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Bullying Victimization among LGBTQ Youth: Current and Future Directions

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Abstract

Purpose of review: This paper examines recent research on bullying victimization among lesbian, gay, bisexual, transgender, and queer (LGBTQ) youth to identify critical issues and advocate for future research priorities.

Recent findings: Recent studies have begun to document the importance of bullying in general, and bias-based bullying (rooted in stigma) in particular, on the health and wellbeing of this vulnerable subgroup of adolescents, as well as drivers of disparities. Current research demonstrates the role of multiple identities for and important differences among LGBTQ youth and has begun to identify protective factors for youth who are the targets of bullying.

Summary: Researchers, clinicians, and those working with and on behalf of LGBTQ youth must measure and acknowledge the multiple reasons for which LGBTQ youth are the targets of bullying. Intervention and prevention efforts should focus on improving the supportiveness of the climates within which LGBTQ youth live.

Keywords

bullying; bias-based bullying; LGBTQ youth; minority stress; intersectionality

Introduction

A growing body of research documents the longitudinal and deleterious effects of bullying victimization on health and wellbeing for youth of all ages [1–5]. For youth who identify as lesbian, gay, bisexual, queer, or questioning (LGBQ) or as transgender or gender diverse

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¹ Variation in terms/acronyms reflects variations in samples in the literature cited. We use LGBTQ as an umbrella term where findings apply to both LGBQ and TGD youth or data from LGBQ and TGD youth were analyzed together without distinctions between groups

(TGD; i.e., those whose current gender identity/expression is different than societal expectations based on their birth-assigned sex), rates of bullying victimization are several times higher than those of their straight cisgender (e.g., birth-assigned sex matches gender identity) peers [6–12]. The latest U. S. national data from the CDC's Youth Risk Behavior Survey (YRBS) indicate that compared to their straight peers, lesbian, gay, and bisexual students report more cyberbullying (27% vs. 13%) and physical bullying on school grounds (33% vs. 17%) [13]. In a national U.S. study that focused on bullying (i.e., aggressive behaviors that occur frequently and with a power differential between actor and target) and harassment (i.e., behaviors that would be considered bullying, but they are infrequent or do not have a clear power imbalance), 80% of LGBQ adolescents reported bullying victimization or peer harassment [14].

The consequences of these bullying victimization experiences shape critical developmental processes and can drive documented health disparities. Given large disparities between LGBTQ youth and their peers in areas such as mental health, substance use, high risk sexual behaviors, and academic performance [7,15–20], understanding drivers of these disparities is urgently needed in order to address them through policy, programs, and other prevention efforts. The current paper reviews recent research on bullying victimization among LGBTQ adolescents, focusing on the last five years and disaggregating LGBQ and TGD youth where possible, with the goal of identifying critical issues and future research priorities. We describe general and bias-based bullying victimization, discuss theoretical foundations that explain the role of victimization in health outcomes, and review emerging issues in the study of bullying victimization for LGBTQ youth.

Important Distinctions in Bullying: General vs. Bias-Based Victimization

Bullying behaviors are diverse; recently, a distinction has emerged in the literature between general bullying and bias-based bullying. Bullying refers to unwanted, aggressive behavior that is repeated or has the possibility to be repeated, and where there is a real or perceived power imbalance between the actor and target [21]. Bullying can take multiple forms, including physical (e.g., hitting, kicking, threats of violence), relational (e.g., social exclusion, spreading rumors), verbal (e.g., name calling), and cyber (e.g., via social media, texts) [22]. We use the term “general bullying” to refer to these behaviors when the motivation for bullying is not based on bias (or motivation is not assessed) and the term “bias-based bullying” when the bullying is rooted in bias related to personal characteristics such as race/ethnicity, gender identity/expression, sexual orientation, or ability status.

General bullying victimization.

Rates of general bullying victimization among youth have decreased in recent years [9,10], although one study documented increases in cyberbullying victimization among LGBQ youth, with no change for straight youth [9]. However, even with these decreases, studies using large, population-based samples have found that the magnitude of disparities in bullying victimization between LGBQ and straight youth has remained the same [9,10]. For example, Massachusetts YRBS data indicates that past-year bullying victimization for straight youth decreased from 20.5% to 14.6% among males and 23.4% to 17.4% among females from 1999–2013. In the same time frame, rates among bisexual males have

significantly decreased from 45.5% to 28.8%, but rates among bisexual females have remained essentially the same (42.9% to 41.0%). In other words, while bullying victimization rates are improving in general, LGBQ youth still experience bullying at higher rates than their straight peers, and some groups have not benefited from decreases at all. Due to the lack of gender identity questions included on most large surveillance surveys, similar trend data are not yet available for TGD youth.

Bullying has received much public health attention for adolescents in general and LGBTQ youth in particular due to its strong association with significant health outcomes [15,23,24]. General bullying victimization among LGBTQ youth is consistently associated with internalizing problems such as depressive symptoms, suicidal ideation, and suicide attempts [14,25–31]. National estimates suggest that lesbian, gay, and queer (LGQ) youth who experience peer harassment or bullying have 5–6 times the odds of suicide attempts compared to LGQ youth who do not report victimization [14]. Additionally, general bullying victimization is associated with poor academic outcomes such as truancy, unexcused absences, academic disengagement, educational aspirations, and lower grades and test scores [32–36]. Predictably, LGBTQ youth who are the targets of general bullying report feeling less safe at school, and it is likely this perceived lack of safety that compromises young people's ability to fully engage in their educational experiences. Further, bullying is related to high risk health behaviors, such as alcohol, tobacco, and other substance use for LGBTQ youth [37–41].

Bias-based bullying.

Historically, research on bullying has focused on specific behaviors (e.g., hitting, spreading rumors, etc.). New research in the last decade, however, has begun to explore motivations and stigma underlying these behaviors, shifting the focus to “bias-based bullying,” sometimes called prejudiced-based harassment, stigma-based bullying, or homophobic teasing when specific to sexual orientation [42–48]. Bias-based bullying victimization is receiving increased attention due to well-replicated studies of its detrimental effects on emotional distress, suicidality, and academic engagement [33,44] as well as economic costs for schools and states [49]. In fact, studies note effects of bias-based bullying that are as large or larger than the effects seen for general bullying victimization [44,49,50]. LGBTQ youth are more likely than their straight cisgender peers to be the targets of bias-based bullying [7,32,42,51,52], and importantly, this is not just bias related to their sexual orientation and gender identity. For example, LGBQ youth are more likely than their straight peers to be the targets of bullying based on race, weight/appearance and ability, even after controlling for race/ethnicity, weight and ability status [42].

Growing understanding of the harm caused by bias-based bullying indicates a clear need and direction for future research. Surveys should include measures of a variety of types of bias-based bullying victimization. It is critical that future research and measures also focus on bias-based bullying experiences that are specific not only to the characteristics of the sample of interest but also a broader range of characteristics. For example, studies of TGD youth should include measure of bullying experiences due to gender identity, expression, and

sexual orientation as well as race/ethnicity, weight, and ability. Clinicians can also be aware of and explicitly address bullying victimization experiences related to bias.

Theoretical Foundations and Implications of Bullying Victimization for Health

The minority stress model can be used to understand the role of bullying victimization on long-term health for LGBTQ youth [53,54]. In addition to the typical stressors of adolescence, LGBTQ youth experience additional stress related to their stigmatized sexual orientation and/or gender identity, some of which comes in the form of victimization experiences including bullying, harassment, and discrimination. LGBTQ youth may internalize experiences of victimization, leading to expectations of rejection from others and hypervigilance about being targeted for future victimization incidents, which in turn influence mental and physical health. Adolescence is a critical time to examine these associations, as stress and psychological distress are particularly high during this developmental period [26].

Several key studies explicitly test and support the underlying tenets of the minority stress model for LGBTQ youth, both concurrently and longitudinally. For example, longitudinal studies document that sexual orientation-based victimization, including bias-based bullying, partially mediated the association between sexual orientation and both depressive symptoms and suicidality in samples of LGBTQ youth [25,26,55]. Cross-lagged analyses indicate that as sexual orientation-related victimization declines across adolescence and into early adulthood, emotional distress decreases [26]. Cross-sectional studies are consistent with these findings [19], indicating, for example, that bias-based victimization mediates associations between sexual orientation and academic achievement and truancy among LGBTQ youth [33] and between sexual orientation and gender identity and substance use for TGD youth [56,39].

Bullying, whether general or bias-biased, cannot be considered in isolation. On their own, experiences of bullying do not completely explain health disparities for LGBTQ youth [27]. Rather, building on the minority stress model and social ecological frameworks, bullying victimization should be understood in the context of other experiences of victimization that may be present for this vulnerable subgroup, such as harassment within families or in the community [35,57]. Although beyond the scope of this review, a body of research documents the ways in which LGBTQ youth are at heightened risk of victimization in the family and the larger community [58–60], and it is likely that these multiple forms of victimization (i.e., polyvictimization) compound resulting emotional distress [59]. When coupled with victimization in multiple contexts (e.g., school, neighborhood, religious institution), the minority stress model suggests that related processes, such as hypervigilance and identity concealment, may be greater, increasing the impact on health. However, this area requires further empirical investigation, with particular attention to social ecological perspectives that suggest factors that can buffer victimization in multiple contexts.

Relatedly, researchers and clinicians must understand the broader climate in which their participants or patients live, as this has direct and important implications for bias-based bullying victimization. Because bias-based bullying is rooted in stigma, experiences of this kind of victimization are organically tied to the broader community climate and social norms

of an area, such as whether the area is welcoming to LGBTQ people [61]. As the social climate of a community becomes more or less supportive of LGBTQ people, due to recent event in the community for example, bias-based bullying rates may fluctuate as well, which can influence the health of LGBTQ youth. For example, LGBTQ youth aged 13–18 in the U.S. report increases in the bias-based bullying they have witnessed, such as hearing someone make derogatory comments about another person, that can be directly attributed to the 2016 U.S. Presidential Election (e.g., because the person making the derogatory comment also repeated a campaign slogan). As a result, youth report modifying their behavior, including changing plans or clothing so they would be less recognizable as LGBTQ [62].

Emerging Research Areas

Informed by the minority stress model and social ecological frameworks, three areas of emerging research will be reviewed that can further our understanding of the role of bullying victimization in the health of LGBTQ youth: intersectionality, variation among LGBTQ youth, and the role of protective factors.

Intersectionality.

The intersectionality framework provides a useful heuristic to understand how a person's multiple identities (e.g., race/ethnicity, sexual orientation, gender identity) come together, with a specific eye toward the ways social structures and systems impinge on individuals because of those identities [63,64]. Youth with more than one stigmatized identity, such as youth who identify as LGBTQ and TGD, may experience increased levels of stigma and minority stress and report more bullying victimization than members of just one group (e.g., either LGBTQ or TGD) [65]. Because LGBTQ youth are more likely than straight cisgender youth to be youth of color [7,66], stress related to experiencing and coping with multiple forms of victimization around the intersections of sexual orientation, gender identity, and race/ethnicity may be particularly challenging to wellbeing [63,67,68].

Many LGBTQ youth navigate multiple identities, for which they may also experience bias-based bullying [69]. For example, birth-assigned male and black and multiracial LGBTQ youth, along with TGD youth report higher levels of bullying based on sexual orientation than their peers with a single stigmatized identity [26,70]. Studies examining the full scope of bullying experiences for youth that take into account their multiple identities are needed. Supporting young people by addressing societal barriers that prevent positive integration of their multiple personal identities in adolescence and early adulthood is a key opportunity for prevention and intervention.

Variation among LGBTQ youth.

A second emerging area of research examines heterogeneity among LGBTQ youth. Researchers and research-focused best practices are clear that disaggregating sexual orientation and gender identity groups is critical to a more accurate understanding of LGBTQ youth. Variation within these groups, however, must also be considered. For example several studies have noted differences in general bullying and bias-based bullying rates between lesbian, gay, bisexual, questioning, and straight youth who report same sex

sexual activity [14,42], all of whom are typically grouped together as LGBQ. Research evidence is building that youth who identify as bisexual report elevated rates of health-risk and health-compromising experiences, and bullying is among them [10,35,71]. Disaggregating groups for analysis will allow for a more nuanced understanding of which groups experience health disparities and which may not.

Among TGD youth, evidence is emerging that not adhering to a binary gender is associated with additional risk, which may be due to transgressing societal stereotypes about gender. Nonbinary youth (i.e., those who do not identify as strictly male or female, but rather as both, neither, or somewhere between masculine/man and feminine/woman) are an understudied group in part because survey questions rarely allow for this response option with larger samples [72]. In a recent study in Canada, 41% of TGD youth identified as nonbinary, and compared to binary transgender youth (i.e. those who were assigned female at birth and identify as male or assigned male at birth and identify as female), the nonbinary group reported poorer mental and physical health and healthcare utilization [73]. In a national U.S. convenience sample, 86.7% of nonbinary (“genderqueer” identified in this study) youth assigned male at birth reported bullying victimization, a rate significantly higher than the rate for assigned males identifying as transgender (78.2%) or LGBQ cisgender (66.9%) [59]. Nonbinary youth were also more likely to report polyvictimization (including bullying) than transgender and LGBQ cisgender youth. These preliminary investigations are intriguing and identify a range of critical needs for support and prevention that can be addressed by clinicians, school personnel, community members and organizations, and families. Further, they highlight variation within the TGD community that typically goes unmeasured or unidentified, due to a lack of survey questions with appropriate response options and a lack of power to examine differences. Researchers and clinicians must ensure that they are using up-to-date terminology for both sexual orientation and gender identity and providing response options that allow youth to identify themselves accurately [72,74,75].

Variation also exists within LGBTQ populations around gender presentation, or how one expresses their gender (through dress, style, mannerisms, etc.) as well as others’ perceptions of one’s presentation, typically assessed on a continuum from masculine to feminine. For example, TGD youth who are perceived by their peers as more incongruent with their birth-assigned sex (e.g., assigned male, perceived by others as somewhat or mostly feminine) are more likely to be the targets of general bullying and bullying based on gender and gender expression than those perceived as congruent with their birth-assigned sex [52]. Among LGBQ youth, similar associations exist. In a key test of this hypothesis, Toomey and colleagues examined associations between retrospective reports of gender expression and LGBT-specific victimization in adolescence (13–19 years) and depression and life satisfaction in young adulthood (21–25 years) [76]. They found that LGBT-specific victimization fully mediated associations between gender non-conformity in adolescence and young adult depression and life satisfaction for both the full LGBTQ sample and the subsample of LGBQ youth. These studies lead the field toward a more complex understanding of the experiences and health drivers of LGBTQ youth; additional research in this vein will allow for more nuanced approaches to promoting health equity.

Protective factors.

With health disparities well-documented among LGBTQ youth relative to their straight cisgender peers, research has begun examining protective factors in this population, grounded in Bronfenbrenner's [77] social ecological model, which specifies risk and protective processes at multiple levels of human ecology. Protective factors are characteristics of the individual (e.g., optimism), relationships (e.g., with family members), organizational contexts (e.g., school) and the broader community (e.g., social climate, resources, public policy) that are associated with better than expected outcomes among youth who have experienced some type of risk or vulnerable identity [77,78]. Consistent with findings from general youth samples [78–80], two key areas of protection consistently emerge as conferring critical protection for both LGBQ [71,81–83] and TGD [19,70,84–89] youth on a range of health-related outcomes: 1) having supportive, caring relationships with parents and important adults and 2) attending schools in which youth feel safe, supported, and connected to teachers and the school community. Importantly, multiple cross-sectional studies document these associations, but the few existing longitudinal examinations are equivocal [26]. This is not surprising, as the persistent levels of victimization experienced by LGBTQ youth likely require ongoing support to navigate.

A significant number of studies examining protective factors with respect to bullying victimization focus on aspects of the school environment. Gay-straight alliances or gender/sexuality alliances (GSAs) have received the most attention, with studies indicating that LGBTQ youth who attend a school with a GSA report less bullying than those attending schools without GSAs [34,90–92]. A recent meta-analysis has extended these findings to bias-based bullying, documenting that GSAs are related to lower levels of personally experiencing as well as witnessing sexual orientation-based bullying and feeling unsafe at school [90]. Effect sizes for this first and second-hand victimization were considered small, whereas the effect of a GSA on feeling safe at school was of a medium size. Further, the presence of a GSA can buffer LGBTQ youth who experience sexual orientation-based bullying from harm, including feelings of hopelessness and suicide attempts [91].

A range of other school practices, including supportive school personnel, curriculum that includes LGBTQ figures or events, safe spaces, and teacher professional development related to sexual orientation and gender identity, protect LGBTQ youth from both general and bias-based bullying victimization [34,81,87,93]. These practices are thought to exert their effects in part through school climate, or the “quality and character” of the school [94,95], which in turn supports adults and students in the school to be supportive of LGBTQ youth and less likely to tolerate bullying, particularly related to bias [90,96]. Emerging research indicates that the effects of these school practices on bullying may extend to straight youth as well, demonstrating beneficial effects of supporting LGBTQ youth for the whole student body [93,97].

Three key limitations of the protective factors work must be noted. First, much of the research in this area is based on non-random sampling strategies that may underestimate the experiences of youth who are less involved in the LGBTQ community, especially those who are not out. Secondly, no studies involve experimental design, which is particularly relevant for school findings. It is possible that schools that choose to have GSAs, for example, are

inclusive in other ways that are unmeasured. Third, research on protective factors has focused largely on interpersonal and school factors. As noted above, the broader community climate may likewise exert influence over bullying of LGBTQ youth, but the few studies that have examined the community have focused on risk factors rather than protective factors. For example, LGBTQ youth living in areas with high levels of LGBTQ hate crimes are more likely to be the targets of relational and cyber bullying [98]. Protective community effects must also be identified; this is a critical area for future research. Finally, it is important to note that LGBTQ youth in general, and TGD youth in particular, report lower levels of many protective factors, including feeling safe at school, parental connectedness, school connectedness, and friend caring [7,11]. These findings point to clear implications for intervention with families, schools, and communities. They also highlight critical recommendations for future research, in particular the use of random or representative sampling techniques and experimental designs.

Conclusions

Disparities in rates of general and bias-based bullying victimization among LGBTQ youth are clear. Emerging research is beginning to elucidate heterogeneity within members of the LGBTQ community, particularly around key questions of intersectionality and the identification of protective factors. Such studies have the potential to drive our understanding of the etiology of health disparities for this vulnerable population and inform new approaches to prevention and intervention.

Clinicians from a range of disciplines have an important role when working with LGBTQ youth and would benefit from training grounded in an understanding of the unique needs of this community and how these needs may be related to the reason the young person is seeking care. Specifically, clinicians need to create a welcoming and inclusive space to help LGBTQ young people feel more comfortable discussing gender, sexual orientation, and sexual health and behaviors - topics that may have been the target of bullying, judgment, and other insensitive experiences by their peers, family members, community members, and possibly previous healthcare providers.

Those working with LGBTQ youth in clinical settings should consider history taking as part of a broader risk assessment that includes asking about bullying victimization. For instance, the use of comprehensive assessment tools, such as the HEADSSS Assessment [99], would allow clinicians to obtain a psychosocial review of a variety of both risk and protective factors from their patients. When working with LGBTQ youth, an understanding of victimization experiences is important, as these experiences may affect identity exploration and self-actualization, foster shame and internalization of negative messages, and increase the likelihood of deleterious health outcomes such as high risk sexual behaviors, emotional distress, and substance use. Patient-provider discussions around these issues are also key for treatment planning and/or for clinicians to identify and facilitate appropriate referrals as necessary. Additionally, a broader understanding of the victimization experiences of LGBTQ people across identities (e.g., sexual orientation, gender identity, race/ethnicity) and contexts (e.g., family, school, community) will inform clinical-, school-, and public health-based approaches to the promotion of health equity in this population.

With regard to next steps for research, the inclusion of items on national or state-level surveillance surveys that assess sexual orientation, gender identity, bias-based bullying, and protective factors has the ability to move the field forward. These samples are large enough to examine variation within LGBTQ youth, including intersections of sexual orientation, gender identity, and race/ethnicity and have the benefit of random or representative sampling techniques to improve generalizability of findings. At the same time, research using smaller and more in-depth samples and methods, particularly longitudinal data collection, will add essential depth to the current knowledge base. For example, qualitative and quantitative studies that examine the coming out process, the role of gender presentation, how community organizations and structures can support LGBTQ youth, and creative approaches to the measurement of LGBTQ-related school and community climate are needed to better understand how factors at all levels of the social ecological model are related to bullying victimization and health among LGBTQ youth. Understanding intrapersonal factors related to bullying victimization is crucial, as is bolstering support for LGBTQ youth in the communities where they live and learn to improve health and wellbeing.

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