sexual problems. Contrary to Hypothesis 3, minority status alone was linked with some outcomes, specifically trauma symptoms [total], depression, sexual abuse sequelae, and sexual problems. Future research that incorporates other forms of violence, as well as societal

**Table 3** Cultural betrayal for minorities: multivariate analysis of variance assessing within-group sexual violence, minority status, and the interaction of within-group sexual violence and minority status on posttraumatic distress

| | Within-group sexual violence $F$ (1, 341) | Minority status[a] $F$ (1, 341) | Interaction term $F$ (1, 341) |
|---|---|---|---|
| Trauma symptoms [total] | 23.52*** | 4.44* | 6.19* |
| Dissociation | 19.65*** | 1.14 | 2.18 |
| Anxiety | 18.20*** | 1.26 | 2.12 |
| Depression | 19.59*** | 5.02* | 6.47* |
| Sexual abuse sequelae | 22.41*** | 4.50* | 6.22* |
| Sleep disturbance | 18.68*** | 2.94 | 4.10* |
| Sexual problems | 15.52*** | 4.89* | 6.97** |

*$p < .05$

**$p < .01$

***$p < .001$

[a]Minorities (coded as '1'): Minorities- in U.S.: identify as racial/ethnic minority, Muslim, foreign national, non-heterosexual (e.g., gay, lesbian, bisexual); Majority Members (coded as '0'): Majority Members- in U.S.: do not identify as racial/ethnic minority, Muslim, foreign national, non-heterosexual (e.g., gay, lesbian, bisexual)

trauma (e.g., [7]) is needed to better understand the factors that put immigrant and minority populations at higher risk for some mental health problems. Hypothesis 4 tested predictions of CBTT specifically [26]. Partially supporting Hypothesis 4, the interaction between within-group sexual violence victimization and minority status impacted trauma symptoms [total], depression, sexual abuse sequelae, sleep disturbance and sexual problems, but not dissociation or anxiety. Specifically, these associations were stronger for minorities. Reasons behind the null findings for dissociation and anxiety are unknown. It is possible that relatively high rates of dissociation [39] and anxiety [49] generally makes finding differences between groups more difficult. Future work should first if these findings are replicated, and if so, what moderators may be impacting the findings.

Our results suggest that the impact of within-group sexual violence cannot be explained through perceived similarity or in-group status of perpetrator(s) alone, as minority status affected the outcomes of sexual violence victimization. Thus, the evidence from the current study points to the usefulness of the construct of *cultural betrayal trauma* to signify within-group violence that occurs in immigrant and minority populations. This conceptualization has implications for how mental health is understood, investigated, and treated in immigrant and minority populations.

Future studies can build upon this knowledge by addressing some of its limitations. Future studies should present demographic information at the end of the survey, as opposed to the beginning. Specifically, priming participants with their cultural minority identity/ies may contribute to reduced disclosure of cultural betrayal trauma due to racial loyalty (e.g., Tillman et al. [56]) and/or (intra)cultural trust (e.g., [29]). Similar to previous studies [28, 29], the current study used adapted trauma measures to assess in-group status of perpetrators; therefore, future studies should create specific measures for cultural betrayal trauma to establish psychometric properties (e.g., reliability; validity).

CBTT is an umbrella conceptualization for multiple types of cultural betrayal (e.g., ethno-cultural betrayal—between members of the same ethnicity). In the current study, we did not differentiate amongst cultural betrayal types or minority identities in an effort to first determine if evidence supported the existence and impact of cultural betrayal. Though there is theoretical reason to believe that various forms of oppression may have a cross-cutting negative impact across minority groups, future studies should examine specific kinds of cultural betrayal in distinct minority populations as communities of interest in order to avoid ethnic gloss [57] and other overgeneralizations. Doing so will also take into account intersectionality and multiplicity (e.g., [12, 13, 36]): that one's self concept is shaped through multiple minority and majority identities (e.g., race, gender, sexuality, etc.).

Specifically, future studies could identify communities of interest and focus on cultural betrayal trauma in those contexts. For example, a future study could assess cultural betrayal trauma between self-identified queer people of color, delineating the impact of the separate and overlapping racial and sexual minority identities on the meaning given to cultural betrayal trauma and its impact on mental health. Another study could explore cultural betrayal trauma in Arab immigrant and/or Muslim populations, with specific hypotheses around how knowledge and perception of interpersonal and systemic discrimination (e.g., travel ban in the U.S. as reported by Sheer and Nixon [55]) increases the need for (intra)cultural trust and exacerbates outcomes of cultural betrayal trauma (e.g., reduced disclosure to official sources, such as police). With this more nuanced examination, CBTT can provide direct specifications for how different types of cultural betrayal and other sociocultural dynamics can be incorporated into mental health interventions for diverse immigrant and minority victims of violence.

In CBTT (e.g., [29]), there are several assumptions about sociocultural contributors of violence outcomes. Though we found some evidence for cultural betrayal by examining within-group sexual violence in a diverse sample, CBTT indicates that harm from cultural betrayal trauma occurs within the context of lowered status (e.g., effects of discrimination) that is in itself harmful. Our findings that minority status predicted depression and other forms of distress lends credence to this supposition. Thus, future studies should utilize quantitative and qualitative methods to examine perceptions of societal trauma and (intra)cultural pressure. Finally, the focus of the current study was on psychological and behavioral outcomes. Future studies should expand the scope of outcomes to include physical health outcomes, as well as those outcomes that particularly may be affected by cultural betrayal, such as reduced disclosure (e.g., [56]), resistance to engage with the police following within-group violence (e.g., [16], as reported by Fisher et al. [18], Gómez [26]), and internalized prejudice [28].

## New Contribution to the Literature

In an effort to advance the field, there have been numerous calls for the meaningful incorporation of cultural minorities, aspects of the sociocultural context, and cultural values/norms to be included in the study of trauma-related outcomes [5, 6, 10, 11, 19, 20, 26–29, 34, 37, 38, 42, 48, 52]. However, the extant literature in this area remains relatively sparse. Empirical research that predominantly informs what is known of violence victimization outcomes and treatment is based primarily on White American women, without reference to the context in which the trauma occurs [58]. Thus,

**Table 5** Cultural betrayal trauma theory (CBTT): frequently asked questions

| Question | Answer |
|---|---|
| Does CBTT treat all minorities as if they are the same? | No. With CBTT, both within-group differences and between-group differences can be systematically examined |
| Does CBTT propose that there is more violence within minority groups? | No. CBTT says nothing about prevalence of trauma, as within-group violence occurs across majority and minority groups |
| Does CBTT assume that between-group violence—particularly with majority perpetrators and minority victims—is not harmful? | No. CBTT focuses on one facet of trauma (within-group) and does not speak to other forms of trauma (between-group) that themselves may be uniquely harmful in their own way |
| Does CBTT ignore all the other harmful aspects of trauma (e.g., severity, high betrayal)? | No. CBTT highlights cultural betrayal as a specific contributing factor of trauma sequelae, but also includes characteristics of trauma, interpersonal betrayal, institutional betrayal, judicial betrayal, and other factors |
| Does CBTT presume that perpetrators of cultural betrayal trauma are actively trying to betray? | No. Similar to BTT (e.g., [21]), the intent of perpetrators is distinct from the betrayal implicit in within-group violence in minority populations |
| Does CBTT ignore the complexity of identity? | No. CBTT is informed by intersectionality (e.g., [13]) and multiplicity [36]. There are multiple types of cultural betrayal that a single individual could experience (e.g., ethno-cultural betrayal; gender cultural betrayal) |
| Do victims of trauma need to explicitly feel cultural betrayal for it to count as such? | No. However, future research should explore if outcomes vary based on individuals' perceptions of cultural betrayal in the trauma |
| Isn't CBTT a cultural betrayal in and of itself, as it highlights trauma, violence, and abuse that occurs within minority groups? | No. The ultimate determinant of cultural betrayal is societal trauma, which promotes silence in order to protect the in-group. The next responsible party are perpetrators for violating (intra)cultural trust. Disclosing and/or discussing cultural betrayal trauma is not a cultural betrayal |



the current study has implications that can contribute to this literature.

Theoretically, CBTT (e.g., [29]) provides a nuanced, contextualized framework for understanding sociocultural contributors to violence outcomes for immigrant and minority populations. This theoretical basis can provide concepts and language for understanding the meaning-making of violence and the differential outcomes for some members of cultural minorities, while being sensitive to within-group differences, stereotyping, and oppression (Table 5). Additionally, a fundamental goal of theories is to engender research. Thus, the value of theories lies not only in their veracity, which data will refine over time, but also in their ability to foment inquiry of particular phenomena. Specifically, CBTT (e.g., [29]) aids in the ability to do the needed contextualized and culturally relevant research on cultural minorities [25]. This research can examine multiple facets unique to violence victimization mental and physical health outcomes for cultural minorities specifically, including: similarities across cultural minority groups that are a function of societal trauma generally; between group differences related to type of societal trauma experienced and cultural values endorsed; and within-group differences between individuals who are societally conceptualized as members of the same group(s).

The current study demonstrates that posttraumatic distress from the same experience—within-group sexual violence—is affected by minority status. Therefore, this study is in line with many others that have discussed the importance of clinical interventions being both culturally adapted and culturally sensitive to minorities [9, 45–47]. Furthermore, given that CBTT suggests that societal trauma is implicated in interpersonal violence outcomes, psychotherapeutic approaches to healing should further be sensitive to sociocultural dynamics [33], including cultural betrayal. This is particularly important in these clinical settings, as mental healthcare institutionally has a potential for further harm through discrimination [27]. Finally, as future work builds upon the evidence base begun in the current study, implications for policy on mental and physical health disparities can include prioritizing government funding to address the primary cause of cultural betrayal in trauma: societal inequality.

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