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Review Article

LGBT Teens and Bullying: What every Social Worker Should Know

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Introduction

What are the psychological scars that remain for vulnerable teenagers who have been bullied for being LGBT? For social workers to provide responsive screening and assessment with this population, follow up qualitative study [1], was administered to continue to try and gain further clarity about the complex psychosocial sequelae of teen LGBT bullying. Two focus groups of LGBT adolescents/young adults who had been bullying targets (n=16) were interviewed regarding their respective psychosocial experiences. After interviewing, a cohort of such young adults, social workers can gain additional insight into how this population might present in psychosocial counseling.

Bullying refers to "repeated aggressive behavior that occurs within particular interpersonal relationships that are characterized by a power imbalance", and while it has been known to peak in early adolescence, it may leave profound psychological after-affects in late adolescence [2]. The consequences of physical and psychological victimization often include lower self-esteem and higher risk for anxiety and depressive symptoms in in late adolescence and early adulthood [3]. Research in bullying and adolescents indicates that LGBT teens are much more vulnerable to becoming targets of bullying (and a different form of bullying) than their heterosexual counterparts [4,5]. Research suggests that while anywhere from 30%-50% of all heterosexual teens might be bullied, anywhere from 70% to 90% of sexual minority adolescents encounter bullying and ongoing victimization [6-11].

Review of Literature

Bullying

International research on the exposure to bullying in adolescence demonstrates this is a universal activity across the globe with estimates anywhere from 8.6% to 45.2% among boys, and from 4.8% to 35.8% among girls [12,13]. Olweus described bullying as the exposure "repeatedly and over time, to negative actions on the part of one or more other students". He includes an important qualification: "It must be stressed that the term bullying is not (or should not be) used when two students of approximately the same strength (physical or psychological) are fighting... there should be an imbalance of strength (an asymmetric power relationship)". However, bullying of LGBT teens, is not the same as school-aged bullying per se, but is part of a larger cultural context of homophobia and violence towards gay and lesbian youth [5]. Bullying can take place in one, some or all of the following forms: emotional, verbal, physical and/or cyber bullying [14-17].

It is essential that social workers understand that while the bullying activities may have taken place in early or mid-adolescence, current research indicates that changes in the prefrontal cortex and the limbic system continue well into the twenties and influence cognitive functioning, psychological adjustment and self-regulation [18]. Research demonstrates that is an incremental and ongoing development and strengthening of emotional, cognitive and behavioral systems through adolescence and these developments can be interrupted and distorted with real and perceived psychosocial threats [19,20]. Social workers in mental health need to understand that typical emotional responses to victimized as youths include anxiety, depression, vengefulness, and self-pity that may present into their early twenties [2,11,21-26]. Indeed, numerous studies have identified bullying as a contributing factor in suicidal behavior [6,19,25,27-30].

Olweus and his colleagues (1993) surveyed 15 young adult males who had been bullied and found that the respondents had significantly higher levels of depression and lower self-esteem than their peers. Elliot, et al. [31] conducted a study of 1,000 young adults, (mostly women) and found that the primary psychosocial aftereffects included: difficulties trusting others and fear of new situations (no percentage given), below-average self-esteem (43%), difficulties making friends (73%), and continuing to be bullied in their further education or in their place of employment (36%) (p. 145). Schafer et al. studied adults (n=884) on the after effects of being bullied in high school and found that "former targets of school bullying scored lower than a control group on self-esteem, higher on emotional loneliness, and reported more difficulties maintaining friendships".

Carlisle, et al, [21] interviewed 15 adult males who had been bullied and identified that as adults, they experience "current symptoms of social isolation, shame, thoughts of revenge, anxiety, and difficulties in forming adult relationships,". Bullying in high school has also been identified as a variable in many school rampage shootings. Vossekuil, et al., [32] studied 37 incidents of targeted school shootings that occurred in the United States between 1974 and 2000 and found that the majority (¾) reported being bullied in school settings and victimized by their peers prior to the incident [32].

Bullying of LGBT Teens

Studies demonstrate that LGBT youth are bullied in schools more often and more severely than their heterosexual counterparts [33-40]. The most recent national study of middle and high school students (n=6,209) found that three fifths (60.8%) felt unsafe at school because of their sexual orientation, and more than one third (38.4%) felt unsafe because of their

gender expression [41]. Within a social context that enforces behavior standards through threats, taunts, and physical attacks, young people who are, or appear to be lgbt are at special risk for these forms of violence [42-46]. These patterns of bullying activities are not only confined to schools. Evidence suggests that gay-baiting, and gay-bashing are common events in other settings, such as child welfare institutions and group homes [15,33,47-51].

With the bullying comes threats to their physical, academic, and psychological well-being [47,50]. Among a sample of LGBT students between the ages of 15 and 24 (n=425) who had disclosed their sexual orientation, nearly 94% reported "some form of sexual orientation-related victimization" [52]. It is assumed that reported data of violence toward LGBT students are significantly underestimated [53-55].

In addition to the higher frequency of bullying in sexual minority youth, LGBT youths are exposed to a different, more dangerous bullying that often includes sexual taunting, "mock rape" and even rape [56]. In verbal, physical and cyber-bullying, the LGBT youth may be humiliated, ridiculed and exposed (as in the Clemente case) as well as sexually assaulted [56]. Of the many complex ways in which young LGBT people experience and cope with heterosexual prejudice/homophobia, must include pre-morbid and co-morbid personality, mood and family matters. The frequency and the severity of LGBT bullying, places our already vulnerable adolescent at a dangerous precipice [48,57].

LGBT teens are also at greater risk of being rejected, mistreated or even disowned by their own families and religious communities [52,53]. Internalized negative authority figures from their community and religious associations can lead to low self-esteem, secret shame, and increased risk of victimization and in some cases significant mental health problems [8,45,52,58].

Over the past decade, the positive news for this population is the amount of growing acceptance on large scale policy messages such as marriage equality, but also daily life in school, with a burgeoning Gay-Straight Alliance movement [13]. Gay Straight Alliance (GSA) clubs are "powerful tools that can transform schools – making them safer and more welcoming for LGBTQ youth, youth with LGBTQ parents, and straight allies" [13]. In this national survey of secondary school students, "less than one quarter (22%) of all LGBT and non-LGBT students report that their school has a GSA or another type of student club that addresses LGBT students' issues", with schools in California and New York having the most and schools in rural south the least. Critical to mental health care providers and educators is the fact that LGBT students of color appear the least likely to have and to make use of the GSA clubs; leaving them at higher risk and affording them less peer and community support [13].

Beckerman, et al. [1] used a qualitative study and interviewed LGBT teens (n=23) who had experienced bullying. In response to bullying based on their sexual orientation, respondents expressed several themes: 1) social withdrawal, 2) hypervigilance and 3) retaliatory fantasies. These themes concur with bullying literature [27,32].

D'Augelli, et al, addressed, family victimization when they studied lesbian, gay, and bisexual youngsters, (n=194) aged 14-21 yrs and living at home, were studied for patterns of disclosure of sexual orientation to families. Three-quarters had told at least 1 parent, more often the mother than the father. Those who had disclosed were generally more open about their sexual orientation than those who had not, and few of the nondisclosed expected parental acceptances. Those who had disclosed reported verbal and physical abuse by family members, and acknowledged more suicidality than those who had not "come out" to their families [59,60].

When families are rejecting or even violent, running away from home, conflict with the law, substance abuse, prostitution, and suicide are more likely to follow [61-65]. In Ryan's study of family rejection and acceptance in the lives of these teens, (n= 245). Family acceptance predicts greater self-esteem, social support, and general health status; it also protects against depression, substance abuse, and suicidal ideation and behaviors [66].

Bullying: the psychological sequelae

Bullied LGBT youth are at high risk for internalized homophobia, low self-esteem, depression, feelings of alienation, self-harm behaviors, substance abuse and engaging in suicidal attempts and completed suicides [16,25,52,66]. Attempted suicide and suicide rates for LGBT youth have been estimated at ten times as high as their heterosexual counterparts [7,27,28,33,68,69].

Another study of 1032 high school students in Massachusetts [4] found that LGBT youth often experience a chronic state of harassment and stress that can result in serious emotional stress and mental health issues. This negative psychological aftermath (including high rates of depression and suicide) has been confirmed by numerous other studies [6,7,18,26,33,35,61,65,70,71]. Hoyt, et al. [15] researched this population (n=425) between the ages of 16 and 24, and reported that just about the entire participant sample (94%) had endured sexual orientation-related victimization. Given the nature and extent of victimization experienced for these teens, studies have identified increased prevalence of internalized psychopathology (e.g., mood and anxiety disorders, psychological distress) among adult sexual minorities [19]. Interesting to note, that while being bullied may result in becoming aggressive or becoming a bully in heterosexual adolescents, it does not appear to be parallel among LGBT cohorts who have been victimized.

Evidence suggests that many LGBT youth lack supportive family, friends and teachers. They avoid seeking support from their parents or other adult figures out of fear that seeking support will lead to further victimization [10,28,70,72]. These harmful and negative messages shape the adolescents' worldview. In fact, Mishna explains that, "...negative messages are experienced across the landscape of the youth's experience; peers, siblings, parents, teachers, religious authorities, and coaches, as well as in social policies, laws, and institutions" [55].

In the sensitive stage of adolescence, identity formation

and separation/individuation from family of origin, bullying by one's peers and others because of sexual orientation, appears to a) be somewhat different in nature, b) occur in a different societal context and c) is more likely to leave enduring emotional scars in psychosocial development [26,41,42]. There is evidence too; that those who have experienced bullying long-term display a constellation of symptoms that closely resembles PTSD [12,47,73,74].

Social Withdrawal

When confronted with danger, many LGBT adolescents will attempt to adapt, to cope, and to try to fit in or find a safe peer cohort [64,75]. The research shows that this is not as successful as one might hope [20,76]. With a worldview of potential threat and harm, as well as rejection, LGBT teens often relied primarily on social withdrawal (when in the extreme- social isolation) as a survival mechanism [26,47,77]. This a standard coping tactic when an adolescent has experienced victimization solely at school, however, the more widespread the bullying (in other social circles) the more likely the teen is to enter into a state of social and withdrawal [26,42]. From literature that is specifically examined LGBT teens and bullying, it appears more likely that lgbt teens have a more encompassing social withdrawal than do their heterosexual counterparts [47]. Perotti's excellent analysis, "When Drama Club is not Enough," highlights the pervasive struggle of trying to integrate an unwelcome and potentially dangerous social stratum in high school [64]. Unfortunately, social isolation can become a way of life that becomes the norm for the young adult, intensifying feelings of shame, low self-esteem and depression [24,2677,78].

Hypervigilance

Hypervigilance is a common and enduring neurobiological response to a real or imagined threat to safety. For the adolescent who has experienced physical, verbal or emotional abuse, one very natural (and in some cases, adaptive) response is to be alert to danger. In numerous studies on high school bullying, the targets appear to live in a state of hyper vigilance, watching, listening and fretting about the next time they may be in harm's way [2,21]. The trauma of physical and verbal bullying appears to have long-lasting impact on the autonomic nervous system leaving the young adult at risk for living in a state of chronic wariness and anxiety [16,55]. This state of hyper vigilance overlaps with the feature of hyper vigilance in a PTSD diagnose, but does not appear to manifest in flashbacks and blunted affect the other two domains of the PTSD diagnosis [73]. The pervasive sense of vulnerability in an adolescent can develop into some of the symptoms of PTSD such as a startle response, but literature has also shown an overlap in Acute Stress Disorder [12,79].

Low Self-Esteem

In addition to mental health challenges such as depression, anxiety and suicidal ideation [40], and social withdrawal as a coping mechanism [5,64], there is a wide range of research that identifies low self-esteem as a pervasive symptom for the bullied LGBT teen [77]. When the community (schools and religious organizations), family and peers have rejected these adolescents, they are at risk to internalize these negative comments and behavior and develop very low self-esteem [12,35,71].

Bullying by family (Family victimization/rejection)

As social workers, we should make the distinction between family victimization and family rejection – those who have been victimized by family more likely to experience significant psychosocial distress; suicide, homelessness, depression and anxiety and substance abuse. Those with family rejection at risk for those significant factors and those with a family of origin that demonstrated acceptance are most likely to move through trauma and recover, functioning adaptively in work and love. Major mitigating factor to negative psychological sequelae of teen bullying is family support. There is also a major buffering effect of positive peer support on the links between family rejection and psychosocial adjustment in LGB emerging adults [7,59,62,80].

Parra, et al. [81] studied LGBT young adults (n = 62) (ages 17-27) and reported on their families' attitudes toward homosexuality, experiences of family victimization, peer social support, anxiety and depression symptoms, and self-esteem. Results showed that peer social support moderated the link between negative family attitudes and anxiety, and also moderated the link between family victimization and depression.

McConnell, et al. [62] studied a sample of LGBT youth (n = 232) aged 16-20 years for over 5 years. Respondents who lacked family support, but who had other forms of support, reported a decrease in psychological distress and an increase in family support across adolescence [62]. The role of families of origin is a critical point of initial assessment, because of their significance as a predictor of realistic goals for a vulnerable young adult [66,82].

Method

Design

The authors selected a qualitative design employing focus groups, seeking to discover more about the range of complex psychosocial concerns for LGBT teens who have been bullied because of their sexual minority status The rationale for using the qualitative approach was that the psychosocial challenges and needs of this population are not well known and the researchers wanted to "capture the lived experience from the perspectives of those who have lived it and created meaning from it" [83]. Focus groups are ideal for an open exploration of this type, providing a safe atmosphere in a small group. Because the members have had similar experiences, they cohere quickly, "normalize" each other's behaviors, and evoke memories [26,84].

Participants

Candidates for the study were referred by social workers currently facilitating individual and group counseling for LGBT young adults. Eligibility criteria were explained and potential focus group participants were screened by social workers

and the researchers. An adolescent was considered eligible if he or she was LGBT, reported "bullying" based on sexual orientation, spoke English as a first or second language, did not suffer from substance abuse or psychiatric issues that might interfere with his or her integration with the group, was capable of understanding the purpose of the study and was willing to participate. Of the 21 respondents,7 were eliminated because of current substance abuse issues or acute psychiatric conditions, because they appeared vulnerable to retraumatization. Another five were either not able to make the scheduled meeting dates or withdrew after initial agreement for reasons unknown.

Two focus groups were conducted. Two groups of 8 teens, were utilized. This phase of research was conducted to explore if similar themes emerged and if any new themes could be detected. The ethical dimension of this study originated with IRB review from both the academic and the agency institutions. Regarding informed consent, participants were informed of the purpose of the study, how the findings would be used, and that participation was on a voluntary basis. Participants were asked to sign an informed consent and were advised that they could follow up with a clinician if the research created subsequent psychological distress.

Measure

The interview guide developed by the author in initial phase of study was used again to ensure consistency. It consisted of four general questions about the sample's experiences in this area. The content of the questions were gleaned from the relevant literature on LGBT bullying and PTSD. The background demographics gathered were age, gender, sexual orientation, race, and experiences with being bullied.

LGBT bullying and PTSD

1) Have you ever been bullied?

a) verbally

b) physically

c) cyber

d) other

2) How did you understand the reason for this bullying?

3) How do you think this bullying affected you?

a. Your mood? Thoughts? Behaviors?

4) If this bullying changed your sense of yourself, how so?

In each group, participants were asked to respond to a series of general open-ended questions designed to identify the participants' shared experiences. The same interview guide was used for all three groups. The data were analyzed from detailed notes, as well as audiotape transcriptions. All responses were confidential; no names or identifying information were collected or tied to individual responses. Participants were informed of the purpose of the study, how the findings would be used, that participation was on a voluntary basis, and that their services would not be negatively impacted if they declined to participate. the sample was de-identified and all information was used anonymously. All comments were used to generate a preliminary understanding of this population's themes. The results were coded, and the codes combined or sub-divided on the basis of their perceived importance to the research.

Limitations

There are several limitations to the study. This is an urban cohort based in a community mental health center (near several high schools and community colleges) which may not be consistent with rural or suburban communities. These participants had sought an LGBT affirmative support group which may skew the sample in that this is a cohort who may have had more motivation or access to counseling, or may have experienced higher degrees of emotional distress than their counterparts. Lastly, the relatively small sample size limits the generalizability of the findings, yet adds further insight and depth to our understanding of this important phenomenon.

Results

Sample Characteristics

Of sixteen respondents, slightly more than half were male (nine). And seven were female and one, transgendered male to female. Half were between 19 and 22, and half between 23 and 25. Regarding race, eight participants were Caucasian, one was Hispanic, two were Caribbean-American, one as Asian and four self-identified as biracial. Each participant reported that they had experienced some form of ongoing bullying (both physical and verbal) due to their sexual orientation throughout their high school years. All sixteen participants (100%) reported being verbally abused by peers in high school due to their sexual orientation and two thirds (12/75% f %) reported some incidence of physical abuse due to their sexual orientation. Half (n = 8) had been cyberbullied by schoolmates. Eight (n = 50) participants explained that they were ridiculed and abused by their siblings or other family members.

Themes that emerged from these groups concurred with previous research. Two primary themes of social withdrawal, hypervigilance, emerged, as well as low self- esteem and retaliatory fantasies [21,32]. Females were more likely to have low self-esteem (4 out of 5) Males were more likely to withdraw (n = 8males-/0 females) and more likely to have retaliatory thoughts (4 males-/0 females). One additional theme emerged; participants being "bullied" by family members, a minor more recently identified in prior studies [1,55] (Table 1).

Hypervigilance

When participants were asked how they thought the bullying affected them, ten participants across both groups (62%) expressed feeling "unsafe", and the need" to stay on guard," "keep my eyes open"

I'm always nervous that somebody's going to start something with me. I'm always looking over my shoulder.

If I'm with my boyfriend, we never let anyone in our

Table 1: Sample Characteristics (N=16).

	N	%
Gender		
Male	10	62%
Female	5	31%
TG (M-F)	1	6%
Age		
18-21	10	62%
22-23	6	37%
Race		
African-American	3	19%
Hispanic	2	12%
White	6	37%
Asian	1	6%
Biracial	4	25%
Abuse		
Physical	12	75%
Verbal	16	100%
Physical and Verbal	16	100%
Cyberbullying	9	56%
Bullyng by Family	8	50%

neighborhood know. That's just not worth the trouble it might cause.

I'm ok at school, there's even a group for me- but at home, I don't let my family know or I'd be out! I'm crazy careful to keep that separate.

In high school, I always expected trouble, and got it. At my job now, as long as I'm careful I'll be alright. If the other guys knew, I'd probably be fired. But I've learned to be careful and have eyes in the back of my head.

Social Withdrawal

Nine members (56%) discussed social withdrawal as a response to being bullied. When asked how they managed being bullied, more than half explained various patterns of social withdrawal and isolation:

I learned to stay to myself. It's easier to not be part of any group.

Once I saw I wasn't going to fit in, and that I didn't like them- and they didn't like me, I just kept to myself. In some ways, life's been easier since I just gave up.

I found a friend or two, but that feels very day by day, for the most part- I think it's safe to just put my head down and avoid kids my own age.

I'm okay on my own. Once I ran into trouble, I just sort of disappeared and only did what I had to do. Even now, I still think the best plan is to avoid people.

I tried to find a place to belong, but I did best on my own. I counted the hours and days until I could just get away from other kids.

Low Self-Esteem

Participants were asked to discuss how being bullied made them feel. Nine (56%) reported strikingly low self-esteem.

I wish I could've stuck for myself, but the more they picked on me, the worse I felt. I was so beaten down, I didn't even have the stomach or the guts to fight back. I just gave up. They won.

I don't blame them. I am a freak. I know I'm a poor excuse for a teen-ager.

I wouldn't even know how to fight back, or even why. I'm just a forever outsider and loser.

If I looked halfway normal, I could've found a way to fit in, but I've always been someone you could laugh at. Not into sports, not into anything the rest of them are, and of course, I'm the laughingstock.

Sometimes, a lot of times, I don't like myself- how can they like me?

Bullying by family

Fifty percent were either rejected or victimized by family (4 males-/4 females) Family members hold tremendous influence, economic safety, physical and emotional safety and emotional acceptance. Mishner, et al. [55] discussed the reticence many LGBT bullied teens have described about reaching out to school and family, and found that LGBT teens were highly suspicious based on numerous negative experiences with community representatives, religious organizations, schools and family members. The following responses illustrate in detail how some of these teens feel.

Oh, my brothers have had their fun. As the youngest of four brothers, they had a field day with me. My sister was my confidante and best friend to me, but my brother, literally pushed me down a flight of stairs when I told him I was gay- My dad too.

I was surprised, my mom took it ok, but my father and brothers totally froze me out and picked on me even after my mother tried to protect me.

My mother and grandmother were impossible because of religion. My dad and brother took it out on me all the time...and always calling me a fairy. They said they were trying to toughen me up. It looks like things have changed for us, but it hasn't.

The first person to beat me up was my mother. It's a big taboo. “An embarrassment” she said and then threw me around the room.

Retaliatory Fantasies

When asked how the bullying may have changed them, several participants shared comments that demonstrated they had numerous aggressive and fantasies (n = 4/25%) towards those who had bullied them.

Damn, if I could get a hold of those guys that made my high school a nightmare, I'd blow them up! I'd tear them up in two!

I have had the thought to hire someone tougher than me to get back at all those kids that drove me crazy with constant needling, and ridiculing.

I've had the thought that someday they'll need a job and I'll

be somebody and man, I'd love to fire them or kick them out of my office!

Discussion

The two most significant (frequent) findings of this study, hypervigilance and social withdrawal as psychological and behavioral reactions to LGBT bullying, are consistent with previous findings of research in this area [1,6,21,52]. LGBT youth such as those in these focus groups, feel they must remain hypervigilant to their environment, and when they can isolate themselves, they will. Isolation holds special appeal because it is the only time when the LGBT youths feel completely out of danger.

Screening with this population must include the impact of family of origin's reaction to client. The possibility that they were victimized by their own siblings, parents and other family members is a serious obstacle to recovering from patterns of withdrawal. Likewise, the nature of family rejection will also be important to ascertain. If family has been accepting and can be brought into the therapeutic relationship, it will provide a vital source of support and mitigating factor to mental health issues for our young adult.

Those working with LGBT youth and young adults should assess if feelings of low self-esteem, hypervigilance lead to a pattern of social withdrawal, and provide a therapeutic relationship marked by safety and respect. Social workers, counselors and educators should be mindful to the possibility that the client's trust may not come easily, and that they may require a slow and compassionate engagement phase. Along with sound screening, assessment and counseling around these issues, it is critical to engage this cohort with great sensitivity and to provide a trusting and safe therapeutic alliance. This alliance; one based on respect and compassion, may be the critical juncture in a vulnerable youth's life that can release shame and enable the client to move through the next stages of psychosocial development with a restored sense of well-being [35,85-87].

Summary

Given the high vulnerability for the LGBT community to experience bullying, and the range of psychosocial sequelae of those traumas, social workers should make every effort to assess if their LGBT clients have been a victim of bullying. Mental health social workers should consider how these negative experiences may have affected the client's self-esteem, social patterns and perceptions of trusting others to become close. Future research in this area should include the identification of effective anti-bullying programs, and ways in which schools, communities and especially families can support coping, adaptation and resiliency for LGBT youth.

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