Chapter 5
Alcohol-Related Sexual Violence Perpetration Toward Sexual and Gender Minority Populations: A Critical Review and Call to Action

Dominic J. Parrott, Ruschelle M. Leone, Anne Marie Schipani-McLaughlin, Laura F. Salazar, Zainab Nizam, and Amanda Gilmore

5.1 Introduction

> "Don't you see," cried some, "if we find out how they're getting in the river, we can stop the problem… By going upstream, we can eliminate the cause of the problem!" – The Parable of the River.

In the parable of the river, villagers find a baby floating down a river. After pulling the baby out, another one floats down the river. Before long, there is a steady stream of babies floating down the river, and the villagers quickly become overwhelmed pulling them out, taking them home, and caring for them. Finally, one villager suggests that in order to eliminate the cause of the problem, they must look upstream to find out how the babies are getting into the river in the first place. In many ways, this parable mirrors the problem of sexual violence (SV) against the sexual and gender minority (SGM) community. Research indicates that SGM individuals experience higher rates of SV compared to cisgender or heterosexual peers (e.g., see Edwards et al., 2015; Flores et al., 2020; James et al., 2016; Messinger, 2011; Walters et al., 2013); yet more is known about the mental health sequelae of experiencing SV among SGM individuals than how to prevent SV from occurring. A central premise of the present chapter is that in order to eliminate the problem of

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D. J. Parrott (✉) · R. M. Leone · A. M. Schipani-McLaughlin · L. F. Salazar · Z. Nizam
A. Gilmore
Georgia State University, Atlanta, GA, USA
e-mail: parrott@gsu.edu

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SV toward the SGM community, efforts must focus on identifying who perpetrates SV and developing etiological models to understand what places these individuals at high risk for perpetration. In essence, we need to know who is throwing SGM people in the river and why they are doing it.

Data from the National Intimate Partner and Sexual Violence Survey (Walters et al., 2013) categorized sexual victimization experiences based on the sex of the perpetrator and found that (1) among lesbian and bisexual female survivors, nearly 85% reported that their perpetrator was a male, and (2) among gay and bisexual male survivors, over 70% reported that their perpetrator was male. However, the gender identity and sexual orientation of perpetrators were not assessed; thus, it is unclear if they were also members of the SGM community. Consistent with this observation, a review of 75 studies that assessed SV victimization in lesbian, gay, and bisexual people highlighted that sex assigned at birth, gender identity, and sexual orientation of the SV perpetrator are rarely assessed (Rothman et al., 2011). This weakness in the rigor of this research limits our understanding of who is most likely to perpetrate SV toward SGM individuals.

This weakness also extends to literature on the link between alcohol and SV in SGM populations. It is well-established that proximal alcohol use is a contributing cause of myriad forms of aggression (Parrott & Eckhardt, 2018), including SV perpetration (Abbey, 2002; George & Stoner, 2000; Testa, 2002). However, data on the effect of alcohol on SV perpetration have typically been demonstrated with respect to cisgender, heterosexual men's perpetration toward (presumably cisgender heterosexual) women (e.g., Abbey, 2002; Testa, 2002). Thus, consistent with the broader SV literature (Rothman et al., 2011), the alcohol-SV literature is characterized by a significant heteronormative bias, in that aspects of the perpetrator's identity are rarely assessed. Nevertheless, it is reasonable to suggest that proximal heavy drinking is also a contributing cause of (1) cisgender heterosexual men's SV perpetration toward SGM individuals and (2) SGM individuals' SV perpetration toward other SGM individuals. For example, nearly 75% of gay and bisexual survivors of SV reported that they believed the perpetrator was consuming alcohol prior to the assault (Hequembourg et al., 2015). Also consistent with this view, research indicates that transgender-identified people's frequency of heavy drinking is associated with their SV victimization (Coulter et al., 2015), which aligns with research indicating that drinking environments can foster SV perpetration (Testa & Cleveland, 2017).

These data just scratch the surface of the role of alcohol in SV perpetration toward SGM people and highlight the major challenge that faces researchers in this area. The link between alcohol and SV is extraordinarily complex and shaped by myriad factors, most notably the temporality of effects (i.e., alcohol use that precedes and/or is subsequent to SV), the extent to which alcohol serves as a causal contributor to SV perpetration, and the interconnectedness of one's role as a perpetrator and/or victim and the relationship context. Adding to this complexity, the stigma associated with sexual and gender minority identities introduces culturally specific constructs (e.g., minority stress) that must be integrated into extant theoretical models of the alcohol-SV link.

The primary aim of this chapter is to unpack this complexity. First, we will review relevant theory on stigma and minority stress, which provides the cultural context in which the present work is situated. Second, we document the scant empirical research literature on the effects of alcohol on SV perpetration toward SGM people, with particular attention to themes that emerge in related lines of research. Third, we advance an integrative theoretical model for alcohol-related SV perpetration that invokes (1) a metatheory (I^3 Model; Finkel, 2007, 2014; Finkel & Eckhardt, 2013), to organize risk and resilience factors across the social ecology, and (2) a proximal process theory (Alcohol Myopia Theory; Steele & Josephs, 1990), to explain the mechanism by which proximal alcohol use facilitates SV perpetration toward SGM populations as a function of individual differences in those factors. This integrative model will inform our review of research and prevention implications. Here, we seek to advance recommendations to strengthen the rigor of this research in a way that facilitates the translation of research findings into intervention or prevention programming that can be implemented easily into routine individual or public health practice.

5.2 Definitions and Theoretical Framework

5.2.1 Sexual and Gender Minority

The Institute of Medicine (2011) report on health among lesbian, gay, bisexual, and transgender people recognizes that this community is comprised of a heterogeneous coalition of groups that vary in numerous ways. In particular, this report emphasized that people vary in terms of their sexual orientation, gender identity, and gender expression. The extant literature invokes multiple terminologies to refer to these constructs, and thus, it is important to first establish the well-accepted definitions put forth by the Institute of Medicine report (2011). *Sexual orientation* refers to "an enduring pattern of or disposition to experience sexual or romantic desires for, and relationships with, people of one's same sex, the opposite sex, or both sexes" (p. 27). *Gender identity* refers to "a person's basic sense of being a man or boy, a woman or girl, or another gender (e.g., transgender, bigender, or gender queer – a rejection of the traditional binary classification of gender)" (p. 25–26). *Gender expression* reflects "the manifestation of characteristics in one's personality, appearance, and behavior that are culturally defined as masculine or feminine" (p. 26). Informed by this work, the National Institutes of Health (2019) defines SGM broadly to include people who endorse a range of sexual orientations (e.g., lesbian, gay, bisexual) and gender identities (e.g., transgender, queer), same-sex or same-gender attractions or behaviors, differences in sex development, and/or nonbinary constructs of sexual orientation, gender, and/or sex.

Literature that examines constructs, such as "antigay violence," "homophobia," or "antigay prejudice," is typically focused on the attitudes or behavior of a person who conforms with society's traditional conceptions of these constructs (e.g., a

cisgender heterosexual male whose gender expression is consistent with cultural norms regarding masculinity) in relation to a person who does not conform with the social expectations related to one or more of these constructs and is consequently perceived as nontraditional or even deviant. Thus, a target may be a person assigned male at birth, who identifies as a man (cisgender) and expresses traditional masculine characteristics yet challenges societal expectations by endorsing a nonheterosexual identity (e.g., gay). Alternatively, a target may not meet societal expectations in terms of their gender identity (e.g., a person assigned male at birth who identifies as a woman) and/or gender expression (e.g., a person assigned male at birth who manifests feminine characteristics).

Thus, while it may seem parsimonious to focus on the link between alcohol and SV perpetration toward *SGM people*, such work actually reflects the study of a coalition of subgroups, who exhibit numerous differences due to their variability in sexual orientation, gender identity, and/or gender expression as well as other intersecting demographic factors (e.g., sex assigned at birth, race, ethnicity). Moreover, gender and sexual identities informed by these constructs are broad and complex and can vary across the life course. Thus, specificity in these terminologies is critical to understand differences in these subgroups. However, it is also true that all these populations share a historically marginalized social status that is the basis of stigma related to one or more of the aforementioned constructs.

In accordance with this literature, the present chapter will employ the term *sexual and gender minority (SGM)* to parsimoniously refer to individuals from these populations. As appropriate, specific subgroups will be referenced as a function of their sexual orientation, gender identity, and/or gender expression. In most cases, we will use *sexual minority* in reference to any individual who endorses a nonheterosexual orientation (e.g., gay, lesbian, bisexual) and *gender minority* in reference to any individual (regardless of their sexual orientation) who endorses a gender identity, which is incongruent with their sex assigned at birth (e.g., transgender, nonbinary).

5.2.2 Sexual Violence

The Centers for Disease Control defines SV as sexual contact where consent is not obtained or given freely (Basile et al., 2014). SV occurs on a continuum from "minor" behaviors (e.g., catcalling, sexual objectification, verbal suggestions of intent to force someone to have sex) to more extreme behaviors (e.g., attempted or completed rape) (Stout & McPhail, 1998). Behaviors on the lower end of the continuum are problematic, because they are associated with deleterious health outcomes and also have the potential to escalate into more severe aggressive behavior (Gervais et al., 2014). Some research among college student populations indicates that SGM people experience higher rates of behaviors on the lower end of the continuum, such as sexual touching or harassment, than cisgender, heterosexual college students (Cantor et al., 2019; Mellins et al., 2017). Therefore, these experiences of SV suggest that SGM people are at risk of experiencing more severe forms of SV.

It is also critical to distinguish between SV perpetration and SV victimization. Indeed, the literature has historically been "siloed" in terms of the interplay between SV perpetration and victimization and the relationship contexts that influence those associations. This limits the ability to consider simultaneously how alcohol use is *proximally and temporally related* to perpetration and/or victimization and the contexts that shape these associations (e.g., intimate vs. non-intimate relationships). The lack of rigor in this area is a key barrier to progress. Further, within intimate relationships, little is known about the prevalence and risk factors for bidirectional, compared to unilateral, SV. Among cisgender heterosexual and SGM couples who report some form of intimate partner violence, approximately half report that this violence is bidirectional (for review, see Langhinrichsen-Rohling et al., 2012; Messinger, 2018). However, there is a dearth of research on rates of bidirectional SV within intimate relationships, with few exceptions. For example, recent data suggests that among cisgender heterosexual couples, wherein at least one partner reported heavy alcohol use and prior IPV perpetration, 65% of couples reported bidirectional SV (Grom et al., 2021). Unfortunately, the rates and risk factors for bidirectional SV in couples with one or more SGM partners remain unclear.

5.2.3 Sexual and Gender Minority Stigma: A Conceptual Framework

Theorists have argued that cultural ideologies and institutions provide the basis for individuals' negative beliefs and enactment of these beliefs toward sexual and gender minorities (Herek, 2000, 2007, 2016; Kimmel, 1997). Thus, we adopt a heuristic framework and terminology, rooted in the constructs of sexual stigma and gender minority stigma, which recognize the existence and operation of stigma directed toward nonnormative sexual orientations, gender identities, experiences, and/or expressions at both societal and individual levels. Advanced by Herek (2007), *sexual stigma* is defined as "the negative regard, inferior status, and relative powerlessness that society collectively accords to any non-heterosexual behavior, identity, relationship, or community" (p. 906–907); in the same spirit, *gender minority stigma* is defined as "stigma directed at non-normative gender identities, experiences, and expressions, as well as gender minority communities" (Herek, 2016, p. 387). Sexual stigma and gender minority stigma are fundamentally rooted in systems that privilege heterosexual and cisgender individuals (Herek, 2007; Winter et al., 2016) and that sanction socially shared knowledge that nonnormative sexual and gender identities are devalued.

At the societal level, sexual and gender minority stigma are reflected in social customs and institutions (e.g., norms about gender roles, religion, laws, and language). This sociocultural context sanctions and normalizes individual-level antipathy toward SGM people. For example, homosexuality is criminalized in 75 countries and is even punishable by death in ten countries (Human Rights Campaign, 2015). There are currently 47 countries where it is illegal to change gender, and only 96

countries have processes that allow transgender people to legally change their gender. However, of these 96 countries, only 25 are free of "prohibitive requirements" that make it easier for transgender individuals to change their gender (ILGA World, 2020). In the United States, notable enactments of sexual and gender minority stigma were reflected by "Don't Ask, Don't Tell (DADT)" and so-called bathroom bills. DADT was the US military policy from 1993 to 2011 (Parco & Levy, 2013), which prohibited discrimination against SGM people while simultaneously prohibiting those who did not conceal their sexual or gender minority identity from serving. Bathroom bills proposed to restrict transgender individuals' access to multiuser restrooms, locker rooms, or other sex-segregated spaces in schools and/or public spaces. Sixteen states proposed to introduce this legislation, which would have required individuals to use the gender-assigned bathroom that is consistent with their assigned sex at birth rather than their gender identity or expression. Although one such bill was passed in North Carolina in 2016, it has since been repealed (National Conference of State Legislators, 2019). Collectively, these policies are stigmatizing, because they deny sexual and gender minority people the rights held by cisgender and heterosexual people.

A comprehensive review of how sexual and gender minority stigma manifest at the societal level is beyond the scope of this chapter (for reviews, see Herek, 2007, 2009, 2015); however, norms about gender roles – and masculine ideology specifically – merit specific attention here, given its strong association with SV perpetration (see Leone & Parrott, 2018). Masculinity ideologies represent the cultural standards for manhood within a given society, community, or social context (Connell, 2005; Thompson Jr. & Pleck, 1995). In particular, the development of heterosexual masculinity, particularly during adolescence, includes socially constructed norms, rules, and expectations that dictate how men are supposed to think, feel, and behave. Numerous theorists (e.g., Brannon, 1976; Deaux & Kite, 1987; Herek, 1986; Kimmel, 1997; Kite, 2001; Pleck, 1981) agree that these cultural standards are the basis for men's expectations of desirable attributes (e.g., dominant, tough, heterosexual) as well as undesirable attributes (e.g., submissive, weak, homosexual). These ideologies provide the sociocultural backdrop that can motivate men to differentiate between the masculine in-group and the feminine outgroup via the perpetration of all forms of aggressive behavior (for a review, see Leone & Parrott, 2018), including the denigration and perpetration of SV toward SGM people.

5.2.3.1 Sexual and Gender Minority Stigma: Effects on SGM People

These societal-level manifestations of sexual and gender minority stigma affect SGM people at the individual level in three primary ways (for a review, see Herek, 2007). First, *enacted stigma* refers to sexual and gender minorities' direct experience of stigma, usually via direct physical, psychological, and/or sexual

victimization related to their sexual orientation or gender identity. These direct victimization experiences cause psychological distress and require them to adapt psychologically to that stress, often in maladaptive ways. Second, even in the absence of direct stigma-based victimization, SGM people can be affected by societal-level manifestations of sexual and gender minority stigma, such as when they witness other SGM people's experiences of enacted stigma. Here, *felt stigma* refers to the relatively constant expectation that one will be discriminated against or victimized and the consequent heightened psychological vigilance and stress required to monitor for such threats. Third, *internalized stigma* (also referred to as internalized homophobia [Weinberg, 1972], internalized heterosexism [Szymanski & Chung, 2003], and internalized homonegativity [Mayfield, 2001]) refers to a sexual or gender minority person's acceptance of sexual or gender minority stigma into their self-concept.

Herek's stigma-based framework provides a parsimonious explanation of the interplay between societal- and individual-level stigma; however, the manner in which these forces impact physical and mental health is most frequently conceptualized within minority stress theory (Meyer, 2003, 2013). This framework posits that SGM populations experience chronic stress related to their stigmatized identities, which in turn is associated with myriad negative health disparities (for a review, see Dürrbaum & Sattler, 2020; Feinstein & Dyar, 2017; Newcomb & Mustanski, 2010), including alcohol use (Goldbach et al., 2014), violence (Edwards et al., 2015), and their nexus (Shorey et al., 2019). Considered together, the psychological distress experienced in response to enacted and felt stigma may be termed "externalized sexual and gender minority stress," whereas the psychological distress associated with internalized stigma may be termed "internalized sexual and gender minority stress."

An extension of minority stress theory (Hatzenbuehler, 2009) posits that minority stress leads to negative health outcomes via interrelated affective, cognitive, and interpersonal mechanisms. SV perpetration has been explained via these mechanisms in cisgender heterosexual men (e.g., detached sexual behavior, sexual dominance, sexual promiscuity; see Malamuth & Hald, 2016); however, these mechanisms also reflect vulnerabilities that are unique to SGM people, such as internalized shame (Newcomb & Mustanski, 2010), rejection sensitivity (Pachankis, 2007), and concealment (Pachankis, 2007). Put simply, external and internal SGM stressors compromise affective and cognitive regulation as well as interpersonal effectiveness. As such, SGM individuals are more likely to engage in maladaptive coping, such as problematic alcohol use and interpersonal violence. Indeed, it is well-documented that sexual and gender minority stress (both external and internal) are positively associated with heightened rates of alcohol use and violence perpetration and victimization in SGM people (Balsam & Szymanski, 2005; Brubaker et al., 2009; Edwards et al., 2015; Lewis et al., 2012; Stephenson & Finneran, 2017).

5.2.3.2 Sexual and Gender Minority Stigma: Effects on Cisgender and Heterosexual People

Extant literature typically considers the effect of sexual and gender minority stigma on SGM people. However, these social forces also impact cisgender and heterosexual people via the same mechanisms (for a review, see Herek, 2007). Because sexual orientation is concealable, heterosexual people can be labeled as any nonheterosexual identity. In the same vein, because gender minority people commonly conceal the fact that their gender identity is not congruent with their sex assigned at birth, cisgender people are similarly vulnerable to being labeled as non-cisgender. Because cisgender and heterosexual people are vulnerable to *enacted stigma*, they also experience *felt stigma,* which can have a particularly strong impact on cisgender, heterosexual men. It is widely theorized that the masculine identity is fragile and elusive (Eisler & Skidmore, 1987; Kaufman, 1997; Pleck, 1981) and thus is in perpetual need of public validation (Kimmel, 1996). For cisgender, heterosexual men, failure to adhere to male gender norms may result in actual or perceived negative consequences (Martin & Ruble, 2010), including being perceived as gay (Bosson & Vandello, 2011). As a result, felt stigma can motivate cisgender and heterosexual people to employ self-presentation strategies that demonstrate publicly their conformity to normative sexual and gender identities. An extreme manifestation of this process is the perpetration of violence, including SV, toward SGM people. For men in particular, these exaggerated masculine displays are a powerful way to demonstrate one's heterosexual masculinity (i.e., a lack of femininity) to other men (Kimmel, 1997; Tomsen, 2002). In fact, Franklin (2000) identified this process, which she termed "peer dynamics," as the most salient motivation for bias-motivated aggressive behavior toward sexual minorities, accounting for three times more variance than other putative mechanisms.

Internalized sexual stigma is manifested in heterosexual people as *sexual prejudice*, which reflects heterosexuals' negative attitudes toward homosexual behaviors, sexual minority identities, and communities of sexual minority individuals (Herek, 2000, 2007). Similarly, *internalized gender minority stigma* is manifested in cisgender people as *transgender prejudice*, which reflects "negative attitudes toward those outside the traditional gender binary of male and female, either in behavior, appearance, or both" (Huffaker & Kwon, 2016, p. 200). Notably, many of the correlates of sexual prejudice are also correlated with transgender prejudice, including authoritarianism, religious fundamentalism, and hostile sexism (Nagoshi et al., 2008). Not surprisingly, there is also a strong correlation between sexual prejudice and transgender prejudice (Hill & Willoughby, 2005; Nagoshi et al., 2008).

Individual-level effects of sexual and gender minority stigma on cisgender and heterosexual people are particularly relevant to the study of violence toward SGM individuals. For instance, it is well-established that sexual prejudice and felt stigma are key risk factors for heterosexual men's perpetration of physical aggression toward sexual minorities (for a review, see Parrott & Leone, 2017). However, as noted previously, SV toward SGM individuals is often perpetrated by cisgender, heterosexual men. While this may appear counterintuitive, the putative mechanisms

that motivate these acts are readily conceptualized through the collective lens of enacted, felt, and internalized stigma.

5.2.3.3 Summary

Invoking a stigma-based framework is a critical prerequisite to understanding the etiology of alcohol-facilitated SV toward SGM people. Indeed, alcohol-facilitated SV toward SGM individuals can be perpetrated by people of various sexual and/or gender identities who endorse individual risk factors rooted in sexual and gender minority stigma. Moreover, intersecting identities within and between perpetrators and victims can magnify the stigma felt by SGM individuals as well as increase the likelihood that certain perpetrators target SGM people with multiple marginalized identities. This framework parsimoniously describes how sexual and gender minority stigma affects all people and, in turn, suggests how that impact can influence SV perpetration toward SGM individuals. Thus, this framework provides the foundation for our proposed integrative model and its implications for future research and proposed prevention efforts.

5.3 Alcohol-Related SV Perpetration Toward SGM Populations

Decades of treating nonnormative sexualities and gender identities as markers of mental illness and criminality have resulted in an extremely narrow body of literature focused on SV perpetration toward SGM people (McKay et al., 2019; Young & Meyer, 2005). In light of this, it is not surprising that empirical studies on the association between alcohol and SV perpetration toward SGM people are almost nonexistent. Among the few available studies (e.g., Davis et al., 2016; Hequembourg et al., 2015; Peitzmeier et al., 2015), data suggest (1) alcohol-related contexts are one of the most likely settings for SV victimization; (2) SV survivors often report alcohol use by the perpetrator prior to the assault, and (3) there is a positive association between problematic alcohol use and likelihood of perpetrating physical or SV toward an intimate partner. However, it should be noted that the methodological rigor of these studies suffers from weakness that characterize this field in general. As reviewed later, these weaknesses include research designs and measurement approaches that do not accurately capture the proximal and temporal occurrences of alcohol use and SV perpetration.

While these findings bear similarities to the substantive evidence base on (presumably cisgender) men's perpetration of SV toward (presumably cisgender) women, they fall woefully short in informing a research agenda to prevent alcohol-facilitated SV toward SGM people. What can we learn in the absence of rigorous research in this area? In our review of the literature on SV in SGM populations, two

notable themes emerged. First, there is a severe paucity of information on who is perpetrating acts of SV toward SGM people. Extant research either specifically samples same-sex couples and focuses on SV within an intimate relationship or asks SGM people to report on SV victimization experiences using measures that do not capture the identities of their perpetrators. In both instances, the use of alcohol by the perpetrator is rarely assessed. Second, there is some more research (though still not an abundance) that examines the link between alcohol use and negative health outcomes in SGM people. While these studies may assess the association between an SGM person's alcohol use and SV victimization, they do not assess the effect of alcohol on SV perpetration toward SGM people.

This is unequivocally not the case in research using samples of (presumably) heterosexual participants. In this work, it is well-established from a range of rigorous research methodologies that proximal alcohol use is a contributing cause of SV perpetration (Abbey, 2002; George & Stoner, 2000; Testa, 2002). Although we are unaware of any theoretical or empirical reason to think that alcohol would not also be a contributing cause of SV perpetration toward SGM people, the empirical research base to date does not allow for this determination. Indeed, as a result of the aforementioned issues, the question of the role of alcohol in SV perpetration is almost impossible to answer based on the available data.

Why is this the case? To begin, the SV epidemic is framed predominately around the heteronormative investigation of violence perpetrated by men and toward women. Evidentially, this makes sense. Women are significantly more likely to experience SV during their lives than men, and the majority of sexually violent acts against women are perpetrated by men (Tharp et al., 2013). However, SGM people experience SV victimization at rates comparable to, if not greater than, cisgender heterosexual women (e.g., see Edwards et al., 2015; Flores et al., 2020; James et al., 2016; Messinger, 2011; Walters et al., 2013). Thus, why is it that research does not focus squarely on this disparity? While the answer to this question is likely due to multiple factors, it is clear that limited sources of funding have played a key role. A study that reviewed records from the NIH RePORTER found that between 1989 and 2011, only 0.1% of NIH-funded studies included a non-HIV/AIDS focus specifically on the health of LGBT populations and, among those very few studies, 3.3% focused on violence and 12.9% focused on alcohol use (Coulter et al., 2014). Consistent with these data, extraordinary efforts were necessary during this time period to provide seed funding and bolster competitive NIH grant applications on SGM health (e.g., see Kimmel et al., 2020; Parrott, 2020).

Put simply, our research enterprise marginalized an already marginalized population. While changes in these practices have been observed in recent years, continued structural changes will be required (e.g., see Abbey & Helmers, 2020). Even with such progress, researchers will ultimately bear the burden of applying the best possible science to understand the role of alcohol in SV perpetration toward SGM individuals. To this end, we propose an integrative theoretical model that serves as one step toward reversing this injustice.

5.4 An Integrative Model

The preceding review has established that the field lacks a comprehensive understanding of the link between alcohol use and SV perpetration toward SGM people. Thus, efforts to develop effective, culturally informed prevention and intervention efforts for alcohol-related SV are limited. To guide research and prevention efforts, we expand upon an integrative theoretical model originally designed to guide research on intimate partner violence in sexual minorities (Shorey et al., 2019). This model invokes (1) a "metatheory" (I^3 Model), to organize risk and resilience factors at the individual and dyadic level, and (2) a proximal process theory (alcohol myopia theory), to explain the mechanism by which proximal alcohol use facilitates SV as a function of individual differences in those factors (Parrott & Eckhardt, 2018).

5.4.1 The I^3 Model

The I^3 Model ("I-Cubed") is a multifactorial metatheory largely used to predict aggressive behavior, typically within intimate relationships (Finkel, 2007, 2014; Finkel & Eckhardt, 2013). The I^3 Model suggests that we can predict whether a given social interaction will result in aggression if we can discern the strength of *I*nstigation, degree of *I*mpellance, and presence of *I*nhibitory factors. Research supports the use of the I^3 Model to predict alcohol-related interpersonal violence generally (Parrott & Eckhardt, 2018) and SV specifically (Grom et al., 2021). However, this model has not been applied to alcohol-related SV (for an exception, see Ngo et al., 2018).

Based on the I^3 Model, the likelihood of SV perpetration can be determined by weighing the relative strength of three factors: instigators, impellors, and inhibitors. *Instigating factors* produce the initial momentum toward an aggressive action. In SGM people, enacted, felt, and/or internalized stigma can result in acute minority stress, which can provide this initial momentum. Similarly, in cisgender heterosexual men, the threat to one's masculinity imposed by enacted or felt stigma – which is often experienced in the form of negative affect or anger (for a review, see Parrott, 2008) – can provide that initial momentum.

Once instigation occurs, the relative balance of impelling and inhibiting factors determines the strength of an aggressive response. *Impelling factors* are dispositional or situational factors that psychologically prepare an individual to experience a strong urge to aggress when encountering instigation in a particular context. In SGM people, chronic minority stress (whether external or internal) is likely to make them more sensitive to the aforementioned instigating triggers. Similarly, in cisgender, heterosexual men, masculinity and sexual prejudice are enduring factors that likely make them more receptive to instigating triggers (e.g., threats to one's masculinity related to felt stigma). Thus, instigating and impelling factors interact to determine the likelihood that the person will perpetrate SV. *Inhibitory factors* increase an

individual's capacity to override the effects of instigating and impelling forces. Thus, inhibitors, which reflect individual- and community-level factors that promote resilience (for a review, see Meyer, 2015), set the threshold beyond which instigator- and impellor-driven urges would result in SV perpetration. Finally, researchers commonly expand the I^3 Model to include disimpellors and disinhibitors (e.g., Finkel, 2014; Sprunger et al., 2015). Compared to impellors, *disimpellors* are factors that reduce the salience of instigators or otherwise interfere with the strengthening of an urge to engage in aggression (Finkel, 2014). Meanwhile, compared to inhibitors, *disinhibitors* reduce the threshold beyond which instigator- and impellor-driven urges would result in aggression, because they reduce a person's ability to override the weight of an impelling force (Finkel, 2014). To this end, evidence strongly suggests that alcohol does not unilaterally impel acts of aggression via direct pharmacologic manipulation; rather, alcohol intoxication functions as a disinhibitor, because it produces key neuropsychological changes that alter executive functioning and impede self-regulatory capacities (Giancola et al., 2010). Put another way, alcohol facilitates SV by taking one's foot off the brake pedal (i.e., disinhibition) rather than by stepping on the gas pedal (i.e., impellance).

In summary, the I^3 Model suggests that we can enhance predictions of whether a given social exchange will result in SV perpetration, if we can discern the strength and patterning of instigation, (dis)impellance, and (dis)inhibition factors. Thus, this model is ideal for understanding whether proximal alcohol use (a disinhibitor) alters the threshold at which the effects of instigating (e.g., acute sexual and gender minority stress, state anger) and impelling forces (e.g., chronic sexual and gender minority stress, masculinity, sexual prejudice) contribute to SV perpetration.

5.4.2 Alcohol Myopia Theory

The proximal effect of alcohol on aggression is most frequently interpreted from the etiologic standpoint of alcohol myopia theory (AMT; Steele & Josephs, 1990). AMT purports that the pharmacological properties of alcohol narrow attentional focus, restrict the cues individuals perceive, and reduce individuals' capacity to process meaning from information they do perceive. One model within AMT, the attention-allocation model, posits that alcohol impairs attentional capacity, which then restricts the inebriate's ability to perceive and process instigatory and inhibitory cues. As a result, intoxicated individuals allocate their attention such that they perceive and process only the most proximal, salient cues of a situation (e.g., a verbal insult) to the exclusion of less salient and often more distal, inhibitory cues (e.g., legal consequences of aggression). AMT has garnered substantial empirical support as a model for understanding *how* alcohol facilitates aggression (for reviews, see Giancola et al., 2010; Parrott & Eckhardt, 2018).

Thus, it follows from AMT, and the attention-allocation model specifically, that proximal alcohol use should potentiate SV perpetration by narrowing attention onto salient, instigatory cues (e.g., desire for sex, felt stigma) and away from inhibitory cues (e.g., lack of explicit consent). This hypothesis is supported by numerous reviews of laboratory experiments involving presumably cisgender, heterosexual men (e.g., Abbey & Wegner, 2015; Abbey et al., 2014; Crane et al., 2016; Davis et al., 2014; George & Stoner, 2000), which collectively demonstrate that acute alcohol intoxication increases laboratory-based SV perpetration toward women.

5.4.3 *Integrative Summary*

A key advantage of the I^3 Model is its theoretical inclusiveness, which allows researchers to incorporate relevant theories to examine how hypotheses related to SV risk can be translated into process-oriented mediation models. Alcohol myopia theory fleshes out the inhibitory process dimension of the I^3 Model. This novel integration is depicted in Fig. 5.1. Alcohol myopia theory also emphasizes the importance of cue salience and, more specifically, indicates that alcohol is most likely to facilitate SV to the extent that SV-promoting cues (i.e., instigators and impellors) are more salient to the inebriate than SV-inhibiting cues (i.e., disimpellors, inhibitors). Put another way, determining the likelihood of alcohol-facilitated SV is based on the premise that *cue salience* is the critical predictor of attentional focus; however, individuals certainly differ in what they perceive to be salient as well as in their

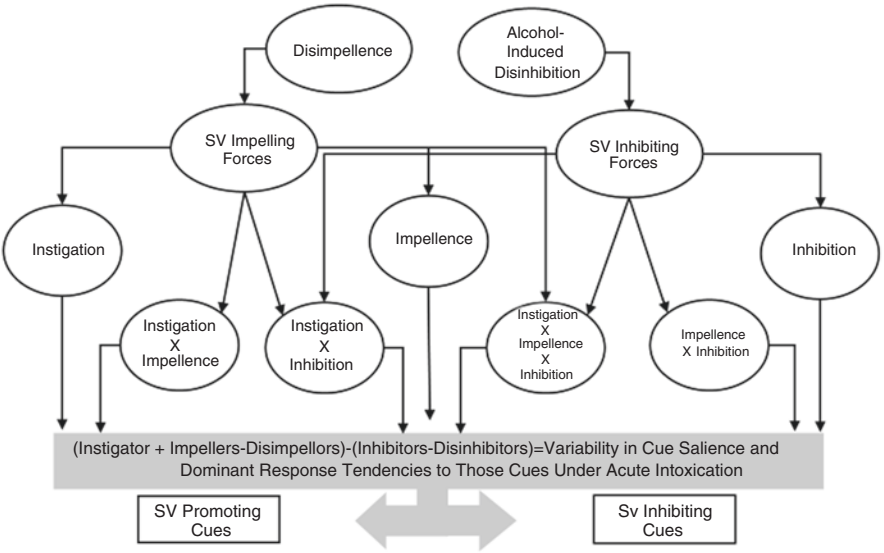

Fig. 5.1 Integrative theoretical model of alcohol-related SV perpetration

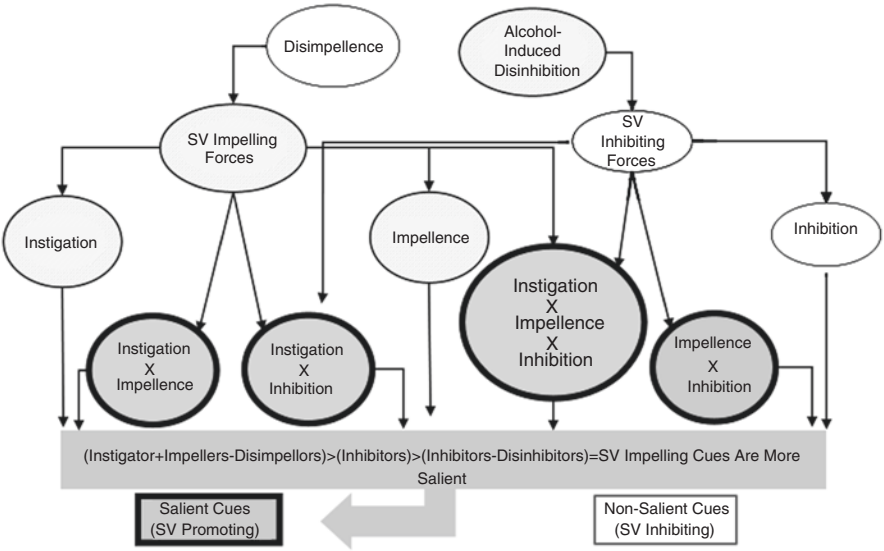

Fig. 5.2 The perfect storm. (Note: Stronger effects are indicated by (1) bolder, relative to lighter, outlines and (2) shaded, relative to light, circles)

dominant response to a given salient cue. These individual differences are captured by the I^3 component of the integrative model, and Fig. 5.2 depicts the "perfect storm," wherein instigation, impellance, and disinhibition are strong and disimpellance and inhibition are weak – thereby heightening the salience of SV promoting, relative to SV inhibiting, cues. Thus, the nexus of the integrative model lies in the premise that alcohol intoxication serves as a contributing cause of SV perpetration as a function of I^3-informed variability in perceived cue salience and response tendencies to those salient cues.

5.5 Implications for Research and Prevention: A Call to Action

The alcohol-SV link is a serious and complex public health and societal problem with broad impacts in many domains. Despite clear evidence that alcohol use is a proximal risk factor for SV perpetration in cisgender, heterosexual populations (Abbey, 2002; George & Stoner, 2000; Testa, 2002), researchers have been less successful at establishing etiological models that characterize the process-based mechanisms of those effects. Similarly, proximal mechanisms for SV perpetration toward SGM individuals are also poorly understood (Blondeel et al., 2018), and alcohol-based mechanisms have not been evaluated to date. Thus, resulting interventions target theoretically based, rather than evidence-based, mechanisms of action. This

problem is not unique to this field. A critical impediment to translational research is that behavioral scientists conducting efficacy research rarely invest significant resources to demonstrate that interventions affect relevant psychosocial mediators (Glasgow et al., 2003; Salazar et al., 2019). Importantly, even when such mechanisms have been tested directly or indirectly, it has been extremely difficult for single, stand-alone research projects to comprehensively address the interconnected nature of alcohol use and violence in sufficiently powered samples of the most at-risk and vulnerable subpopulations. This gap is particularly evident for SV perpetrated toward SGM populations, because factors related to sexual and gender minority stigma (e.g., minority stress, sexual prejudice, adherence to gender roles) surely influence these putative mechanisms. Because SGM people experience heightened rates of SV victimization relative to heterosexual and cisgender people (Edwards et al., 2015; Flores et al., 2020; James et al., 2016; Messinger, 2011; Walters et al., 2013), understanding these complexities is critical to the development of interventions for this particularly vulnerable population.

The proposed integrative model has high potential to address these gaps and thus advance the field. It provides an organizational structure for predicting risk for alcohol-facilitated SV perpetration that is not clearly defined within stigma-based frameworks (e.g., Herek, 2007) or minority stress theory (e.g., Hatzenbuehler, 2009; Meyer, 2003). Thus, it can organize the study of intersecting identities by disentangling acute and chronic minority stressors related to those identities. In turn, researchers will be better positioned to examine interactive effects of those stressors and proximal alcohol use on SV perpetration. To this end, invoking alcohol myopia theory brings a necessary focus to the proximal effects of alcohol and how it may alter the threshold at which the effects of instigating (e.g., acute sexual and gender minority stress, state anger) and impelling forces (e.g., chronic sexual and gender minority stress, masculinity, sexual prejudice) contribute to SV perpetration. Importantly, the extent to which alcohol alters one's threshold for SV perpetration lies in the extent to which instigating and impelling forces collectively elicit cues that are *highly salient* and for which *sexual behavior is the dominant response tendency*. This focus highlights the need for rigorous designs that allow for the assessment of proximal and temporal effects. As the evidence base develops, this integrative model can also be utilized to inform best practices for prevention.

5.5.1 Implications for Research

Recent reviews of alcohol use (Gilbert et al., 2018; Hughes et al., 2020) and interpersonal violence (Blondeel et al., 2018; Yerke & DeFeo, 2016) in SGM populations have identified critical weaknesses in the rigor of this literature, which include the following: (1) few studies that distinguish between sex assigned at birth, sexual orientation, and gender identity; (2) inadequate sample sizes; (3) poor operational definitions, and thus weak measurement, of alcohol use and SV; and (4) dependence on cross-sectional study designs that cannot test temporal relations between risk

factors and alcohol use or SV perpetration and victimization. Given these weaknesses, we propose the following recommendations.

5.5.1.1 Eliminate Heteronormative Sampling Biases

Research on the alcohol-SV link suffers from a heteronormative sampling bias. That is, sampling methods assume participants identify as cisgender and heterosexual or exclude SGM people for parsimony. Relatedly, it is also rare for research on SV perpetrators to assess sex assigned at birth, gender identity, gender expression, and sexual orientation (Rothman et al., 2011). This weakness not only prevents researchers from ascertaining who is perpetrating SV toward SGM people, but it in turn prevents researchers from understanding the varied etiological mechanisms that underlie SV toward SGM people. Collectively, these approaches are directly responsible for the marginalization of SGM people in this research literature. At the core of this problem is that, relative to heterosexual and cisgender individuals, SGM people face unique health risks due to their experience of a unique set of stressors. When these identities are not assessed or considered, *these unique stressors are also not considered*.

As research begins to address these weaknesses, the proposed integrative model will allow for the inclusion of factors that are associated with SV risk in perpetrators who vary across these dimensions. For example, although the effects of felt stigma manifest differently in SGM, relative to cisgender heterosexual people, they can be conceptualized as instigators in both SGM perpetrators (e.g., externalized sexual minority stress) and cisgender heterosexual male perpetrators (e.g., threatened masculinity).

5.5.1.2 Increase Methodological Rigor

To have high impact and best inform development of prevention approaches, studies must utilize research designs and measurement approaches that can accurately and precisely capture the proximal and temporal occurrences of alcohol use and SV. As previously noted, there are few studies that focus on perpetrators of SV toward SGM people, and we could not identify any studies that examined perpetrator alcohol use as a *proximal* antecedent to SV. The lack of data, and thus understanding, of this association, in many ways, mirrors the literature in cisgender, heterosexual populations from 40 to 50 years ago (Carpenter & Armenti, 1972; Wilson, 1977). At that time, Carpenter and Armenti (1972) noted that scholars often assumed that alcohol caused SV despite the confoundingly small amount of empirical data to support that assumption. They concluded that this lack of research "indicates how little modern society knows of the relationships of three of its more significant aspects – alcohol, sexual behavior, and aggression" (p. 509). Since then, much has been learned about the effect of alcohol on sexual behavior generally, and SV perpetration specifically, in cisgender, heterosexual populations. The same conclusion

cannot be made with respect to SGM victims. Thus, there is a critical need for studies that employ a range of research designs, which will allow for the convergence of evidence that speaks to the proximal effect of alcohol on SV toward SGM people.

Based on work with cisgender and heterosexual populations, such work will likely begin with the use of qualitative and cross-sectional designs. Indeed, these designs are typically easier to employ, allow for more rapid data collection, and require fewer resources relative to longitudinal or laboratory-based designs. While informative, we must be mindful that these designs do not allow for the modeling of temporal associations between variables. This need is best met via the use of laboratory-based experimental designs, longitudinal panel designs, and intensive longitudinal designs (e.g., experiential sampling through daily diaries or ecological momentary assessments). Among these, only experimental and intensive longitudinal designs are able to assess the *proximal and temporal effects* between variables. To this end, studies of cisgender, heterosexual individuals that examine alcohol use as proximal antecedent to SV violence perpetration have successfully employed experimental (e.g., Abbey & Helmers, 2020) and intensive longitudinal designs (e.g., Shorey et al., 2014; Testa et al., 2019). As a result, there is considerable cross-method convergence to demonstrate that alcohol use is a contributing cause of SV perpetration among cisgender, heterosexual men (e.g., George & Stoner, 2000). A clear and attainable goal for research focused on alcohol-facilitated SV perpetration toward SGM individuals is to employ designs and methods that are of comparably high methodological rigor. In doing so, we will better understand the alcohol-SV perpetration link and, in turn, be better equipped to address questions that continue to challenge the alcohol-violence field in general, namely, the identification of the most influential instigating and inhibiting factors and associated process-based mechanisms for alcohol-facilitated violence (Leonard & Quigley, 2017; Parrott & Eckhardt, 2018). As these complexities are better understood, interventions can be directed at these fundamental determinants.

It is well-established that SV can occur within the context of intimate relationships (Bagwell-Gray et al., 2015). However, when we focus specifically on mechanisms for alcohol-facilitated SV perpetration within intimate relationships, the literature is sparse (for exceptions, see Gallagher et al., 2010; Lisco et al., 2012). Thus, etiological models of alcohol-facilitated sexual intimate partner violence (IPV) remain relatively underdeveloped for all populations, and SGM populations in particular.

To this end, there are compelling reasons for understanding dyadic factors that may contribute to alcohol-facilitated IPV (Eckhardt et al., 2019). In research on nonsexual forms of IPV with cisgender, heterosexual populations, it is increasingly common to take a dyadic approach by using the Actor-Partner Interdependence Model (APIM) analytic framework (Kenny & Cook, 1999; Kenny et al., 2006). Relative to an analysis of only one partner's characteristics, this approach more accurately models IPV perpetration and victimization risk by considering the interpersonal nature of relationship; specifically, it provides the unique ability to examine potential effects of both partners' characteristics (i.e., instigating, impelling, and inhibiting factors) on IPV perpetration and victimization while accounting for the

other partner's characteristics and perpetration. For instance, research with cisgender, heterosexual couples suggests that both actor and partner alcohol and substance use is associated with S-IPV perpetration (e.g., Low et al., 2016) and nonsexual IPV perpetration (e.g., Leone et al., 2016). Thus, whereas research has often focused on the role of alcohol use as a disinhibitor of perpetrator IPV, an APIM framework provides the opportunity to examine how the interpersonal dynamics of a *partner's alcohol use* may also relate to Actor S-IPV perpetration.

However, only one study to date has examined risk factors for cisgender, heterosexual people's sexual IPV perpetration within the dyadic context (Grom et al., 2021). No study has used this analytic approach to study SGM people's sexual IPV perpetration or to model the proximal effect of alcohol on sexual IPV perpetration. Collectively, this work suggests that conclusions about the proximal effect of alcohol on sexual IPV perpetration toward SGM people will be limited if the interpersonal nature of IPV is not considered. Applying an APIM framework to the study of alcohol-related sexual IPV is consistent with the Institute of Medicine's (2011) prioritization of a social-ecological perspective in the study of LGBT health.

In summary, we can draw several important conclusions from the extant literature. First, there is little data on the link between alcohol use and SV perpetration toward SGM people. This need must be met with the use of multiple and rigorous methodological designs. There must also be a particular focus on designs that can identify the proximal and temporal association between alcohol and SV perpetration. Second, as the use of these methods begin to clarify the proximal effect of alcohol on SV perpetration, we need to understand in whom, and in what situations, these effects are mostly likely to be observed. This latter question must consider the perpetrator-victim relationship, inclusive of the relationship context. Until these goals are met, the field will remain significantly limited in its ability to develop prevention approaches.

5.5.1.3 Design Research to Assess Differences Within the SGM Population

As has been emphasized in this chapter, few studies on SV perpetration toward SGM individuals assess, let alone distinguish between, the perpetrator's sex assigned at birth, sexual orientation, and gender identity. Importantly, for studies that include a focus on sexual and/or gender minority perpetrators, it will also be critical to assess these constructs. Specifically, as research questions dictate, sampling approaches should be designed to capture and assess the broad diversity of identities among the SGM population or target a specific subgroup(s). When specific subgroups are the focus of the research, the precise assessment of these identity constructs in sufficiently powered samples will allow researchers to examine group differences in relevant outcomes of interest.

5.5.1.4 Incorporate an Intersectional Approach

Intersectionality theory posits that multiple forms of oppression converge to create social conditions, leading to discrimination over subpopulations (Crenshaw, 1989, 1990). The multiple oppressions experienced by SGM populations include stigma and discrimination related not only to their sexual orientation and to their gender identity but also to their race/ethnicity and class. Although the literature indicates that these interlocking oppressions result in extreme disparities in rates of mental health, violence, and heavy alcohol use (Arayasirikul et al., 2018; Bazargan & Galvan, 2012; Bockting et al., 2013; Carmody et al., 2020; Institute of Medicine, 2011; Parent et al., 2019), this body of research has focused mainly on victimization and the subsequent negative health consequences. An examination of how these interlocking oppressions result in SV perpetration is lacking.

A major tenet of the intersectional approach is an assumption that an individual's experience and their health are not simply the sum of their parts. For example, what it means to be a lesbian and the associated health implications may be different for Black lesbians relative to White lesbians. It is not appropriate simply to examine differences in any one health issue by race and add those to differences found by sexual orientation. Research is greatly needed that can more specifically (1) document inequalities in SV perpetration, specifically alcohol-facilitated SV perpetration, at these varying intersectional positions, and (2) study the potential individual- and group-level causes that may drive these observed inequalities. For example, it will be important to understand the specific and unique stressors that act as instigators for SV perpetration among Black, gay men, as we cannot assume that they would be the same for White, gay men. Similarly, identifying the dispositional or situational factors that act as impelling factors that position Latino transmen to perpetrate is likely different for Asian transmen. Furthermore, if alcohol acts as a disinhibitor for SV perpetration among White, transwomen, does it similarly reduce the threshold for SV perpetration among Black, transwomen? Incorporating intersectionality into health research among racially diverse heteronormative, cisgender populations has a host of methodological challenges (see Bauer, 2014); however, within the context of research with racially and economically diverse SGM individuals, the complexities and challenges are even greater. With the call made to better understand in whom, and in what situations, the proximal effects of alcohol on SV perpetration are mostly likely to be observed, an intersectional approach will improve the validity and specificity of the findings. Understanding racially, ethnically, and economically diverse SGMs in the context of multiple oppressions and within our proposed integrated model is a necessary step for furthering our understanding of alcohol-facilitated SV perpetration. In doing so, the field will be better positioned to develop and implement more precise interventions that address the social conditions unique and specific to SGM of color and of lower socioeconomic status.

5.5.1.5 Assess SV Across Relationship Type

The study of SV in SGM populations must account for the range of perpetrator-victim relationships along the spectrum of stranger-casual-intimate relationships. While attention to such relationships is a relative weakness in the rigor of research on SV (Anderson et al., 2020), it is particularly relevant for SGM people. Analysis of data from the National Crime Victimization Survey found that, whereas the rates of violence for non-SGM people were comparable across the continuum of relationship types (i.e., close relationships to strangers), the rate of violence was significantly higher among perpetrators who knew the SGM victim well relative those who did not know the SGM victim. Thus, SGM people may be at most risk for SV from people who they know well.

Research in this area is currently limited due to measures that historically either assess SV from a heteronormative framework or fail to assess the perpetrator-victim relationship (for an exception, see Dyar et al., 2019). For example, the Sexual Strategies Scale (Strang et al., 2013) only assesses male-to-female SV perpetration and does not consider relationship content. Similarly, the Sexual Experiences Survey (Koss et al., 2007) includes a range of tactics (e.g., verbal pressure, physical force) but does not include specific tactics that may be specific within the SGM community (e.g., threatening to expose a victim's identity to others). These measures could be modified with feedback from the SGM community to be more inclusive, as well as account for relationship type.

5.5.2 Implications for Prevention

Individuals within the SGM community experience higher rates of SV victimization compared to their cisgender heterosexual peers (e.g., see Edwards et al., 2015; Flores et al., 2020; James et al., 2016; Messinger, 2011; Walters et al., 2013). However, there remains a dearth of research on SV perpetration generally, and alcohol-facilitated SV perpetration specifically, within the SGM community and especially outside of intimate relationships. Extant evidence suggests men are the most common perpetrators of SV toward lesbian and bisexual women and gay men (Martin et al., 2020; Walters et al., 2013). In contrast, SV perpetration among women, nonbinary, and gender non-conforming individuals within the SGM community is not well understood. Toward this end, to make the biggest impact on reducing rates of alcohol-facilitated SV perpetration, efforts are especially needed that target men, *regardless of sexual identity*. Moreover, the field needs more evidence on the risk factors for alcohol-facilitated SV perpetration among SGM communities.

In the absence of such empirical evidence, our review of implications for prevention are drawn from the integrative model proposed above. Because comprehensive programming efforts are needed, we organized these recommendations within a social ecological framework and thus discuss proposed prevention approaches at the

individual, relationship, community, and societal levels. Until empirical evidence can support this integrative model, theory-based recommendations should be implemented with input from the SGM community through formative work, community advisory boards, and inclusion of members of the SGM community as research staff. In addition, interventions should undergo ongoing evaluation and be modified accordingly when new empirical evidence is disseminated.

5.5.2.1 Individual- and Relationship-Level Efforts

Despite over three decades of developing, evaluating, and implementing individual-level SV prevention programs, rates of SV remain consistent (Koss et al., 2007; Muehlenhard et al., 2017). To our knowledge, only two rigorously evaluated individual-level programs have reduced rates of SV perpetration: *Safe Dates* (Foshee et al., 1998, 2000, 2004, 2005) and *RealConsent* (Salazar et al., 2014). However, neither of these programs is tailored to SGM populations. Moreover, because these programs do not specifically target alcohol-related SV, it remains unclear if they reduce alcohol-related SV perpetration.

Efforts to reduce alcohol use among SGM individuals are a necessary first step toward mitigating alcohol-facilitated SV perpetration. Indeed, if SGM people are consuming alcohol in smaller quantities or not at all, alcohol is less likely to be a contributing factor in SV perpetration. These person-centered efforts are particularly needed, because research indicates higher rates of alcohol use in SGM, relative to cisgender heterosexual, populations (Coulter et al., 2015). Unfortunately, there is a lack of evidence- and theory-based alcohol prevention and treatment programs available for this population (Glynn & van den Berg, 2017), and more research is needed to inform these programs (see Talley et al., 2016). Ultimately, integrating evidence-based alcohol prevention content into SV programming is likely to be the most effective at reducing alcohol-related SV perpetration.

Even if treatment for an alcohol use disorder was deemed a first-line intervention in SGM people, it would likely not be sufficient to prevent SV perpetration. The reality is that many patients do not achieve sustained abstinence, and the long-term effects of extant interventions are unknown. Moreover, as has been established, perpetrators of SV toward SGM are often cisgender, heterosexual men. Thus, prevention efforts that target groups at high risk for SV perpetration (e.g., cisgender heterosexual and sexual minority men) toward SGM populations are needed. As reviewed, given the theorized impellors for SV perpetration in cisgender, heterosexual men (e.g., masculinity, sexual prejudice) and members of the SGM community (e.g., masculinity, chronic external and internal minority stress), tailored prevention efforts may be most fruitful. There are also several robust factors for SV perpetration related to, or intertwined with, gender and sexual norms (DeGue et al., 2014; Casey & Lindhorst, 2009; Heise, 1998) that can be targeted in programs for individuals within and outside of the SGM community. For example, some gender-specific programs aim to restructure traditional male norms (Katz et al., 2011; Katz, 2018; Wong et al., 2020) and could be modified to target sexual minority men who

may equate masculinity with sexual behavior (e.g., Halkitis, 2001). Further, gender and sexual norm risk factors are likely exacerbated when individuals are consuming alcohol (e.g., Leone & Parrott, 2015), which may help to reduce alcohol-related SV. Targeting social norms may be an effective cross-cutting strategy, because in addition to their potential to change traditional male norms (e.g., Berkowitz et al., 2020), this approach is recommended by NIAAA due to its high effectiveness, low cost, and high reach (NIAAA, 2019).

In addition to *decreasing SV impellor*s, it would also be prudent for prevention efforts to *strengthen disimpellors* that can mitigate the development of the urge to aggress. As noted in our integrative model, strengthening disimpellors should mitigate the development of aggressive urges. In the relative absence of internal and external cues associated with aggressive urges, SV perpetrated fueled by alcohol myopia is less likely. For example, a recent study showed that higher levels of psychological flexibility were negatively associated with SV in the content of heterosexual intimate partner relationships (Grom et al., 2021). These data suggest that, even in the context of impelling factors (e.g., heightened minority stress), strengthening disimpellance may help to mitigate risk for alcohol-facilitated SV perpetration. In the same spirit, individual-based interventions based on our integrative model suggest that interventions that *bolster inhibition* (e.g., increased emotion regulation) and *reduce disinhibition* (e.g., alcohol reduction strategies) have high potential to reduce alcohol-facilitated SV violence.

In line with best practices for intervention (Nation et al., 2003), efforts need to be appropriately timed. Prevention efforts should ideally begin in adolescence, before one enters into high-risk time periods for SV (e.g., college). The Sexuality Information and Education Council of the United States (SIECUS) and healthcare providers have recognized sexual and gender identity as a crucial component of comprehensive sex education (SIECUS, 2004; Breuner et al., 2016). Providing sex education on sexual orientation and gender identity can foster affirmation for one's own sexual and gender identity and foster respect for others' sexual and gender identity. Despite a call for sex education inclusive of sexual and gender identity, only a handful of evidence-based sex education programs delivered in schools include content on sexual and gender identity. Creating a culture of respect around sexual and gender identity can contribute to greater acceptance and normalization of SGM individuals. Such efforts should reduce sexual and gender minority stigma and, in turn, reduce stigma-based violence toward SGM individuals.

Moreover, in recent years, there has been a call for comprehensive sexual education that extends to other areas of development, including but not limited to interpersonal relationships, sexual consent, and alcohol and substance use (Breuner et al., 2016). Sexual education is critical to healthy development, and a key part of development includes learning about healthy dating and sexual relationships as well as sexual consent (SIECUS, 2004; Breuner et al., 2016). To prepare adolescents for college entry, where alcohol and substance use are both highly prevalent (Hingson et al., 2016; White & Hingson, 2013), it is important to discuss alcohol use and substance use in sexual education. This may be especially important among SGM people, who are more likely to use alcohol and substances in sexual situations (Lawn et al., 2019; Lorenz, 2021) and are at risk of problematic alcohol and

substance use in adolescence and adulthood (Talley et al., 2016). Therefore, there is a need for more inclusive sexual education that includes program content on sexual and gender identity, healthy sexual and dating relationships, and sexual consent as well as addresses risk behaviors, such as alcohol use and substance use.

It is important to recognize that while perpetrators are ultimately responsible for SV, there are few evidence-based programs that have demonstrated reductions in SV perpetration. Scholars have recently called for comprehensive and integrated programming that is focused on (1) targeting men's social norms to reduce perpetration, (2) SV risk reduction, and (3) bystander training (Orchowski et al., 2020). We echo these calls and highlight the need for these programming efforts to both include integrated alcohol content that specifically targets SGM populations. For example, SV risk reduction programs have demonstrated reductions in victimization up to 24 months and are inclusive of SGM populations (Senn et al., 2015; Senn et al., 2017); however, these programs do not yet integrate alcohol use content, which likely limits their effectiveness to reduce alcohol-related SV perpetration. Similarly, a recent large cluster randomized controlled trial found that an evidence-based bystander training program, *Green Dot*, was less effective at reducing violence for sexual minority, compared to sexual majority youth (Coker et al., 2020). Thus, tailored content specific to the SGM community is likely needed and should also include specific alcohol-related content. One program, +*Change* (Gilmore et al., 2022), has integrated alcohol use, SV perpetration, SV risk reduction, and bystander training and is tailored based on gender and sexual orientation. Initial work has shown +*Change* to be an acceptable and feasible approach with promising preliminary findings in reductions in alcohol use and SV-related constructs (Gilmore et al., 2022). However, more research is needed to determine its efficacy. Nonetheless, it suggests that tailoring content to SGM is feasible and promising for already evidence-based programs to provide tailored content to this population using a comprehensive and integrated approach.

A variety of evidence-based programs exist that prevent or reduce the burden of HIV transmission among transgender women and men who have sex with men (Matacotta et al., 2020). These programs may provide an opportunity to maximize prevention via the integration of content relevant to SV and alcohol use. Such an approach would provide more integrated programming for these populations rather than developing new programs on alcohol use and violence prevention. Programs have successfully used an integrated approach to reduce sexual risk behaviors, SV, and alcohol use (e.g., Testa et al., 2020). However, few specifically address health behaviors among lesbian and bisexual women and transgender men. Therefore, targeted SV and alcohol programs would need to be developed for these groups.

5.5.2.2 Societal- and Community-Level Efforts

Efforts are also needed that target the outer levels of the social ecology. The 2020 Human Rights Campaign Foundation report on violence toward gender minority individuals calls for efforts to increase inclusivity and humanization of SGM among cisgender, heterosexual individuals to reduce anti-SGM violence (Human Rights

Campaign Foundation, 2020). Recommendations for prevention include eliminating stigma against SGMs, increasing cisgender people's awareness of gender identity and nonbinary inclusion, and supporting and elevating the voices of SGM individuals (Human Rights Campaign Foundation, 2020). These recommendations are consistent with the previously reviewed heuristic framework of sexual and gender minority stigma (Herek, 2007). As such, they have high potential for reducing alcohol-facilitated SV perpetration by weakening key stigma-based mechanisms (i.e., enacted, felt, and internalized stigma), highlighted within the proposed integrative model, and should be part of a comprehensive approach for SV prevention.

A social marketing campaign is a promising strategy to achieve these goals. For instance, by promoting positive social norms and raising awareness of sexual and gender identity, social marketing campaigns reduce sexual and gender minority stigma at the societal level which, ultimately, functions to prevent SV perpetration toward SGM people. Thus, social marketing campaigns are needed to target cisgender and heterosexual individuals to increase their awareness and knowledge of nonbinary gender identities, nonheterosexual sexual identity, normalize conversations about pronouns, differentiate between gender and sexual identity, and emphasize that gender and sexual identity is an identity rather than an individual choice. Through a social marketing campaign or other community-level prevention approach that diffuses messages of acceptance of SGM to the greater community, we can create a culture of anti-violence.

Laws and policies at the community and societal level may also help to reduce alcohol-related SV perpetration toward the SGM community. Indeed, scholars have identified six key policies that may help reduce SV perpetration, including the following: drinking environment (e.g., rules about over service), marketing, alcohol pricing, sale time, alcohol outlet density, and college policies. It is unclear whether changes in these policies may impact SV perpetration within SGM communities or if culturally specific alcohol-related policy changes are needed. In addition to alcohol-related policies, policy changes specific to SGM rights have had impacts on SGM populations. For example, analyses of the National Epidemiologic Survey on Alcohol and Related Conditions examined the effect of bans on same sex marriage that occurred in several states between wave 1 (2001–2002) and wave 2 (2004–2005; Hatzenbuehler et al., 2010). These data revealed a 41.9% increase in alcohol use among sexual minority individuals in states where same sex marriage was banned. In related work, evidence suggests that charges of discrimination related to one's sexual orientation or gender identity to the Equal Employment Opportunity Commission reflected more severe harassment and violence when those charges were filed from US states without nondiscrimination laws relative to states with nondiscrimination laws (Baumle et al., 2020). Collectively, these data show how embedding sexual and gender minority stigma within laws and policy (e.g., via banning same-sex marriage or failure to adopt nondiscrimination laws) can influence individual-level behavior. Given these data, it would be expected that corresponding increases in alcohol-facilitated SV toward SGM populations would also be observed in these analyses. Likewise, it also follows that laws and policies that eliminate sexual and gender minority stigma and support SGM communities would result in

a reduction in alcohol-related SV perpetration to SGM individuals; however, to our knowledge, no empirical data has been reported that addresses this question.

5.6 Conclusions

The preceding review has demonstrated that the link between alcohol and SV toward SGM individuals is extraordinarily complex; yet, the complexity of the problem has not been met with the necessary rigor of research to bring clarity to its etiology. The dire need for this work is undeniable and grounded in empirical data, which indicate that (1) rates of SV victimization are as high, if not higher, among SGM populations relative to their cisgender, heterosexual peers and (2) proximal alcohol use is a contributing cause of SV perpetration toward cisgender, heterosexual women. However, the field is characterized by such little data on the role of alcohol in SV perpetration toward SGM populations. As a result, we do not know who is throwing SGM people into the river, why they are doing it, or how alcohol use plays a role. Until such an evidence base exists, we are in many ways powerless to prevent it.

Thus, we call for collaborative, interdisciplinary research to bring the best possible science to this area. The proposed integrative model, which we situate within a heuristic framework of sexual and gender minority stigma, provides a parsimonious way to unpack this complexity and guide that work. Importantly, our model calls attention to the need for rigorous designs that allow for the assessment of proximal and temporal effects of alcohol on SV perpetration. It also provides theoretically based targets for intervention at multiple levels of the social ecology. With these intended effects, we must be reminded that the entanglement of SV and alcohol use is as much (if not more) a social problem as it is an individual problem – regardless of the perpetrator and victim's identities. Thus, our pursuit of etiological research and prevention approaches for alcohol-facilitated SV perpetration must address sexual and gender minority stigma as well as its effects throughout the social ecology. In doing so, we will have a greater and more sustained impact on individual-level behavioral change

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