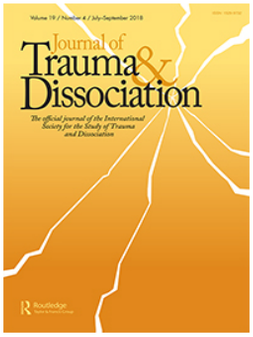

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ARTICLE

On hate crime victimization: Rates, types, and links with suicide risk among sexual orientation minority special interest group members

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ABSTRACT

Hate crimes remain pressing traumatic events for sexual orientation minority adults. Previous literature documents patterns in which hate crime victimization is associated with elevated risk for poor mental health. The present paper held 2 aims to advance literature. First, we investigated the rates and types of hate crime victimization among sexual orientation minority adults. Second, adopting a mental health amplification risk model, we evaluated whether symptoms of depression, impulsivity, or post-traumatic stress exacerbated the hate crime victimization–suicide risk link. Participants were 521 adult sexual orientation minority-identifying members of the National Coalition for Sexual Freedom (i.e., a bondage and discipline, and sadomasochism-identifying sexuality special interest group). Participants completed demographic and mental health inventories via online administration. Results showed: (1) low rates of total lifetime hate crime victimization and (2) higher rates of interpersonal violence compared to property crime victimization within the sample. Regression results showed: (1) independent positive main effects of all 3 mental health symptom categories with suicide risk; (2) an interaction pattern in which impulsivity was positively associated with suicide risk for non-victims; and (3) an interaction pattern in which post-traumatic stress was positively associated with suicide risk for hate crime victims and non-victims. Results are discussed concerning implications for trauma-informed mental healthcare, mental health amplification models, and hate crime and suicide prevention policies.

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Introduction

Much of the sexual orientation and mental health literature centers on lesbian, gay, and bisexual (LGB) identities, at the exclusion of others. Indeed, focus on LGB categories is inconsistent with empirical literature demonstrating that sexual orientation identities are much more expansive (Eliason, Radix, McElroy, Garbers, & Haynes, 2016; Ridolfo, Miller, & Maitland, 2012). Because a significant percentage of sexual orientation minority persons identify with labels beyond LGB (e.g., questioning, pansexual, etc. [i.e., LGBQ+]; see Ridolfo et al., 2012; Russell, Clarke, & Clary, 2009), it is essential that literature engages with communities facilitating research across the full range of minority identities (Herek, 2016).

Many circumstances echo the need to incorporate Q+ persons in the growing body of sexual orientation minority identity literature. For instance, qualitative data reported by Ridolfo and colleagues (2012) highlight a potential circumstance where queer or questioning persons may identify as such in the face of stress and the coming out process. Moreover, assessing the full range of LGBQ+ identities helps inform the association with intersecting minority identity statuses (e.g., gender, race; e.g., Boss & Chiodo, 2016). Finally, there is emerging evidence suggesting queer and questioning, compared to LG and B counterparts, may experience more discrimination and difficulty when trying to access healthcare (e.g., Macapagal, Bhatia, & Greene, 2016). Failure to include the full scope of sexual orientation minority labels in any of these health-related situations would miss vital data. The present paper includes Q+ persons to examine within-LGBQ+ group variation in life hate crime victimization, recruiting the full spectrum of lesbian, gay, bisexual, questioning, and other identifying persons.

A common form of traumatic experience for LGBQ+ persons is that of a hate crime. A hate crime is defined by the perpetrator's intent to harm based on perceptions of the victim's minority group (in this case, LGBQ+) status (Hate Crimes Prevention Act, 2009; Herek, Gillis, & Cogan, 1999). A wealth of theoretical and empirical literature (see Herek, Gillis, & Cogan, 2009; Meyer, 2003; for review) suggests that these experiences are particularly traumatizing forms of sexual minority-specific stress. That is, the victimization serves as a heterosexist message that can lead to internalized stigma and an expectation of future victimization (Herek et al., 2009). An overview of relevant data (e.g., Burks et al., in press; FBI, 2013; Herek et al., 1999) notes the following general trends in frequencies of hate crime experiences among adult LGB persons: (1) overall lifetime prevalence rates range between 20 and 33% (higher among gay men); (2) lifetime violent crime prevalence is generally high (21–54%); (3) lifetime property crime prevalence estimates are lower (0.1–21%), depending on the subtype reported (e.g., burglary vs. vandalism); and (4) sexual assault is common when measured (e.g., 30%

among an urban adult sample; Burks et al., press). An important gap in this literature is a notable lack of data concerning experiences among those identifying as "queer," "questioning," or "other" (i.e., Q+).

It is well known that, compared to heterosexual counterparts, LGBQ+ individuals have increased rates of psychiatric disorders (e.g., King et al., 2008) and suicidal behavior (e.g., Silenzio, Pena, Duberstein, Cerel, & Knox, 2007). Concerning suicide, recent meta-analytic evidence suggests that LGB persons specifically report lifetime suicide attempts at rates 3 to 4 times greater than heterosexual counterparts depending on survey methodology (Hottes, Bogaert, Rhodes, Brennan, & Gesink, 2016). Although there is clear evidence for the negative effects of hate crime victimization on psychological distress (e.g., depression, fear, anxiety; Herek et al., 1999), studies on potential interaction effects of hate crime victimization and mental health symptoms on suicide risk are rare. One study suggesting potential interaction reported that sexual orientation minority violent crime victims, compared to heterosexual victims, were more likely to experience trauma-related symptoms (Cramer, McNiel, Holley, Shumway, & Boccellari, 2011). Depression (e.g., Skegg, 2005), post-traumatic stress (Bryan, 2016), and impulsivity (Rimkeviciene, O'Gorman, & De Leo, 2015) are important risk factors for suicide in general, as well as among LGBQ+ minorities (Plöderl et al., 2014; Smith, Armelie, Boarts, Brazil, & Delahanty, 2016). Such data suggest that symptoms of depression, post-traumatic stress, and impulsivity may also interact with hate crime victimization in understanding risk for suicide.

The bondage and discipline, and sadomasochism (BDSM) practitioner community offers a unique subset of LGBQ+ persons in which to investigate the intersection of hate crime victimization and mental health. This is the case for several reasons. First, BDSM practice may share a considerable identity-related overlap with sexual orientation (Gemberling, Cramer, & Miller, 2015). Second, a dense literature (e.g., Ellis, 2004; Rye, Serafini, & Bramberger, 2015; Wright, 2010a, 2010b) demonstrates that members of the BDSM community have been the subject of a range of inaccurate or debunked stereotypes, myths, or misconceptions including, but not limited to: (1) a high degree of belief that BDSM practice is sick or disgusting; (2) BDSM practice is the same as violence; (3) BDSM practitioners are mentally ill; (4) BDSM-related behavior equates to a form of paternalistic oppression of women; and (5) BDSM behavior serves to escape self-awareness. Such negative public perceptions have led to frequent experiences of discrimination toward the BDSM community in forms such as interpersonal violence victimization, harassment, employment discrimination, and legal decisions (e.g., child custody) (Wright, 2010b). Further, despite the popularity of assuming BDSM constitutes pathology, empirical data show that BDSM-related behavior serves adaptive functions such as personal freedom, self-expression, and stress reduction (Williams, Prior, Alvarado, Thomas, & Christensen, 2016). Following the idea of BDSM practice as adaptive, a small

literature has largely demonstrated that BDSM practitioners are mentally healthier than or equal to non-practitioners concerning measures of psychopathology, aggression, sexual difficulties, attachment styles, subjective well-being, and hostility (e.g., Connolly, 2006; Cross & Matheson, 2006; Richters, de Visser, Rissel, Grulich, & Smith, 2008). Practitioners are, however, sometimes found to have high rates of narcissism and suicidality (Brown, Roush, Mitchell, & Cukrowicz, in press; Connolly, 2006; Roush, Brown, Mitchell, & Cukrowicz, 2017). Most germane to the present investigation, 2 recent studies suggest: (1) male members of the BDSM community may be at elevated risk for developing the ability to attempt suicide due to exposure to pain (Brown et al., in press) and (2) BDSM practitioners may be likely to experience stigma-based emotions of shame and guilt, contributing to formation of depressive and suicidal thinking (Roush et al., 2017). In all, the question remains whether there may be unique intersections between discrimination-based hate crime victimization, mental health, and suicide risk among sexual orientation minority members of a BDSM special interest group.

The present study

The current study possesses 2 aims. First, we sought to describe the frequency, types, and variation by subgroup of hate crime victimization among self-identified LGBQ+ adult members of the National Coalition for Sexual Freedom (NCSF; i.e., BDSM practitioners).

H1: *In an exploratory question, we examine whether there is within-group variation of lifetime hate crime victimization prevalence (i.e., victim vs. non-victim), comparing Q+ persons to LG and B counterparts. Further, it is hypothesized that participants will report generally higher prevalence rates of interpersonal violence compared to property or other crimes.*

The second aim was to understand interactions between hate crime victimization and mental health symptoms (specifically depression, posttraumatic stress, and impulsivity) in understanding suicide risk. We do so adopting an established interaction framework of "amplification" (e.g., Capron, Lamis, & Schmidt, 2014) in which mental health symptoms, such as depression, impulsivity, or other noted suicide risk factors, exacerbate the negative effect of an experience, such as hate crimes, on suicide risk.

H2–H4: *Depressive (H2), posttraumatic stress (H3), and impulsivity (H4) symptoms will interact with hate crime victimization in understanding suicide risk scores, such that the combination of hate crime*

victimization and higher symptoms in each category will be associated with elevated suicide risk.

Method

Participants

Participants were 521 adult LGBQ+-identifying members of the NCSF. Full sample demographic patterns are reported elsewhere (see Gemberling et al., 2015b). The sample consisted of the following self-labeled LGBQ+ identities in descending order of frequency: bisexual (n = 227), lesbian/gay (n = 121), pansexual (n = 48), prefer no label (n = 40), queer (n = 23), questioning (n = 18), heteroflexible (n = 18), asexual (n = 7), and a range of other less common responses (e.g., demisexual; n range = 2–7) . Importantly, for hypothesis testing, participants were reclassified for statistical power purposes. Specifically, for lifetime victimization analyses (i.e., H1), lesbian/gay and bisexual subgroups were retained, with a third group of participants from different sexual minority categories (pansexual, queer, etc.) categorized as Q+/other.

Measures

Table 1 (see online supplement) contains descriptive statistics and internal consistency values for mental health measures.

Demographics

Demographic information requested on this survey included: gender, race, sexual orientation, romantic relationship status, education, and annual income.

Hate crime victimization

The Victimization Experiences Inventory (VEI; Herek et al., 1999) measured hate crime victimization based on actual or perceived sexual minority status. The VEI asks participants whether they have experienced a hate crime in their lifetime (i.e., yes/no), and if so, asks the person to report frequencies over the lifetime and within the last year. Respondents then report details concerning the most recent experience (i.e., type of victimization). For each crime or attempted crime, the participants were asked 4 follow-up questions.

Depression

Depressive symptoms were measured by the Depression Anxiety Stress Scales-21 (DASS-21) depression subscale, which has internal consistency values of .82 and above in previous literature (Osman et al., 2012).

Post-traumatic stress

Post-traumatic stress symptoms were measured by the Posttraumatic Stress Disorder Checklist–Civilian (PCLC), a 17-item self-report measure (summed for a total score) which has been shown to have an internal consistency of .92 and above (Conybeare, Behar, Solomon, Newman, & Borkovec, 2012). Subscales are obtainable in the following domains: reexperiencing, avoidance, and arousal.

Impulsivity

Impulsivity was captured through the impulsivity subscale of the Low Self-Control scale (Grasmick, Tittle, Bursik, & Arneklev, 1993), a 24-item inventory tapping 6 dimensions of low self-control; this subscale has internal consistency of .79 in prior research (DeLisi, Hochstetler, & Murphy, 2003).

Suicide risk

Suicide risk was assessed with the Suicidal Behaviors Questionnaire-Revised (SBQ-R; Osman et al., 2001), a 4-item questionnaire capturing historical and recent suicide ideation, attempt, and intent, as well as future estimation of an attempt. The total score has an internal consistency of .76 in the validation study (Osman et al., 2001).

Procedure

This study was approved by an institutional review board. Participants were recruited through postings via the NCSF website and listserv concerning the opportunity for participation in an online survey on the topic of victimization experiences and psychological health. The website and listserv reach only identified members of the NCSF or those BDSM-practicing persons who are also members. After self-selecting into the study via electronic consent, participants were directed to the questionnaire. Participants were debriefed at the end of the questionnaire and provided mental health support numbers and referral information.

Results

All analyses were conducted using SPSS v.23. Where significant interactions emerged, they were probed using established SPSS-based approaches in the statistical literature (Bauer & Curran, 2005).

H1: Hypothesis 1 posed 2 premises. First, within-group variation of lifetime hate crime victimization prevalence was examined by comparing Q+ persons to LG and B counterparts. Further, it was hypothesized that participants will report generally higher prevalence rates of interpersonal violence compared to property or other crimes in this sample. A total of 76 (14.7%) out of 516 participants with complete data reported lifetime hate crime victimization due to sexual orientation minority status (lifetime *M#* of victimization experiences = 2.96, *SD* = 3.10; *M#* within last year = 0.51, SD = 3.73). Consistent with expectations concerning interpersonal versus property crimes, of the most recent victimization experiences, the frequency of reported subtypes in descending order (a person could report more than one co-occurring subtype) was: physical assault (n = 34), attempted physical assault (n = 19), vandalism (n = 14), sexual assault (n = 8), attempted sexual assault (n = 7), burglary/theft (n = 7), and attempted property crime (n = 6). Concerning exploratory within-sample variation in lifetime hate crime victimization rates, a chi-square test demonstrated significant variation of hate crime victimization by sexual orientation identity subgroup, χ^2 (2) = 61.23, $p < .001$. In descending order, sexual orientation identity groups reported the following lifetime hate crime victimization rates: 44/119 gay/lesbian (37.0%), 20/225 bisexual (8.9%), and 12/172 other (7.0%).

H2 through H4: Hypotheses 2 through 4 posited interaction effects between mental health symptoms (i.e., depression, post-traumatic stress, and impulsivity) with hate crime victimization. In total, 495 participants reported sufficient responses to be included in analyses. Prior to the full model examining suicide risk score, the bivariate association between hate crime victimization and suicide risk scores was assessed using an independent-samples *t*-test. No significant effect emerged for the association of hate crime victimization and suicide risk scores, $t(494) = -0.67$, $p = .51$).

Linear regression was implemented with the following parameters: (1) criterion measure of total suicide risk score; (2) main effects of sexual orientation (dummy coded as bisexual and other versus lesbian/gay as the reference group), hate crime victimization ("no" as the reference group), and symptoms of depression, post-traumatic stress, and impulsivity; (3) 2-way interaction terms for each mental health indicator by hate crime victimization status.

The model accounted for significant variance in total suicide risk scores, $F(9, 486) = 30.15$, $p < .001$, Adj. $R^2 = .35$. Significant predictors in the model were: main effect of depressive symptoms ($\beta = 1.16$, $p < .001$), main effect of post-traumatic stress symptoms ($\beta = 1.02$, $p < .001$), main effect of impulsivity ($\beta = .32$, $p = .03$), the hate crime victimization by post-traumatic stress interaction ($\beta = 1.10$, $p = .02$), and the hate crime victimization by impulsivity interaction ($\beta = -.99$, $p = .02$). Hypothesis 2, concerning a depression interaction effect, was not supported. The influence of post-traumatic stress symptoms on suicide risk was significant for

both victims (t[485] = 4.91, p < .001) and non-victims (t[485] = 5.55, p < .001); supporting hypothesis 3, the greatest risk for suicide, relative to other levels of post-traumatic stress and victim status, results from the combination of hate crime victimization and higher post-traumatic stress symptoms. Specific patterns can be seen in Figure 1 in the online supplement. Contrary to hypothesis 4, the influence of impulsivity was only significant for non-victims (t[485] = 2.17, p = .03), suggesting that high suicide risk is associated with greater impulsivity for non-victims (see Figure 2 in the online supplement).

Exploratory follow-up concerning post-traumatic stress interaction findings

Exploratory analyses were conducted to clarify which post-traumatic stress symptom subtype influenced the interaction pattern. Linear regression was implemented with the same set of predictors and criterion measures as the primary model, except a main effect of each post-traumatic stress symptom cluster (i.e., avoidance, arousal, and reexperiencing) was added in place of the total score. An interaction term was also added for each post-traumatic stress symptom cluster by hate crime victimization. The model accounted for significant variance in total suicide risk scores, F(13, 482) = 21.28, p < .001, Adj. R^2 = .35. Main effects of depressive symptoms (β = 1.11, p < .001) and impulsivity (β = .32, p = .03), as well as the hate crime victimization by impulsivity interaction (β = −.98, p = .02), all remained significant. Only the avoidance main effect (β = .65, p = .03) and hate crime victimization by avoidance interaction (β = 1.49, p = .05) accounted for significant variance in suicide risk. The influence of avoidance symptoms on suicide risk was significant for both victims (t[485] = 3.06, p < .001) and non-victims (t[485] = 2.17, p = .03); supporting hypothesis 3, the greatest risk for suicide, relative to other levels of avoidance and victim status, results from the combination of hate crime victimization and higher avoidance post-traumatic stress symptoms (the pattern of the interaction mirrored that depicted in Figure 1).

Discussion

The present study represents one of the first in-depth evaluations concerning mental health and victimization of LGBQ+-identifying members of the BDSM community. Hypothesis 1 addressing rates and types of hate crime victimization was partially supported: Overall, a trend of violent/interpersonal crimes exceeding property crimes was observed. Interestingly, bisexual and Q+-identifying persons in the present sample reported substantially lower rates of lifetime hate crime victimization. This pattern may be simply

due to the concept of outness or the extent to which an LGBQ+ person publically shares their identity. Existing research suggests that concealing one's sexual minority identity is moderately negatively associated with outness (Mohr & Kendra, 2011) and that concerns about being out may be especially prominent among bisexual persons (Mohr, Jackson, & Sheets, in press). Following this logic, bisexual and Q+ persons may be more motivated to conceal their orientations. Lack of social acknowledgment of one's identity may yield less frequent victimization.

The less frequent rate of hate crime victimization experiences may also be a reflection of theoretically supported protective factors, such as minority group resiliency and community involvement (Meyer, 2003), mitigating the risk for victimization. Indeed, empirical support exists for resilience serving protective roles for stress and mental health-related outcomes (Lira & Morais, in press; Shilo & Mor, 2014). As such, to the extent LGBQ+ persons demonstrate personal resilience or community involvement, they may be less at risk for victimization.

Hypotheses 2 through 4 offered novel insight into the potential interactive influences of mental health symptoms on the previously documented hate crime–suicide link among LGBQ+ adults. The amplification (e.g., Capron et al., 2014) pattern only held true for post-traumatic stress symptoms, specifically avoidance symptoms. Viewed from the trauma-informed (e.g., Reeves, 2015) mental health care perspective, this pattern seems understandable, as LGBQ+ persons who experience victimization as a subjective trauma may also be more susceptible to post-traumatic symptoms. Avoidance symptoms may form or increase as a reaction to, or coping mechanism for, victimization – of course, the cross-sectional nature of the data limits causal inference. It is also worthy to note that we included Q+ persons in the overall sexual orientation minority suicide risk research. However, this is merely an intermediary advancement. Future work needs to obtain sample sizes of sufficient size to examine within-group (e.g., Q+ vs. bisexual, gay, etc.) consistency or variation of the interaction effects observed in the present study.

The present study highlights victimization rates, as well as mental health patterns, among LGBQ+-identifying BDSM practitioners. A natural question may arise in considering how this subgroup of sexual orientation minority persons experiences victimization and mental health similarly or differently compared to other LGBQ+ samples (e.g., general population, college students, and youth). The likely answer is that both are probably the case. As highlighted earlier, bisexual and Q+ persons reported relatively low rates of lifetime hate crime victimization. In terms of different experiences for BDSM-practicing LGBQ+ persons, there may be something implicitly buffering against victimization experiences for bisexual and Q+ BDSM community members. That is, NCSF members may tend to be heavily involved with their sexual special interest community and potentially less likely to be surrounded

by less socially accepting environments. This could account for different experiences and rates of part of hate crime victimization, at least for those identifying as bisexual or Q+. On the other hand, considerable literature implicates hate crime victimization or discrimination as a direct or interacting factor in LGBQ+ mental health among youth (e.g., Duncan & Hatzenbueler, 2014), college students (e.g., Craig, Austin, Rashidi, & Adams, 2017), and the general population (e.g., Herek et al., 1999). Meyer's (2003) minority stress perspective defines hate crime victimization/discrimination as a distal risk factor for mental health. In other words, LGBQ+ persons may experience such victimization as stigma and, therefore, be more prone to mental health concerns. In the case of the present sample, this specifically seems the case for post-traumatic stress and suicide risk. The potential of BDSM-practicing LGBQ+ adults experiencing victimization and mental health within a stigmatizing backdrop is furthered by recent evidence, suggesting that stigma-based emotions (i.e., shame and guilt) are associated with increased depressive cognitions and suicidality among BDSM practitioners (Roush, Brown, Mitchell, & Cukrowicz, 2017).

In light of LGBQ+ adults falling within federally protected vulnerable groups, the present study holds potential implications for health law and policy. For instance, the federal Hate Crimes Prevention Act (HCPA; 2009) included sexual orientation minority persons under the list of federally protected groups. Our findings that hate crime victims may display unique patterns of suicide risk (i.e., the pronounced role of post-traumatic stress among hate crime victims) support several social and legal arguments for the law, such as extension of group inclusion to those enduring poor health outcomes and symbolic government support of vulnerable groups (see Cabeldue, Cramer, Kehn, Crosby, & Anastasi, in press for overview). Likewise, a next question that may be worthy of consideration concerns whether discrimination and victimization based on sexuality special interest group membership (i.e., BDSM identification) merits discussion for protection under the scope of the HCPA. From the suicide prevention policy perspective, many federal and foundation prevention program initiatives already target certain settings (e.g., college campuses) and populations (e.g., military persons). Such initiatives may benefit from considering targeting specific subgroups within sexuality special interest and LGBQ+ populations as well, particularly if such targeting addresses the specific sensitivities and barriers to service utilization. Much more research is necessary to provide needed empirical grounding.

The present study possesses methodological limitations requiring attention. The study is cross-sectional in nature and limited to self-report data. These limit conclusions in terms of causal inference and subjectivity bias, respectively. Moreover, the self-report nature of the data raises a common concern in hate crime research: underreporting. It is well understood that

victims tend to underreport hate crimes (e.g., Zaykowski, 2010). Concerns such as institutional betrayal may be salient for victims of violence, potentially exacerbating suicide risk for those who report yet find insufficient support from the legal system (e.g., Monteith, Bahraini, Matazarro, Soberay, & Smith, 2016). Future work may need to account for this and other drivers of underreporting or post-reporting experiences. Also, the present sample is drawn from a sexuality special interest group; that is, only BDSM-practicing persons who are members of NCSF were recruited for the study. Generalizability is therefore limited with regard to drawing conclusions for LGBQ+ non-NCSF members. Present findings are in need of replication in other LGBQ+ and BDSM samples. Moreover, next questions worthy of investigation concern whether discrimination and victimization based on special interest group membership (i.e., BDSM-identifying status) occurs at similar rates and in association with mental health concerns.

In conclusion, we observed that the association between hate crime victimization and suicide risk is moderated by post-traumatic stress symptoms. Likewise, symptoms of depression and impulsivity demonstrated direct associations with suicide risk. However, self-reported victimization rates were lower among BDSM-involved LGBQ+ adults when compared to those reported elsewhere in the literature. In all, this set of findings, coupled with other BDSM and sexual orientation minority literature, sets the backdrop for intriguing future vulnerable population health risk and protective factor research.

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