THE EFFECTS OF BULLYING AND INTERNALIZED HOMOPHOBIA ON PSYCHOPATHOLOGICAL SYMPTOM SEVERITY IN A COMMUNITY SAMPLE OF GAY MEN

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CHAPTER I

INTRODUCTION

The experience of being bullied can be highly stressful (Newman, Holden, & Delville, 2005; Rivers, 2001). Approximately 30% of children report being victims of bullying at some point (Rigby & Slee, 1991; Olweus, 1993), and estimates of specific physical violence against gay and lesbian youth range from 40% to 50% (Remafedi, Farrow, & Deisher, 1991; Hunter, 1990). Additionally, the victimization of gay males is significantly higher than victimization of lesbians, with victimization of gay men in a high school as high as 59% (Gross, Aurand, & Addessa, 1988). This would indicate that bullying and victimization may be a normative experience for gay boys. Bullying has traditionally been defined by direct physical or verbal aggression, and boys' accounts include more physical harm, threats, and rejection than bullying against girls (Baldry, 1998).

Research on the impact of bullying and victimization among youth in general suggests that it negatively affects mental health, particularly depressive or posttraumatic stress disorder (PTSD) symptoms (Morrow, 1991; Newman et al., 2005). Higher rates of reported victimization may lead to a heightened susceptibility to psychological distress among gay men. Although research into bullying and long-term correlates of functioning in lesbians, bisexual, and gay youth is relatively recent and lacking, prior research suggests that a stigmatized sexual orientation alone may already increase vulnerability to

mental health problems (Hershberger & D'Augelli, 1995; Gonsiorek, 1988; Remafedi, 1987) that is exacerbated by bullying. Victimization may contribute to this experience of stigmatization in unique ways that further heighten the risks of negative outcomes.

There is a paucity of research on factors that may limit the negative impact of bullying. Of particular relevance are factors that include familial support and self-efficacy in handling bullying situations. Research on the influence of familial support on gay, lesbian, and bisexual adults suggests that it may be a major protective factor against psychological distress (Strommen, 1989), and parental support, specifically, is beneficial for gay, bisexual, and lesbian adolescents (e.g., Savin-Williams, 2001). Hershberger and D'Augelli (1995) found that family support may mediate the relationship between victimization and mental health. Unfortunately, many young gay adolescents lack support (Strommen, 1989), making them even more vulnerable to the psychological impact of bullying. In this regard, suicide attempts among gay adolescents were predicted by bullying as well as isolation and rejection by peers, family, and the community (Hershberger & D'Augelli, 1995). Though this current study does not explore suicidality among victims of bullying, this finding does stress the importance and relevance of gaining a better understanding of how bullying effects gay boys.

Bullying

Bullying can have enduring effects, particularly among students that are socially isolated (Newman et al., 2005). Rigby (2000) defines bullying as "repeated unprovoked aggressive behavior in which the perpetrator or perpetrators are more powerful than the person or person being attacked." Research on bullying has recently flourished, primarily

due to school-based initiatives to curb violence and better understand what factors contribute to bullying or victimization (Rigby, 2003). The psychological impact of bullying has been observed, enduring into adulthood in a number of studies (Olweus, 1993; Craig, 1998), with most studies focusing on the impact it has on self-image and depressive symptoms.

Important differences may exist depending the type and duration of bullying activities that these boys experience. Some findings suggest that a subset of men exist who were chronically bullied through school; their bullying often continuing into adulthood. These boys are referred to as "whipping boys" by Olweus (1978), and his data suggest that a small percentage of boys at each grade level typically inhabit this role. Because gay adolescents are known to be bullied at a much higher rate than heterosexual boys, gay adolescents may be more likely to fill the role of whipping boy.

Olweus' (1993) research suggests that increased frequency and duration of bullying increase psychopathological outcomes, but that this relationship is moderated by perceived isolation or support. This would indicate that more socially isolated whipping boys are particularly vulnerable to psychopathological outcomes. Men reporting a perception of social isolation or low support during bullying experiences in childhood report enduring symptom severity as a result (Newman et al., 2005), impacting these adolescents long into adulthood. Similarly, Hodges and Perry (1999) found evidence indicating a relationship between childhood internalizing disorders, such as depression or anxiety, and bullying. Additionally, internalizing disorders, physical weakness, and peer rejection all contributed to victimization over time in a longitudinal study of elementary

school bullying, and the onset of victimization increased subsequent peer rejection and internalizing symptoms (Hodges & Perry, 1999). Overall, these studies indicate that at-risk boys may be more vulnerable to bullying, pushing them into a more negative trajectory.

Enduring Effects of Childhood Events

As reviewed above, research on bullying has indicated that its effects last well past the event. A Canadian sample demonstrated ongoing depressive symptoms among adult men that reported bullying (Craig, 1998), and Olweus (1993) observed enduring symptoms related to bullying after high school and well into the participants' twenties. It is important, however, that this research differentiate between the lasting impact of adolescent bullying and bias in memory due to the adult onset of a psychiatric disorder. Specifically, there has been some criticism that among those experiencing depression or other psychological disorders, there may be some distortion of memory so that reported antecedents are not actually accurate representations of events that occurred (Williams, Watts, MacLeod, & Mathews, 1988). The specific impact of depression on memory, however, is unclear (Brewin, Andrews, & Gotlib, 1993). The richest area of research demonstrating the enduring effects of childhood events on psychopathology is in the area of childhood abuse (Bagley & Ramsay, 1986; Bifulco, Brown, & Adler, 1991). In this research, childhood abuse has been found to have lasting effects for some children, and increase the odds of depressive or anxious symptoms.

Bullying research does not challenge the difficulties inherent in establishing truthful historical accounts, but the current literature indicates that memories of bullying

are fairly stable (Rivers, 2001). Types of bullying experienced and the duration of the bullying appear to maintain reliability across interview times, though there is also some evidence that memories of the resolution of bullying episodes are highly unreliable (Rivers, 2001). Olweus (1993) suggested that retrospective research into bullying should target the first seven years after graduation, when past research has indicated a reliable and consistent reporting of events. It has also been indicated that the severity and duration of bullying may further increase reliability, with the most severe accounts also being the most stable (Rigby, 2003).

Bullying and Psychological Distress

Depressive symptoms and bullying. The current literature indicates that depressive symptom measures may be superior to a broader assessment of general distress when investigating the lasting impact of bullying. Recent research has demonstrated that the risk of depression in children who have experienced bullying is three times greater than the risk of anxiety disorders or other forms of psychological distress (Salmon, James, & Smith, 1998; Bond, Carlin, Thomas, Rubin, & Patton, 2001). Bond et al. also observed an increase in depressive symptoms in direct response to increased severity of bullying. This finding has been replicated in bullying research specific to gay men, with bullying and negative affect consistently positively correlated (e.g., Rivers, 2001). Some exceptions occur, however, with many studies noting that short-term experiences of victimization, particularly later during the educational process, may not lead to such severe results (Bond et al.).

Bullying and PTSD. Symptoms of trauma may arise after exposure to extreme violence, so gay adolescents that have been bullied or witnessed severe bullying may be more susceptible to PTSD symptoms (Rivers, 2001). Unfortunately, the literature on school-age samples has left the presence of PTSD symptoms largely unexamined. In a rare example of the presence of trauma among a high school sample, Mauk and Rogers (1994) found PTSD symptoms among a population that had experienced the suicide of a peer, yielding some indication that the likelihood of PTSD symptoms in response to a traumatic event may be similar in both children and adults. Recent research has also suggested that the experience of being bullied may lead to significantly greater levels of distress than those found among survivors of natural disasters or other life-threatening events (Janson & Hazler, 2004). Weaver (2000) observed PTSD symptoms in a 14 year-old that had no single catastrophic stressor, but rather a long history of emotional bullying. Each of these findings illustrates the importance of incorporating an assessment of PTSD symptoms in research on the impact of bullying.

Bullying and Posttraumatic Growth

It is important to note that victimization may not always lead to psychopathology. Since the 1980s, attention has shifted from the deleterious effects of traumatic events to signs of positive outcomes (Tedeschi & Calhoun, 1995), such as improved psychological adjustment and well-being. Tedeschi and Calhoun (1995) conceptualized posttraumatic growth (PTG) as an outcome of overcoming an extreme life event. Taylor (1983) noted that there are three common factors found in the literature on cognitive responses to threatening events: a search for meaning, an attempt to regain mastery over one's life,

and an attempt to restore self-esteem. Reports of growth experiences range from 20 to 50% in trauma victims, although the percentage varies greatly depending on the measure or assessment methods used (Nolen-Hoeksema & Davis, 2004).

There is a general tendency toward drawing meaning from negative life events, as well as the impetus toward creating a positive evaluation of oneself, but the possibility that this is a cognitive bias, not objective growth, has been the source of most major criticisms of the concept of PTG (Hobfoll et al., 2006). First, remembering is a reconstructive event. As noted by Tedeschi and Calhoun (1995) in their initial presentation of their model, any retrospective measure of change following a traumatic event is vulnerable to the "construal of benefits," and may actually measure cognitive bias as opposed to actual growth. In a recent attempt to control for this possibility, Calhoun and Tedeschi (2004) noted that evidence of self-reported growth has been corroborated by others in the individual's social network.

Calhoun and Tedeschi's (2004) conception of PTG includes changes in one's perception of self, relationships with others, and a changed perspective on what it means to live a meaningful life. This incorporation is the opposite of avoidance, implicated in the exacerbation of PTSD symptoms observed by many researchers (e.g., Nolen-Hoeksema & Davis, 2004). Additionally, PTG applies the meaning-making that arises out of experiential acceptance to the memory of the traumatic event (Janoff-Bulman, 2004). This indicates that it is through actively engaging memories of the traumatic experience that growth occurs, not through simply passively ruminating (Nolen-Hoeksema & Davis, 2004).

Mediating Factors

Bullying may not directly impact psychological distress over the lifespan. There is some research indicating that victimization may act as a confirmation of gay men's negative self-evaluations (Meyer, 1995). In this case, it may not be the effect of physical or verbal assault that leads to feelings of isolation and symptoms of depression, but instead the realization that fears about the way the world views homosexuality may be true.

Internalized Homophobia as a Mediator

Internalized homophobia is typically defined as the "set of negative attitudes and affects toward homosexuality in other persons and toward homosexual features in oneself" (Shidlo, 1994). These negative attitudes toward gay men, or for gay men toward themselves, are seen as an internalization of anti-gay bias in the greater culture (Garnets, Herek, & Levy, 2003). Internalized homophobia may best be conceptualized as a unique form of stigma felt by gay men and lesbians in response to a societal devaluation of non-heterosexuals. It has been associated with poor physical and mental health outcomes, such as maladaptive coping styles (Nicholson & Long, 1990) and unsafe sexual behaviors (Huebner, Davis, Nemeroff, & Aiken, 2002), as well as psychological distress outcomes such as symptoms of depression and anxiety (Shidlo, 1994; Herek, Cogan, Gillis, & Glunt, 1997).

Meyer (1995) demonstrated an additive effect between internalized homophobia, perceptions of stigma, and actual experiences of victimization. He found that this *minority stress* correlated positively with clinical measures of distress. Lewis, Derlega,

Griffin, and Krowinski (2003) found similar results focusing on a "gay-related" stress model, demonstrating that stigma consciousness and gay-related stress accounted for a significant amount of the variance in depression, independent of the influence of simple life stress. Herek et al. (1997) reported a positive correlation between internalized homophobia and depression using the Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977). Likewise, Shidlo (1994) demonstrated similar effects using a variety of internalized homophobia scales and exploring their relationship to various measures of psychological distress.

It may be that it is the impact of bullying on internalized homophobia, a form of self-hatred, which leads to a greater risk of pathological outcomes. Further, if gay men feel negative about their own sexual orientation, they might be reticent to turn to heterosexual family or friends for fear of rejection, revealing themselves, or having their negative self perceptions confirmed.

Moderating Factors

There is some evidence, as well, that the relationship between bullying and self-hatred might be lessened by certain resilience factors. As indicated above, parental social support may be a primary source of protection for gay adolescents, protecting against the perception that heterosexual society is entirely rejecting. When parental support is high, the actions of the peer group to isolate or bully gay youths may be more realistically viewed as the actions of a few individuals, and not a reflection of a world that will always be hostile. This would weaken the relationship between bullying and internalized homophobia, in turn decreasing the likelihood of symptoms of depression or PTSD.

Another possible source of resilience against internalized homophobia is self-efficacy. Self-efficacy relates to individuals' beliefs about their capability to take control over the events in their lives (Bandura, 1997). A strong sense of efficacy prior to a traumatic event reduces the likelihood of eventual depression or PTSD. In this case, a sense of efficacy toward handling being bullied may protect against internalized homophobia. Rather than bullying being perceived as evidence for the validity of self-hatred and society's stigmatizing view of homosexuality, the efficacious person will treat the bullying experience as an obstacle that can be managed.

Resilience Factors

Parental social support. Social support has been defined as relationships that provide actual assistance to individuals, or an individual's feelings of attachment to a person or group perceived as caring or loving (Hobfoll & Stokes, 1988). It is not surprising that gay adolescents would similarly require such attachments and succorance, especially given the additional stressors that gay adolescents face (Meyer, 1995). Zich and Temoshok (1987) demonstrated that, particularly in relation to gay and bisexual men who experienced the high stress of recently sero-converting (i.e., testing HIV-positive), perceptions of associated social support loss were most predictive of reported feelings of helplessness and depression. Similarly, Elizur and Mintzer (2003) found a positive relationship between social support and relationship duration in gay men, suggesting that social support also aids interpersonal functioning. As reviewed above, familial support, particularly parental support, may be a major resource for gay, bisexual, and lesbian youth.

As illustrated by Hobfoll and Freedy (1990), however, accessing interpersonal resources is a complex process, with some resources acting either to facilitate or hinder the use of extended resources. For example, the use of certain resources may be contraindicated by certain situations or environments that impede the support process. In this case, a number of routes could be hypothesized that would lead to the blocking of adequate utilization of social support by gay youths. Hershberger and D'Augelli (1995) note that over half of their sample of gay and lesbian youths reported fear of parental response to disclosures of sexual orientation. In this case, the context of dependence and fear of rejection that block gay youths from utilizing their parents as a support would not protect these boys from the full impact of being bullied or assaulted.

Individuals inherit many of their values from their family of origin, so gay men with a high degree of internalized homophobia may share these values with their parents (Holtzen & Agresti, 1990). This might, in turn, preclude using their parents as a resource when a stressor involves either a romantic partner or situations that arise due to being gay or lesbian, such as when bullying occurs as a result of being perceived as gay. This selective ability to use existing social support is explained by stigma. As noted by Crocker, Major, and Steele (1998), stigma uniquely interacts with this same system of social interaction, and is conceptualized by many researchers as "involving some internalization of the stigmatizing images and stereotypes of one's group, an internalization that, in turn, can alter, even damage, the individual's personality." Internalized homophobia may best be conceptualized as a unique form of stigma felt by gay men in response to a societal devaluation of non-heterosexuals. As such, the

hypothesized blocking of social resources is founded in the way this stigma permeates self, family, and social constructions.

Bullying self-efficacy. Individuals that have witnessed traumatic events may respond in a variety of ways, from recurring nightmares or flashbacks to a sense of growth and pride for having withstood such threats. Just as self-efficacy was described above as individuals' beliefs about their ability to control events in their lives, specific self-efficacy refers to individuals' beliefs in their ability to manage specific types of events (Bandura, 1997). In the case of traumatic episodes of victimization, coping self-efficacy appears to significantly lessen the impact of a traumatic event on psychopathological outcomes. Individuals with a strong sense of coping self-efficacy are able to more quickly recover from loss, regain new resources, and move on with their lives (Benight, Ironson, Klebe, Carver, Wynings, Burnett, et al., 1999). A recent review by Benight and Bandura (2004) found that self-efficacy may be a primary mechanism in the process of posttraumatic recovery. Not only does it prevent the likelihood of PTSD, but it also may protect traumatized individuals against other forms of distress following traumatic events. Benight (1997) found that, following Hurricane Andrew, self-efficacy was a primary predictor of emotional distress or PTSD symptoms among survivors. The relationship between bullying and coping self-efficacy has not been researched in the past. The findings referenced above, however, indicate that self-efficacy may serve as a significant source of resilience.

Hypotheses

Following these arguments, several predictions were made:

1. Bullying experiences will be related to greater depressive symptoms, PTSD symptoms, and PTG.

2. Internalized homophobia will mediate the relationship between bullying and the symptoms of depressive symptoms, PTSD symptoms, and PTG.

3. The relationship of bullying on internalized homophobia will be moderated by both parental social support and behavior specific self-efficacy, such that those with higher parental support and bullying-specific self efficacy will be significantly less negatively impacted by bullying than those with lower parental social support and bullying-specific self-efficacy.

4. The model best predicting psychopathological outcomes and PTG will be a moderated-mediation path, with internalized homophobia mediating between bullying and the outcome variables, but moderated by self-efficacy and parental social support in the directions indicated in hypotheses 1–3 (see Figure 1).

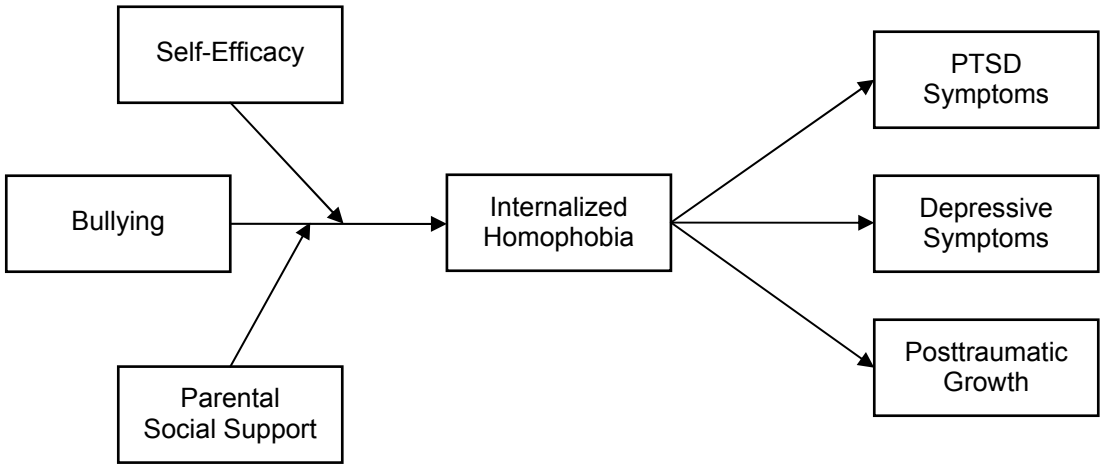


Figure 1. Model of moderated-mediation. PTSD: posttraumatic stress disorder.

CHAPTER II

METHODS

Sample and Procedure

The data used in this study are an original sample collected for the purpose of the following analyses. Self-identified gay men between the ages of 18 and 23 years old were recruited through community venues and snowball sampling in a mid-sized, Midwestern city, as well as a mid-sized, Southeastern city. In most cases, interested men were interviewed at the site of recruitment (e.g., a community center, bar, or gay pride event), and at the end of the structured interview were provided with an information brochure with facts about this current study, as well as contact information for the researcher and a plea for the names of friends who might agree to participate (i.e., snowball sampling, described below). Individuals that contacted this researcher via e-mail or telephone were scheduled for an interview in a public setting. It is difficult to determine if recruitment was improved via snowball sampling, as all individuals that requested an interview through the contact information in the debriefing brochure had been approached in a primary venue and had the study explained to them at that time. Some individuals recruited in crowded or noisy locations requested a quieter location for the scheduled interview, which was allowed. Those interviews took place in public locations with some degree of privacy, such as study rooms in libraries or coffee shops.

The interview protocol was standardized. First, participants were provided with a consent form that included community referral agencies and contact information for the primary investigator, faculty advisor, and Human Subjects Review Board. This was an anonymous study, so participants were not required to sign the form and were encouraged to keep the original in their possession. A copy of the consent form is included in Appendix A. The interview was administered orally, and took approximately 30 minutes to complete. A copy of the interview protocol and instructions are provided in Appendix B. Finally, a copy of the debriefing brochure was verbally reviewed with the participant, questions were answered, and a request was made for referrals. A copy of the text included in the debriefing brochure is included in Appendix C.

A total of 107 interviews were completed. 17 interviews were rejected due interviewer error resulting in incomplete or erroneous data, yielding a final sample of N = 90. Additionally, data collection was completed following the relocation of the primary researcher, such that n = 28 interviews were completed in a different state than the others. There were no differences across demographic variables, however, between the interviews conducted at different sites (all p values were > .45).

The mean age for men was 21 years (SD = 1.5, range = 18–23). The majority were Caucasian (67.8%), and the remainder were African American (11.1%), Hispanic (8.9%), Asian American (1.1%), Native American (1.1%), or multi-racial (10.0%). Almost all reported at least a high school education (97.8%), and more than two-thirds had attended at least one year of college (70.0%).

Additional demographic data demonstrated that these men were typical of young gay men sampled in other studies. These men reported that they realized they were gay at a relatively young age (M = 13.4, SD = 3.4), and the majority came out to others while still in high school (M = 16.8, SD = 2.2, range = 12–23; two participants reported they were not out at the time of interview. Most participants also reported that they were enrolled students at the time of interview (73.3%). A slight majority indicated that they were not a member of an organized religious faith, with most endorsing the labels of "agnostic" or "atheist" (52.2%); 42.2% self-identified as Protestant or Catholic Christians. A majority were not currently in romantic relationships (74.4%). A large subset lived with their parents or other family members (38.9%), followed by those who lived with friends (30.0%) or alone (21.1%); 10.0% currently lived with romantic partners. Complete sample characteristics are presented in Table 1.

Procedures

Graduate and undergraduate student research assistants assisted the collection of data for this study. Participants were recruited through the social networks of interviewers, collegiate campus groups, free HIV testing sites, and area bars and dance clubs.[1] Efforts were made to recruit in a variety of settings to achieve as representative a sample as possible. Additionally, participants were recruited through snowball sampling. At the end of each interview, participants were provided with contact information for the primary investigator which they could distribute within their social network for referrals.

[1]Men at social events and bars were not approached if they appeared inebriated; recruitment at these sites occurred at early hours when patrons were generally sober.

Community recruitment. In community settings, men were approached individually, and asked by an interviewer to participate in a study about gay men's experiences with bullying or harassment, as well as attitudes about themselves, the community, and its relationship with psychological health. Participants were told that findings may benefit the community. Participants were then asked their age and sexual orientation to determine eligibility in the study. Men who self-identified as bisexual or heterosexual were excluded from the study, due to the inapplicability of some of the questions. Interviewers also explained to the men that this study was voluntary and completely anonymous, and that they could withdraw at any point during administration. A copy of the consent form was provided, which included contact numbers for community and mental health resources. In one case, a participant requested a return call with the names of individual providers rather than an agency referral; this request was fulfilled.

Snowball recruitment. As noted by Sell and Petrulio (1996), the use of probability sampling in research on sexual minorities is extremely rare. Due to the existence of ongoing stigma and the limited venues with predominantly gay or lesbian populations, most research resorts to some variation of a sample of convenience. Recent research has attempted to incorporate snowball sampling to increase the diversity of research samples (e.g., Sampaio, Brites, Stall, Hudes, & Hearst, 2002; King et al., 2003;

Table 1

*Sample Characteristics (*N = *90)*

Variable	*n*	%[a]	*M*	*SD*
Socioeconomic status				
Less than $10,000	30	33.3		
$10,001 to $15,000	11	12.2		
$15,001 to $25,000	6	6.7		
$25,001 or higher	43	47.8		
Religious orientation				
Protestant	22	24.4		
Jewish	2	2.2		
Muslim	0	0.0		
Catholic	16	17.8		
Pagan/Wiccan	3	3.3		
None/agnostic	47	52.2		
Race				
Caucasian	61	67.8		
African American	10	11.1		
Hispanic	8	8.9		
Asian	1	1.1		
Native American	1	1.1		
Mixed	9	10.0		
Age			21.0	1.5
Age realized was gay			13.4	3.4
Age came out			16.8	2.2
Age first bullied			11.7	3.3

[a]Percentages may not total 100% due to rounding.

Warner, Wright, Blanchard, & King, 2003). In snowball sampling, the participants themselves are asked to refer or recruit additional potential participants. The research of Sampaio et al. is illustrative of recruiting practices using snowball sampling. Initial research participants were recruited through traditional routes used by researchers working with gay men, such as advertisements in gay publications and personal recruitment at gay bars and beaches. These participants were provided with five information packets about the research to distribute to their friends. Those who responded to the researchers were included in the study. This allowed for the recruitment of individuals that did not regularly attend gay establishments or consume gay-directed media. In a study using both direct and snowball recruiting methods, King et al. (2003) reported that gay and lesbian participants were more likely to be recruited than heterosexual participants in the initial wave of snowball recruitment. As noted above, however, this particular sample was comprised entirely of first wave recruits.

Interviewer Training

Interviewers were trained by the primary investigator. Training began with education on the correlates of bullying and potential psychological effects, such as symptoms of trauma or depressed affect. In the event that participant scores on these measures were elevated into a clinically significant range, referrals were to be made to agencies that provide psychological services. Interviewers were also trained in interviewing protocol, building rapport, and responding effectively to participant distress, which included encouragement to discontinue the interview if necessary. Successful

training was determined through the use of role play between the primary investigator and the interviewer.

Regular meetings during the course of data collection ensured the consistent quality of the data. Additional training focused on the APA ethics code and policies to protect human research participants, to insure knowledge of participants' rights to confidentiality, and the right to leave the study at any time. Local resources for gay men were listed on the consent form, as well as the debriefing brochure. Interviewers and participants had access to contact information for the primary investigator in the event that other difficulties should arise, including cell phone and work contact information for the primary investigator for more immediate access.

Measures

Bullying experience. Bullying experience in adolescence, as well as queries about adult instances of assault, were derived from Rivers' (2001) probe into the types of bullying reported by gay men, bisexuals, and lesbians. Questions explore the frequency and duration of physical, sexual, or verbal assault, as well as how these instances were responded to by others. Test-retest reliability supports the stability of retrospective accounts of bullying among this population, although the report of the resolution of particular instances of bullying appears to deteriorate rapidly in older adults (r = .72 and .34, respectively). This measure is followed by a revised version of the bullying survey questions, pertaining to harassment or assault that has occurred since the participant has turned 18 or graduated from high school.

Olweus (1993) found individuals to be accurate in their report of bullying up to 7 years later, and suggested retrospective interviews of bullying should target men between the ages of 18 and 23. In Olweus' (1993) longitudinal study, the retrospective report of victim status correlated significantly with victim/non-victim status as designated by researchers at the time the participant was attending school (9th grade) at $r = .42$. When compared with peer nomination data during that period, retrospective self-report improved ($r = .58$), suggesting that some negative events were being reliably recalled. After this age, the consistency and reliability of report rapidly diminished, with irregularities occurring between each interview.

The selection of groups of comparison in this particular sample was difficult, because 68.8% of bullied participants reported that their bullying was chronic (i.e., occurring for more than 1 year), and an even larger percentage (80.0%) reported that their perceived sexual orientation may have been the cause of their being bullied, so these were not sufficiently unique reports to base group separation on. Additionally, there was significant overlap among types of bullying. For example, 96.3% of bullied boys reported some active bullying such as name-calling. Relational forms of bullying, such as rumors being spread or ostracization, occurred in addition to, and not to the exclusion of, name-calling and teasing. The sample was divided into three groups: those with either no bullying or low bullying (i.e., teasing or name-calling only), those with relational bullying in addition to name calling (i.e., spreading rumors or ostracization), and a severely bullied group consisting only of those young men that reported physical and/or

sexual assault as a part of their experience. A sample of responses is given in Table 2. Full responses are provided in Appendix D.

Bullying specific self-efficacy. Participants' perceived ability to manage situations in which they are bullied or harassed were measured by five items, such as "how well were you able to enlist the aid of adults when necessary to protect yourself?" Complete measures are reprinted in Appendix B. For each item, participants rated their belief on a 5-point scale of how much efficacy they had in handling the bullying or harassment related event. This is based on the 5-item design proposed by Bandura (1997) for establishing behavior specific self-efficacy. These items were generated by the researcher, each worded to probe a specific aspect of coping efficacy. Each item was coded in the positive direction, so that a score of 5 indicated no efficacy, and 25 indicated a belief in complete efficacy. The mean amount of bullying specific self-efficacy reported was 15.1 (SD = 4.7; range = 5–25; α = .74).

Table 2

*Some Responses to Questions about Bullying (*N = *90)*

Question	Yes[a]	No[a]	*M*	*SD*
Were you ever bullied?[b]	88.9	11.1		
Was this because you were gay, or perceived as gay?	71.3	20.0		
How were you bullied?				
Called names	96.3	3.8		
Teased	83.8	16.3		
Hit or kicked	31.3	68.8		
Given threatening looks	35.0	65.0		
No one would speak to me	31.3	68.8		
Rumors were spread	70.0	30.0		
Ridiculed in front of others	58.8	41.3		
Sexually assaulted	8.8	91.3		
Belongings stolen	27.5	72.5		
Other	21.3	78.8		
Were you ever beaten so badly you required medical attention?	11.4	88.6		
Could you go to anyone that would stop others from bullying you, like a parent or teacher?	37.5	62.5		
How old were you when the bullying began?			11.5	3.3
How old were you when the bullying ended?			16.8	2.1
Duration of bullying (years)[c]			5.0	3.8
Have you ever experienced harassment as an adult?[b]	32.2	67.8		

Note. Except as indicated with subscript *b*, questions were asked only of bullied participants (i.e., those answering "yes" to the first question).

[a]Values are specified in percentages, which may not total 100% due to rounding. [b]Asked of all participants. [c]Duration of bullying was derived from the bullying start and end ages.

Internalized homophobia. The Shidlo (1994) text revision of the Nungesser Homosexual Attitude Inventory (NHAI; Nungesser, 1983) is a 36-item questionnaire designed to measure three subscales of attitudes toward gay men's sexuality, gay men in general, and attitudes toward others' knowledge of their own sexual orientation. The literature reviewing internalized homophobia as a construct in the literature most frequently cites Nungesser's measure, or measures derived from it, as tapping relevant components of attitudes of the self concerning the fact of minority sexual orientation. The Shidlo (1994) revision is the most frequently used measure of internalized homophobia (Huebner et al., 2002; Rivers, 2004), and was used here. Participants rated each item on a 5-point scale, indicating *Strongly Disagree* to *Strongly Agree*, such as for Item 9: "I have been in counseling because I wanted to stop having sexual feelings for other men." This scale has demonstrated excellent concurrent and criterion validity (Shidlo, 1994), and internal consistency is good, with Cronbach's alpha = .91 or above reported in research that utilizes the measure. The mean of internalized homophobia reported in this sample was 2.16 (SD = 4.5, range = 1.42–3.47, α = .87).

Parental social support. The Quality of Relationships Inventory (QRI; Pierce, 1994) was used to estimate support. Pierce (1994) developed this 20-item measure to quantify perceived social support quality provided by specific sources. In this interview, items were reworded to specify familial support. Past research in a local community sample has indicated that poor familial, specifically parental, support is most predictive of symptoms of psychological distress in samples of gay men (Skinta, 2004). The relative importance of parental over friend support on gay male functioning has been

maintained throughout the literature (e.g., Elizur & Mintzer, 2003), so only parental support is assessed in this interview. Items from the initial 20 items can be used to determine subscales of relationship support, depth, or conflict. The measure of support was used in this study. Reliability varies depending on the types of support the measure refers to, with more consistent report among family than friends (α = .70–.94). The mean of social support reported in this sample was 19.82 (*SD* = 5.18; range = 8–28; α = .88).

PTSD symptoms. The PTSD Symptom Scale-Interview (PSS; Foa, Riggs, Dancu, & Rothbaum, 1993) was used to measure severity and estimate diagnosis of bullying or assault-related PTSD symptoms at the worst time reported. To screen for potential current symptoms of PTSD, participants were then asked, "have you recently become emotionally upset because of physical, sexual, or any other type assault that you've experienced?" All participants were asked to respond to items related to the worst period of time they were bullied, then for the past two weeks. All items were administered, regardless of response to the screener question. This scale consisted of 17 items, each corresponding to symptoms of the diagnostic criteria for PTSD (Clusters B–D), as reported in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.) (DSM-IV; American Psychiatric Association, 1994). Symptom severity was assessed by the response to each item on a 4-point scale (*Not at All* to *Very Much*). This scale has demonstrated excellent concurrent and criterion validity (Foa et al.; Norris & Riad, 1997), and internal reliability for severity scores in this study was excellent (α = .96). A recent survey suggests that at least 17% of gay, lesbian, and bisexual identified

adolescents may suffer from PTSD. The mean of recent PTSD symptoms reported in this sample was 9.28 (*SD* = 11.29, range = 0–46, α = .94).

Depressive symptoms. The CES-D consists of 20 questions related to somatic and affective symptoms of depression that may have occurred in the past week (Roberts & Vernon, 1983). This study used the CESD-10, a short-form version of the CES-D, which has been found to perform similarly to the CES-D and is ideal for difficult-to-reach samples or inclusion as part of a lengthier battery (Andresen, Carter, Malmgren, & Patrick, 1994). Participants were asked to rank these statements on a scale of 1 to 4 (traditionally 0 to 3, but altered to bring it into line with other measures in this interview). Questions include items such as "I felt depressed," "I am hopeful," or "I could not get 'going.'" Depressive symptoms are frequently reported at elevated levels in community samples of gay men and lesbians (Huebner et al., 2002; Herek et al., 1997). Test-retest reliability data are not reported, because the responses should vary according to the time period being observed. Participants were first asked about depressive symptoms experienced currently. Next, the interviewer would ask the participant to think of the worst period of harassment or bullying, and answer for that period. Cronbach's alpha is reported as .85, indicating good internal reliability (Harrison & Stuifbergen, 2002). The mean of recent depressive symptoms reported in this sample was 10.5 (*SD* = 6.8, range = 1–27, α = .87). Because the cut-off on this screening measure is 11, a mean of 10.5 indicates that many participants in this sample endorse greater depressive symptoms than would be expected in the general population.

Posttraumatic growth. An adaptation of the Post Traumatic Growth Inventory (PTGI; Tedeschi & Calhoun, 1995) was used to estimate growth that occurred as a result of bullying or assault. Tedeschi and Calhoun (1995) developed this 20-item measure to quantify growth that occurs as a result of successful coping with a traumatic event, and in its original format measures growth along five dimensions: relating to others, new possibilities, personal strength, spiritual change, and appreciation of life. The measure was shortened to a 10-item measure in this study to eliminate items related to natural disasters or other events not relevant to assault. Additionally, the spiritual change dimension was deleted, because past research indicates that a majority of gay male adolescents question or leave their familial faith tradition at this age, postponing spiritual growth until later periods of life. Participants were asked to rate the degree of change experienced as a result of bullying or harassment from *No Change* to *A Very Great Degree of Change* on descriptive statements such as "a sense of closeness with others." Internal consistency of the PTGI is good (α = .90), and additional research indicates a higher report of gain among individuals that have experienced more severe trauma. The mean of PTG reported in this sample was 27.1 (*SD* = 13.5, range = 0–50, α = .91).

The means and standard deviations for each of the observed variables are provided in Table 3.

Table 3

*Observed Variables (*N = *90)*

Variable	*M*	*SD*
Internalized homophobia	2.2	0.5
Quality of parental social support	19.8	5.2
Bullying-specific self-efficacy	15.1	4.7
Depressive symptoms	10.5	6.8
Posttraumatic stress disorder symptoms	9.3	11.3
Posttraumatic growth	27.1	13.5

Planned Analyses

Preliminary analyses. Several tests were conducted to detect whether the assumptions of the applied statistics were met for the first set of analyses (Tabachnick & Fidel, 2001). All analyses were performed using SPSS 15.0 for Windows. First, bivariate correlations were examined to observe whether the observed measures were related in the expected direction. This allowed for the selection of appropriate control variables for subsequent analyses. Second, multivariate normality was assessed to ensure that the distributions and means of the dependent variables are normally and linearly distributed. Internalized homophobia, PTG, and depressive symptoms were normally distributed, with skewness and kurtosis statistics within acceptable ranges. A log transformation was performed (Tabachnick & Fidell, 2001) to decrease the extreme skew of recent PTSD symptoms. Transformed data on that measure were used in all analyses. Secondly, Box's M-test was used to examine the extent to which the dependent variable and covariances within each group are separate estimates of the same population variance (i.e., homogeneity of variance-covariance matrices). Box's M test was not significant ($p > .10$) for any of the dependent variables, indicating that the assumption of homogeneity of variance-covariance matrices was not violated. All covariates were examined for outliers. Race and religion were regrouped for ease of analysis, due to the low number of minority participants (recoded Caucasian = 0, non-Caucasian = 1) and the relative homogeneity of responses to religious self-identification (recoded Christian = 0, atheist/agnostic/spiritual = 1). Point biserial correlations are calculated the same as Pearson product-moment correlations, so these are presented in their dichotomized form

in the correlation matrix below. Additionally, because primary effects are tested through regression analyses, continuous independent variables (i.e., bullying-specific self-efficacy and parental support) were centered on their respective means prior to the following analyses (Jaccard & Turrisi, 2003).

To determine whether there was a multivariate effect across dependent variables and to examine the differences between levels of bullying and the dependent measures of depressive symptoms, PTSD symptoms, and PTG, a one-way multivariate analysis of covariance (MANCOVA) was conducted. MANCOVA is an appropriate test of group differences when examining multiple dependent variables that are empirically or conceptually related because it tests the null hypothesis that a collection of means on a group of dependent variables (i.e., vector of means) is equal at each level of the dependent variable (Weinfurt, 1995). In addition, it allows for the inclusion of covariates to minimize the amount of unexplained or unreliable variance (i.e., error variance) in the test, thus providing a more accurate test of mean differences between groups (Weinfurt, 1995).

Tests of the impact of bullying on dependent variables. The first hypothesis states that bullying experiences will increase depressive symptoms, PTSD symptoms, and PTG. This can be most parsimoniously examined through an exploration of regression coefficients calculated in the test of Hypothesis 2.

Tests of mediation model. Hypothesis 2 predicts that internalized homophobia will mediate the relationship between bullying and the outcome measures. A variety of macros are available to assist in the testing of hypotheses of mediation with linear

regression. Baron and Kenny (1986) suggest that four criteria must be met for simple mediation to occur. Restated with the hypothesized variables from this study, these are: (a) bullying significantly predicts the outcome variables, (b) bullying significantly predicts internalized homophobia, (c) internalized homophobia significantly predicts the outcome measures controlling for bullying, and (d) the effect of bullying on the outcome measures decreases when controlling for internalized homophobia.

As noted by Preacher and Hayes (2004), there are a number of limitations to testing mediation exclusively according to the criteria set forth by Baron and Kenny (1986), which is particularly vulnerable to Type II error when using an underpowered sample. Additionally, a test of indirect effects, such as the Sobel test, requires only the establishment of a relationship between the predictor variable and dependent variable. Because mediation is a special type of indirect effect, this approach allows for a single test of a reduction of the impact of bullying upon PTSD symptoms when the effect of internalized homophobia is taken into account. Preacher and Hayes (2004) provide criteria for Sobel's test of indirect effects in SPSS. As they note, although these tests may be performed with SEM software, it is unnecessary to use a more sophisticated program with a simple model and small sample, such as those tested in this specific study.

Tests of the moderated model. Hypothesis 3 predicts that bullying-specific self-efficacy and parental support and bullying moderate each others effect on internalized homophobia. To parsimoniously test the moderated model, a series of hierarchical regression equations were conducted (Jaccard & Turrisi, 2003). Jaccard and Turrisi

(2003) suggest that more than one moderator may be analyzed simultaneously. Conducting a simultaneous test of the proposed model reduces the probability of Type I statistical error associated with multiple statistical tests (Tabachnick & Fidell, 2001). This model included bullying, self-efficacy, parental support, and examined their association with internalized homophobia.

The moderated-mediation model. Moderated-mediation has been defined in multiple ways by numerous theorists since the term was first coined by James and Brett (1984). Preacher, Rucker, and Hayes (in press) identify five competing definitions of moderated-mediation. The hypothesis under review best fits the definition that Morgan-Lopez and MacKinnon (in press) provide: Moderated-mediation is present when "the effect of a mediator on the outcome differs across the moderator variable." In this case, the hypothesis postulates that the effect of internalized homophobia on the relationship between bullying and the outcomes varies across levels of parental support and bullying-specific self-efficacy. Preacher et al. argue that all moderated-mediation models are ultimately "conditional indirect effects," because they essentially posit that the indirect effect (i.e., mediation) is conditional upon the mediator. A number of tests have been developed that interpret significant interaction effects in regression (Aiken & West, 1991). In this case, Preacher et al. provide the syntax for an SPSS macro that tests the data in this way.

CHAPTER III

RESULTS

Preliminary Analyses

Correlation matrix

The bivariate correlations (and coding for demographic variables) of control and outcome variables are presented in Table 4. There is a significant, positive correlation between between religion and depressive symptoms ($r = .28$, $p < .05$). Additionally, race bears a small, significant positive correlation with PTSD symptoms ($r = .21$, $p < .05$), as do religion and PTSD symptoms ($r = .26$, $p < .05$). For this reason, religion will be used as controls in subsequent analyses involving depressive symptoms, and race and religion will be used as controls in subsequent analyses involving PTSD symptoms. Measures of psychological distress were related; depressive symptoms were significantly, highly and positively correlated with PTSD symptoms ($r = .68$, $p < .01$). Correlation coefficients ranging from $r = .30$ to $r = .50$ are considered to be medium effect sizes (Cohen et al., 2002). Additionally, it should be noted that PTG was significantly positively correlated with PTSD symptoms ($r = .26$, $p < .05$), as well as negatively correlated with bullying-specific self-efficacy ($r = -.21$, $p < .05$).

Table 4

*Bivariate Correlations among Dependent Variables and Demographic Variables (*N = *90)*

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. Age	—													
2. Race[a]	–.07	—												
3. Religion[a]	.01	–.17	—											
4. Education (years)	.36**	–.07	.21*	—										
5. Age realized was gay	.28**	–.01	–.04	.21	—									
6. Age came out	.39**	.15	.01	.24*	.59**	—								
7. Income	.11	–.04	–.07	–.24*	–.19	–.07	—							
8. Internalized homophobia	.19	.00	–.17	.11	.18	.14	–.10	—						
9. Parental support	–.02	.03	–.13	–.07	.12	.09	–.01	–.16	—					
10. Bullying-specific self-efficacy	–.02	–.14	–.17	–.11	.00	.10	.02	–.23*	.37**	—				
11. Depressive symptoms	–.13	–.02	.28*	.04	–.19	.04	–.13	.09	–.18	–.20	—			
12. PTSD symptoms	–.07	.21*	.26*	.05	–.11	.07	–.12	.23*	–.09	–.23*	.68**	—		
13. Posttraumatic growth	–.01	.08	.11	.06	–.04	–.10	–.05	.11	–.14	–.21*	.16	.26*	—	
14. Bullying (Low/No vs. Relational)	.05	–.10	.14	–.09	–.03	–.16	.24	.10	–.02	–.24	.04	.23	.33*	—
15. Bullying (Low/No vs. Severe)	.13	–.04	.05	–.01	.05	–.12	–.08	.06	.15	–.17	.12	.33*	.43**	—[b]

Note. Bivariate correlations between bullying variables, race, and religion with continuous variables are point-biserial; others are Pearson product-moment correlations. PTSD: posttraumatic stress disorder.
[a]Race and religion were dichotomized (Caucasian vs. non-Caucasian and Christian vs. Agnostic/Spiritual/Atheist, respectively). [b]Variables 14 and 15 partitioned values of a single underlying variable, so no correlations were computed.
*p < .05. **p < .01. *p < .001.

There was a small, significant positive correlation between internalized homophobia and PTSD symptoms ($r = .23$, $p < .05$), but the relationship between internalized homophobia and depressive symptoms was not significant ($r = .09$, $p > .05$). Additionally, there was no significant relationship between internalized homophobia and PTG ($r = .11$, $p > .05$). Bullying-specific self-efficacy was also significantly negatively correlated with internalized homophobia ($r = -.23$, $p < .05$) and PTSD symptoms ($r = -.23$, $p < .05$), and had a significant positive relationship with family support ($r = .37$, $p < .01$).

For entry into the correlation matrix, bullying was separated into two dichotomized variables: low/no bullying vs. relational bullying, and no/low bullying vs. severe bullying. The low/no bullying vs. relational bullying variable was only significantly positively correlated with posttraumatic growth ($r = .33$, $p < .05$). The low/no bullying vs. severe bullying variable was also significantly positively correlated with PTSD symptoms ($r = .33$, $p < .05$), as well as with PTG ($r = .43$, $p < .01$).

MANCOVA revealed a multivariate main effect for bullying on depressive symptoms, PTSD symptoms, and PTG (Wilkes' $\lambda = .81$, $F[6, 89] = 3.14$, $p = .006$ [Obs. Power = .91]), after controlling for religion. Pairwise comparisons revealed a significant between-group effect between no/low bullied participants and those with relational bullying on PTG ($p = .005$). There was also a significant between-group effect between no/low bullied participants and those reporting severe bullying on PTSD symptoms ($p = .007$) and PTG ($p = .001$). This held true across all outcome variables. Low/no bullying

was related to lower PTSD symptoms and less PTG. There were no significant pairwise comparisons for depressive symptoms. The relational and severe bullying conditions did not vary significantly from one another in any condition. For this reason, the relational and severe bullying conditions were combined in subsequent analyses, so that it was dichotomized with low/no bullying = 0 (n = 27), relational/severe bullying = 1 (n = 63). Graphic illustration demonstrates a progressive increase in the outcome variables as the level of bullying increases, as shown in Figures 2, 3, and 4 as well as Table 5.

Figure 2. Differences by level of bullying severity across posttraumatic growth (PTG). PTG measured using a modified version of the Post Traumatic Growth Inventory.

Figure 3. Differences by level of bullying severity across depressive symptoms. Depressive symptoms measured using the Center for Epidemiologic Studies Depression Scale, short form.

Figure 4. Differences by level of bullying severity across posttraumatic stress disorder (PTSD) symptoms. PTSD symptoms measured using the PTSD Symptom Scale Interview.

Table 5

*Differences in Psychopathological Symptoms by Level of Bullying Severity (*N = *90)*

	Low/No Bullying		Relational Bullying		Severe Bullying	
	M	*SD*	*M*	*SD*	*M*	*SD*
Posttraumatic growth	19.8	14.3	29.4	13.6	31.3	9.7
Depressive symptoms	9.7	7.0	10.2	5.6	11.5	7.7
PTSD symptoms	5.0	8.6	9.3	9.8	13.0	13.7

Note. PTSD: posttraumatic stress disorder.

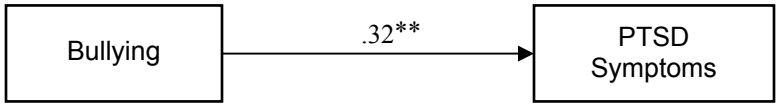
The Impact of Bullying on Depressive Symptoms, PTSD Symptoms, and PTG

The first hypothesis predicted that bullying experiences would be related to greater (a) depressive symptoms, (b) PTSD symptoms, and (c) PTG. This direct effect can be established through regression, which was tested simultaneously with Hypothesis 2, below.

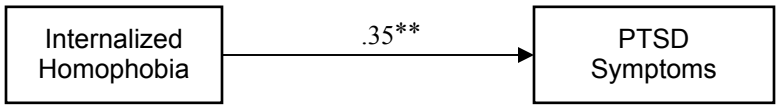
The Role of Internalized Homophobia as a Mediator

The second hypothesis predicted that internalized homophobia would mediate the relationship between bullying and the outcome measures (i.e., depressive symptoms, PTSD symptoms, and PTG). Mediation requires that bullying have a significant direct effect across outcomes. This step is significant for all outcomes (see Figures 5−7). With an alpha level of .05, bullying has a significant direct effect on PTSD symptoms (p = .002) and PTG (p = .001), but not depressive symptoms (p = .68). This supports the first hypothesis, that bullying has a direct effect upon the outcomes. Second, mediation requires that bullying have a direct effect upon the proposed mediator, internalized homophobia. This was not significant (p = .41). Third, mediation requires that the proposed mediator have a direct effect upon outcomes. This was only significant for PTSD symptoms (p = .001), not for depressive symptoms (p = .16) or PTG (p = .35). Fourth, the direct effect that bullying has on the outcomes should be reduced when internalized homophobia is controlled.

(a)



(b)



(c)

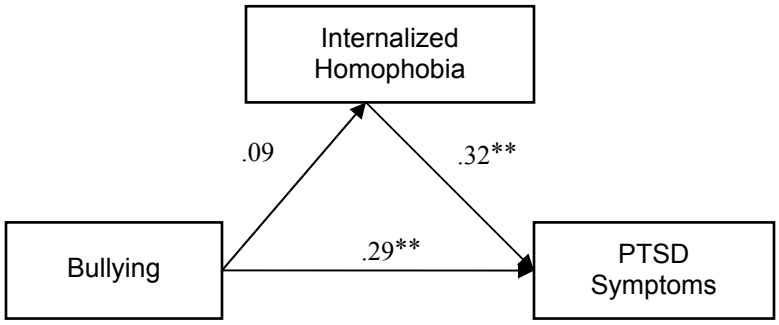
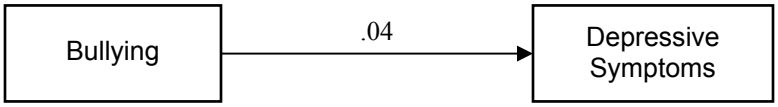
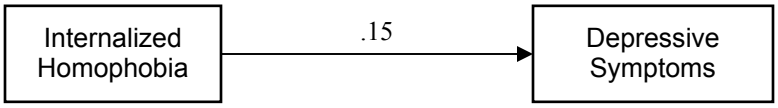


Figure 5. Test of internalized homophobia as a mediator between bullying and posttraumatic stress disorder (PTSD) symptoms. Model (a) depicts the direct effect of bullying upon PTSD symptoms, controlling for race and religion. Model (b) depicts the direct effect of internalized homophobia upon PTSD symptoms, controlling for race and religion. Model (c) depicts the relationship between bullying and PTSD symptoms when internalized homophobia is entered as a mediator. Statistics given are standardized correlation coefficients. $^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$.

(a)



(b)



(c)

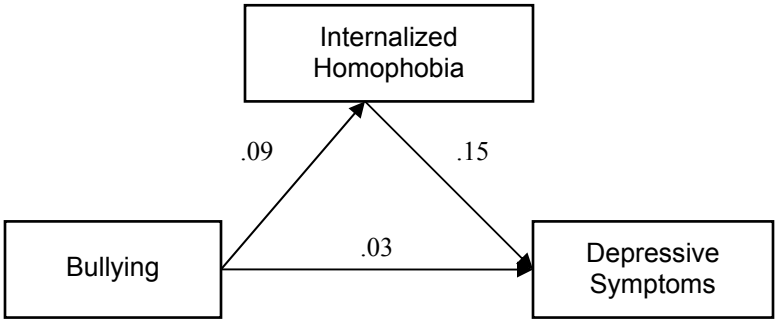
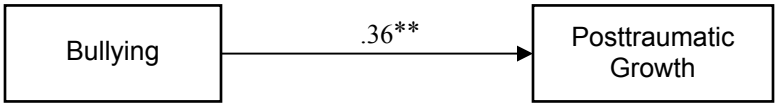
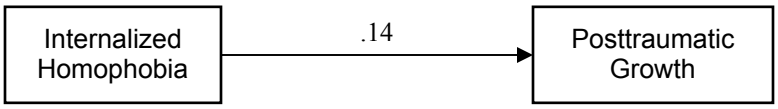


Figure 6. Test of internalized homophobia as a mediator between bullying and depressive symptoms. Model (a) depicts the direct effect of bullying upon depressive symptoms, controlling for race and education. Model (b) depicts the direct effect of internalized homophobia upon depressive symptoms, controlling for religion. Model (c) depicts the relationship between bullying and depressive symptoms when internalized homophobia is entered as a mediator. Statistics given are standardized correlation coefficients. $^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$.

(a)



(b)



(c)

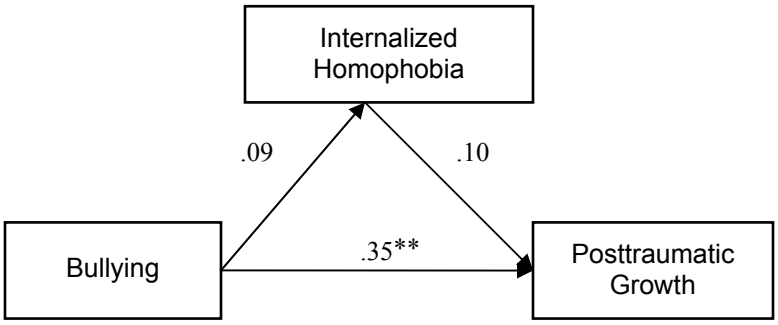


Figure 7. Test of internalized homophobia as a mediator between bullying and posttraumatic growth (PTG). Model (a) depicts the direct effect of bullying upon PTG. Model (b) depicts the direct effect of internalized homophobia upon PTG, controlling for race and religion. Model (c) depicts the relationship between bullying and PTG when internalized homophobia is entered as a mediator. Statistics given are standardized correlation coefficients. $^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$.

The Impact of Protective Factors on the Relationship between Bullying and Internalized Homophobia

The third hypothesis predicted that parental social support and bullying self-efficacy would moderate the relationship between bullying experiences and internalized homophobia. As noted by Jaccard and Turrisi (2003), only demographic variables associated with the dependent variable should be included in the model as controls. Demographic variables such as age, education, and income were not significantly correlated with internalized homophobia (see Table 4), so were excluded from the model. Only religion was significant, so it was included as a control (see Table 6).

In hierarchical analysis the potential interacting impact of both parental support and bullying-specific self-efficacy on internalized homophobia were simultaneously tested. Bullying was entered into the second step of the model, and was not significant ($t = 0.86$, $p = .39$). Secondly, bullying-specific self-efficacy ($t = -1.92$, $p = .05$) and parental support ($t = -1.03$, $p = .31$) were entered; this block accounted for a significant amount of the variance ($\Delta R^2 = .08$, $p = .03$). This finding supports that there is a direct effect of bullying-specific self-efficacy on internalized homophobia. Finally, the interaction term of bullying and parental support ($t = 0.87$, $p = .39$), and bullying and bullying-specific self-efficacy ($t = 0.01$, $p = .99$), were entered into the model. These two interactions did not significantly increase the variance accounted for either singly or jointly ($\Delta R^2 = .01$, $p = .64$), indicating no moderation effect.

Table 6

*Hierarchical Regression Model Testing Moderation Hypothesis: Moderation of the Relationship between Bullying, Bullying Self-Efficacy, and Parental Support on Internalized Homophobia (*N = *90)*

	Step 1			Step 2			Step 3			Step 4		
Predictor	*B*	*SE B*	β	*B*	*SE B*	β	*B*	*SE B*	β	*B*	*SE B*	β
Religion	–.16	.10	–.17	–.16	.10	–.18	–.21	.10	–.23*	–.21	.10	–.23*
Bullying				.09	.11	.09	.06	.10	.06	.06	.06	.06
Bullying self-efficacy							–.02	.01	–.27*	–.02	.02	–.26*
Parental support							–.01	.01	–.19	.00	.02	.19
Bullying Self-Efficacy × Bullying										.00	.02	.06
Parental Support × Bullying										.01	.01	.17
R^2 for model			.03			.04			.11			.12
F statistic for ” R^2			2.61			0.74			3.57*			0.45

*$p < .05$. **$p < .01$. ***$p < .001$.

The Moderated-Mediation Model

The fourth hypothesis predicted that the model best predicting psychopathological outcomes and PTG would be a moderated-mediation path, with internalized homophobia mediating bullying and the outcomes, but moderated by self-efficacy and parental social support. The above analyses have already tested aspects of that model, and have failed to find support for a moderator effect. There was also no direct effect of bullying onto internalized homophobia, and tests of indirect effects were not significant. Thus, internalized homophobia is not a mediator, and therefore the final hypothesis was not tested.

Post Hoc Analyses

Cognitive Coping

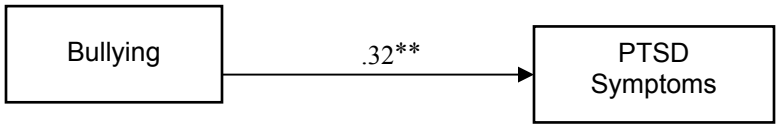
One of the most striking features of the initial analysis was the relationship that PTG had with symptoms of psychopathological distress (see Table 4). These relationships suggest the possibility of a negative coping trajectory, wherein a focus on posttraumatic *growth* contributes to psychopathology. In contrast, bullying-specific self-efficacy may represent a more adaptive kind of cognitive coping.

As Helgeson, Reynolds, and Tomich (2006) observed, PTG may not simply be an outcome, but can be conceptualized as a form of cognitive coping through active reappraisal of traumatic events. Zoellner and Maercker (2006) proposed the Janus-Face model of PTG, which posits that, although in some instances, PTG might be a sign of recovery of pre-morbid functioning, it also may indicate self-deception to avoid

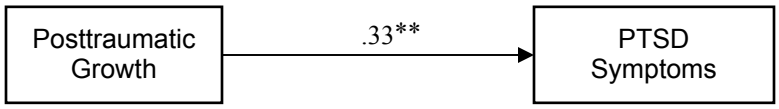
recognizing the real costs of the trauma. If PTG is reframed as a cognitive coping strategy with negative outcomes in this study, the pattern of correlations to other variables may indicate mediation. Thus, it was hypothesized that PTG would mediate the relationship between bullying and PTSD symptoms.

Results of these analyses are shown in Figure 8, below. Following Baron and Kenny's (1986) criteria outlined above, mediation requires that bullying have a significant direct effect across outcomes. This step is significant for PTSD symptoms (p = .002), as described above. Second, mediation requires that bullying have a direct effect upon the proposed mediator, PTG. This was significant (p = .001). Third, mediation requires that the proposed mediator have a direct effect upon outcomes. This was significant; PTG had a direct effect on PTSD symptoms (p = .001). Fourth, the direct effect that bullying has on the outcomes should be reduced when PTG is controlled. There was a reduction in the significance of the effect of bullying on the outcome measures, but the relationship was still significant, so conditions for full mediation are not met. However, the data meet Barron and Kenny's (1986) criteria for partial mediation for PTSD symptoms. Thus, the hypothesis is supported, such that PTG partially mediates the relationship between bullying and PTSD. Those who are bullied more have greater PTG, and in turn, greater PTSD.

(a)



(b)



(c)

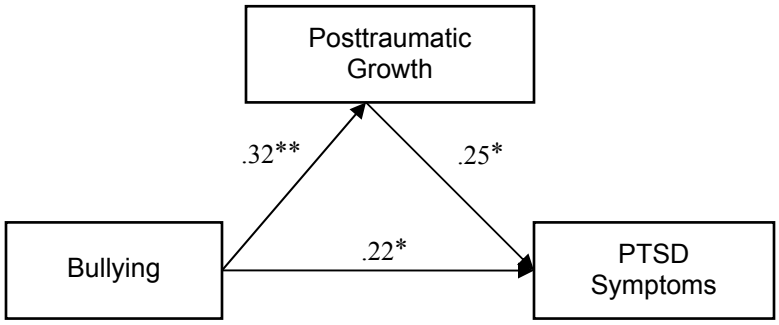


Figure 8. Test of posttraumatic growth (PTG) as a mediator between bullying and posttraumatic stress disorder (PTSD) symptoms. Model (a) depicts the direct effect of bullying upon PTSD symptoms, controlling for race and religion. Model (b) depicts the direct effect of PTG upon PTSD symptoms, controlling for race and religion. Model (c) depicts the relationship between bullying and PTSD symptoms when PTG is entered as a mediator. Statistics given are standardized correlation coefficients. $^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$.

Minority Stress Model

Due to failure to support the original moderated-mediation model, an alternate model was next explored integrating Meyer's Minority Stress Model with the original ideas about cognitive coping explored above. To examine if Meyer's (1995) minority stress theory better explained relationships among study variables, an additional multiple hierarchical regression was run. Meyer (2003) suggests specific findings when examining prejudice (i.e., bullying/teasing) and its relationship with self-stigma/internalized homophobia. Despite a large body of literature suggesting ongoing distress among bullied heterosexual and homosexual men alike, internalized homophobia must account for variance in excess of what would be expected from bullying alone (Meyer, 2003). Furthermore, Meyer (1995, 2003) suggests there should be no significant interaction or indirect relationship between internalized homophobia and bullying. Hence, tests of the effects of bullying and internalized homophobia as predicted by minority stress theory require (a) the establishment of a relationship between bullying and internalized homophobia and outcome variables, (b) the absence of interaction effects between bullying and internalized homophobia, and (c) a significant increase in the outcome variables' variance accounted for by each independent variable. The first two propositions have been satisfied in analyses described above. Internalized homophobia and bullying each have significant direct effects on PTSD symptoms, and tests of indirect effects indicate no significant interaction. Added to this is the concept of cognitive coping. PTG appears to be a negative cognitive pathway in this study. As examined above, it partially mediates the relationship between bullying severity and

psychopathological outcomes. Specifically, the role of PTG as a mediator may indicate that a focus on growth actually leads to a worsening of symptoms. This can be contrasted with bullying-specific self-efficacy, which captures cognitions about the ability to handle those stressors. These cognitive coping strategies are examined in the final step of the model. What remains is to test the change in R^2 as each variable is entered into the regression equation. Minority stress, according to Meyer (2003), consists of three parts: stigma, self-stigma, and prejudice. As discussed above, the latter corresponds to internalized homophobia and bullying, respectively, but there is no observed measure in this data that corresponds well to stigma, which is defined as "expectations of [stressful] events and the vigilance this expectation requires" (Meyer, 2003, p. 676).

The results in Table 7 indicate that these data do, in fact, meet the criteria set forth for minority stress. As noted above, religion ($t = 2.87$, $p < .01$) and race ($t = 1.42$, $p = .16$) are related to PTSD symptoms, so were added to the model in the first step as control variables and significantly contributed to the variance. Bullying was added in the next step, and also significantly increased the variance ($t = 3.22$, $p < .01$). Third, internalized homophobia was inserted into the model, and accounted for an additional 10% of the variance ($t = 3.41$, $p < .01$). Fourth, the cognitive coping variables were entered into the model simultaneously, and accounted for a significant increase in the variance accounted for. The relationship between PTG and PTSD symptoms was significant ($t = 2.12$, $p = .04$), but the relationship between bullying-specific self-efficacy and PTSD symptoms was non-significant ($t = -1.05$, $p = .30$).

Table 7

*Hierarichical Multiple Regression Examining the Direct Effects of Bullying, Internalized Homophobia, and Cognitive Coping Strategies on Posttraumatic Stress Disorder Symptoms (*N = *90)*

	Step 1			Step 2			Step 3			Step 4		
Predictor	*B*	*SE B*	β	*B*	*SE B*	β	*B*	*SE B*	β	*B*	*SE B*	β
Race	.17	.12	.15	.20	.12	.17	.21	.11	.18	.15	.11	.13
Religion	.33	.11	.30**	.37	.12	.32**	.37	.10	.33**	.31	.11	.28**
Bullying				.37	.12	.32**	.34	.11	.29**	.23	.12	.20*
Internalized homophobia							.38	.11	.32***	.32	.11	.27**
Posttraumatic growth										.01	.00	.21*
Bullying self-efficacy										–.01	.01	–.10
R^2 for model			.10			.19			.29			.34
F statistic for ” R^2			4.58*			10.34**			11.60***			3.04*

*p < .05. **p < .01. ***p < .001.

CHAPTER IV

DISCUSSION

The present study examined the interaction of childhood bullying experiences, internalized homophobia, bullying specific self-efficacy, and parental support among young gay men. The overarching aim was to examine how these variables contributed to psychopathological symptom severity and growth experiences. This study also examined a proposed causal mechanism through which bullying contributed to ongoing attitudes about being gay in the world. This chapter begins with a summary and interpretation of major findings from the present study as they relate to each hypothesis. Next, an alternate theoretical model that may better fit the data is reviewed, followed by possible clinical implications. Strengths and weaknesses of the design are also reviewed.

Hypothesis 1: The Effect of Bullying on Psychopathological Symptom Severity

The pattern of results that emerged for different levels of bullying on psychopathological symptom severity was generally consistent with the first study hypothesis. Results indicated that those with low or no bullying experiences experienced significantly less distress than those men that experienced relational or severe bullying. Surprisingly, however, there was no significant difference in outcomes between men with relational bullying or severe bullying. This finding could be explained, in part, by the limited sample size. Figure 3, for example, depicts a trend toward increased symptom

severity with each level of bullying. Alternately, chronicity of bullying is reported by most participants, which may exaggerate the symptom severity compared with a sample with more isolated instances of bullying. Measurement error could also be a factor, either due to the measures selected, or aspects of the interview process.

Hypothesis 2: The Effect of Internalized Homophobia on Psychopathological Symptom Severity

The pattern of results for internalized homophobia was somewhat inconsistent with the second study hypothesis. Bullying had a direct effect on all outcome measures. Internalized homophobia did not have a direct effect on PTG or depressive symptoms; however, it was related to PTSD symptoms. There is a single study—with an equally small sample size—that found a similar effect (i.e., non-significant findings for depression and a positive significant relationship between internalized homophobia and PTSD symptoms) when focusing on the impact of internalized homophobia on psychopathological symptoms among gay men that experienced childhood sexual abuse (Gold, Marx, & Lexington, 2007). It may be an artifact of the measures selected, because the CESD-10 particularly targets affective statements, whereas the PTSD Symptom Severity Checklist focuses on patterns of emotional and behavioral avoidance, combined with the broad physiological sequelae of vigilance and arousal. These latter traits are conceptually linked to internalized homophobia that focuses not only on rejecting and avoidant strategies in managing one's expression of sexuality, but also vigilance in monitoring for the threat of discovery.

This hypothesis posits that self-stigma is a consequence of early stigmatizing events. It was initially expected that there would be an indirect effect of internalized homophobia on the relationship between bullying and PTSD symptoms (e.g., the context of anti-gay bullying would increase a view that it is dangerous and undesirable to be a gay male, increasing or contributing to self-stigma). This was not found to be the case in this sample. Rather, the results indicated that although there were direct effects of bullying upon psychopathological symptoms, there was no relationship between bullying and internalized homophobia. The effect of bullying on psychopathological symptoms was not lessened when internalized homophobia was introduced to the model (see Figure 2), indicating no mediation effect. There was, however, a direct effect of internalized homophobia on PTSD symptoms when controlling for bullying, which is consistent with Meyer's minority stress model, further described below.

Hypothesis 3: The Protective Role of Parental Social Support and Bullying-Specific Self-Efficacy

The third hypothesis predicted that parental social support and bullying-specific self-efficacy would moderate the relationship between bullying severity and internalized homophobia. Parental social support and bullying-specific self-efficacy did not moderate the relationship between bullying severity and internalized homophobia. In combination, they contributed to the variance of internalized homophobia, but only bullying-specific self-efficacy contributed negatively and significantly to the variance explained by the multiple regression model. This suggests that a lack of efficacy dealing with gay-specific

stressors contributes in small part to elevations in internalized homophobia, which is consistent with previous conceptualizations (Nungesser, 1983; Shidlo, 1994).

Although the influence of parental support was not a significant predictor for this sequence of coping within this sample of young men, it has been noted in other samples (e.g., Elizur & Mintzer, 2003; Skinta, 2004). It can be noted by the zero-order correlations that parental social support had a borderline negative relationship with PTSD and depressive symptoms and with PTG. It was also markedly related to greater bullying self-efficacy. This suggests that parental social support indirectly aided these men by decreasing their use of PTG and increasing their bullying self-efficacy. Because prior studies did not consider gay men's coping with bullying as comprehensively, such complex relationships would not have been apparent.

Post Hoc Analyses

Cognitive coping. Most notably, PTG was found to partially mediate the relationship between bullying severity and psychopathological symptom severity. This highlights the importance of cognitive appraisal in reaction to and recovery from trauma. Specifically, a focus on growth due to trauma may be either a part of the process of construing meaning, or a normative rumination of the attempt to actively cope with the experience (Zoellner & Maercker, 2006). Neither of these possibilities precludes co-morbid psychological distress, and there is mixed empirical support for the original assumption (Tedeschi & Calhoun, 1995) that all self-perceived PTG is functional (Helgeson et al., 2006). Studies exploring rumination following a traumatic experience, for example, often fail to distinguish constructive rumination from intrusive thoughts

(e.g., Calhoun, Cann, Tedeschi, & McMillan, 2000). All rumination unrelated to intrusive thoughts is not necessarily helpful, either. First, a greater focus on the impact that traumatic events had on individuals' lives could be a sign that the events had not been well incorporated into an overall life narrative, but are still fearfully avoided. This is considered a sign of poor adjustment to trauma according to many perspectives on treatment (Foa & Kozak, 1986). An alternate perspective is that the report of growth does not preclude, and in fact frequently co-occurs with, simultaneous report of significant psychological distress (Wortman, 2004). In fact, what is described as PTG is typically the measurement of self-perceived PTG (Helgeson et al.). Wortman (2004) has noted that considerable questions remain as to the veracity of a report of PTG, as it is frequently measured in the absence of longitudinal data that could confirm or disconfirm positive life change. A recent exploration of responses to terrorism indicated that the report of PTG was associated with "greater psychological distress, more right wing political attitudes, and support for retaliatory violence" (Hobfoll et al., 2006). Clinically, this would indicate that when a person reports experiencing growth after being bullied, even when perceived as positive, it might imply poorer overall adjustment to the traumatic event. Finally, as many years would have passed since the bullying, this finding for PTG also argues against the theoretical proposition that PTG may not be related to adjustment at first, but "gels" to have a positive impact over time (Calhoun & Tedeschi, 2006).

There are additional attributes of this sample that might increase the explanatory power of negative cognitive coping. First, this is a sample exclusively comprised of

younger men. There is some indication that young adults perceive traumatic events as more threatening than older adults. For example, Stanton and colleagues (2006) found a trend for younger persons to demonstrate more concurrent PTSD symptoms associated with the perception of benefits. Additionally, this sample is primarily Caucasian. Helgeson et al.'s (2006) recent meta-analysis found that the co-occurrence of psychological distress and PTG was more common among European American samples, whereas in African American samples PTG was related to positive outcomes.

Minority stress. In describing minority stress, Meyer (1995, p. 38) wrote, "This concept is based on the premise that gay people, like members of other minority groups, are subjected to chronic stress related to their stigmatization." Meyer (2003) proposed three specific factors that contribute to minority stress among LGB individuals: (a) objective, external stressors, such as being fired from a job or being physically assaulted due to sexual orientation, (b) beliefs that such events could occur and subsequent vigilance, and (c) the internalization of anti-gay societal attitudes. Specifically, it is proposed that each of these sources of minority stress contributes unique, non-interacting amounts of variance among psychopathological symptoms. This was supported by the data in this study, and each source of minority stress and the added component of cognitive coping contributed significantly to the variance accounted for with this model.

Cognitive coping fits well with the framework of minority stress. As noted by Meyer (1995), minority stress theory is an amalgam of sociological, social psychological, and psychological theory; that being said, the primary predictors in the model are interpersonal, in that even stigma and self-stigma are operationalized as social processes.

Cognitive coping, such as the cognitive appraisal model introduced above, adds a unique contribution to this model when predicting the impact of traumatic prejudice events, in that it proposes one possible path by which these social stressors act upon the individual. It may be that the relatively uncontrollable experience of victimization from prejudicial acts increases the likelihood of maladaptive meaning-making, although attempts to empirically explore whether some stressors are more likely than others to lead to maladaptive, positive reappraisal is currently inconclusive (Helgeson et al., 2006). The inference of perceived benefits may be one cognitive route of avoiding recognizing the harmful repercussions of victimization.

It is of note that religious affiliation contributes so significantly to the level of PTSD symptoms experienced. Those participants that self-identified as Christian reported fewer symptoms of trauma ($M = 5.7$, $SD = 8.9$, compared with those who self-identified with other religious affiliations $M = 11.4$, $SD = 11.9$). The literature concerning young gay males and religious affiliation is complex, however. Schuck and Liddle (2001) found that two-thirds of their community sample of gay men and lesbians perceived a conflict between their familial religion and their sexual orientation, which was resolved primarily through identifying as spiritual or agnostic. This may also be related to negative cognitive coping, however. Calhoun et al. (2000) observed a relationship between an increased perception of PTG following a traumatic experience, and an increase in openness to religious experiences. Re-identification as "agnostic" or "spiritual" may reflect that occurrence within this study.

Limitations and Strengths of the Current Study

The study had several limitations. First, data were cross-sectional, thus causality could not be inferred. Second, the report of bullying was retrospective. Despite past studies reporting good reliability of retrospective accounts of bullying when age constraints are applied, as done in the current study, there is no objective or corollary data to confirm participant report. There is also the possibility that current beliefs about bullying and prejudice might impact the report of past bullying. The analyses above, however, suggest that there is no relationship between reported bullying and internalized homophobia in either direction. Additionally, report of the presence or absence of harassment as an adult, though rare, was unrelated to either predictor or dependent variables, consistent with minority stress theory. Findings related to PTG tend to show a relationship between PTG and higher distress in cross-sectional studies, although this is certainly not conclusive as some longitudinal studies also find evidence that it is a negative cognitive coping strategy (e.g., Best, Streisand, Catania, & Kazak, 2001).

Third, the data are self-reported, thus subject to a number of biases that may unpredictably affect results. Further, the face-to-face interviews may have contributed to measurement error. Although every effort was made to stress that there was no desired style of response, there were no internal measures of social desirability, and participants may have represented themselves to better reflect self-presentation goals, or to fit what they believed to be the desired response set. For example, some participants seemed to perceive the invitation to interview as an initiation of a romantic interlude, and as a result, some made sexual innuendoes. This perception may have led to greater motivation to

give "correct" responses. However, Cronbach's alpha was examined for each scale, and there were some redundant items across the PSS and CESD-10, which suggest that, in the least, participants were able to respond in a consistent manner, increasing the reliability of measures.

Fourth, it is unclear how results would vary in other samples, including more other ethnic groups, more urban men, or more rural men (e.g., Cody & Welch, 1997). An inherent difficulty in researching any stigmatizing population lies in reaching participants with greater levels of self-stigma or fear of prejudice that may shy away from the overt self-identification as gay that participation in a study would require. In fact, two participants reported that they were not yet "out" at the time of their participation. The present study also limited participation to adults, and two-thirds of men were 21 to 23 years old. It would be interesting to see if the same pattern of results emerged in samples where participants were still in high school. Minority stress theory would suggest that the results should be the same (Meyer, 2003). Thus, bullying should not predict internalized homophobia, but both should predict current distress. Also, the sample was relatively racially homogenous. The intersection of race-related self-stigma and internalized homophobia is not empirically well understood. However, minority stress theory posits that membership in a minority race and sexuality both have a strong impact on psychological distress due to minority stress, such that some prejudice events (i.e., bullying or discrimination) due to either minority status would contribute separately to distress, as would self-stigma related to either status. Because development of an ethnic minority identity appears to occur independent of other types of identity (e.g., sexual;

Greene, 1994), it could be hypothesized that the degree of internalized stigma would also vary across each identity. There is also some evidence that non-white persons are less likely to use the negative cognitive coping strategies observed here, which are related to illusory positive reappraisal and avoidance (Helgeson et al., 2006). Thus, a more diverse sample would likely alter many of the relationships observed in this study.

Finally, snowball sampling was attempted as a means of remedying this difficulty of demographically homogenous participants. Snowball sampling offers the potential to reach difficult-to-recruit participants that could not be contacted through convenience samples, but in this particular sample second wave participants were entirely comprised of individuals that had been approached at community sites first, then encouraged by friends to participate. Snowball recruitment was not fully successful in reaching difficult-to-reach participants, which could be due to a variety of causes (e.g., the small size of the local gay communities, and competing studies targeting an overlapping demographic offering significant financial remuneration). Furthermore, this sampling method has primarily been used in studies outside the United States, and with remuneration as an added incentive.

The study also had multiple strengths. Although snowball sampling was not successful in reaching men outside of primary recruitment sites, it may have increased participation within those sites. Many participants also reported a curiosity in the topic, which may have facilitated the encouragement they subsequently gave their friends to participate.

Second, the present study also tests a more complex design than those proposed in earlier studies of gay-related bullying (e.g., Hershberger & D'Augelli, 1995). Despite the aforementioned fit of the data with minority stress models, previous research has not examined the possibility that pre-adult experiences with prejudice might contribute to internalized homophobia. Additionally, minority stress theory suggests that self-stigma develops separately from prejudicial events (Meyer, 2003). Therefore, it is likely that the patterns of internalized homophobia and bullying that emerged in this study were reflections of their independent origins predicted by minority stress theory.

Third, this study relied exclusively upon interview data. Past research in this community indicates over 30% of survey data was corrupted due to incompletion, misunderstood directions, idiographic response styles (e.g., narrative data instead of response on Likert scales), and incomplete survey packets (Skinta, 2004). As noted above, all correctly administered interview data were able to be used, and the excluded protocol was removed based upon interviewer error. The interview format allowed for immediate feedback regarding participant confusion, compliance with the required response format, and completion of the entire interview. Additionally, many participants reported that they enjoyed the opportunity to share their story with someone who would listen. Some stated that they had never been able to talk fully about their bullying experiences, or that they were uncertain how to obtain referrals for psychological resources prior to contact with the interviewer.

Fourth, this current study pushes the lower limit of available information regarding the experiences of gay boys in adolescence. There are multiple methodological

flaws inherent in conducting cross-sectional research during adolescence with gay-identified youth, not the least of which is the fact that many youth do not publicly identify as gay until after graduation from high school (Savin-Williams, 2001). In fact, extensive qualitative data from Savin-Williams's (2005) *The New Gay Teenager* suggests that many young men who eschew self-identifying their sexuality during high school adopt a label as gay very quickly following graduation from high school. For these reasons, young men that have recently graduated from high school may better represent gay-identified men than a cross-section of younger men.

Finally, the important role of PTG as a partial mediator of the relationship between bullying severity and psychopathological distress symptoms contributes to the ongoing empirical debates over the meaning and utility of PTG. Specifically, this finding argues for conceptualizing PTG as an ongoing style of cognitive coping, not merely an outcome. Future research should explore these relationships more closely.

Clinical Implications of the Results

Results from this study have several clinical implications for gay men with histories of bullying and negative cognitions about being gay. Of primary note is the direct effect that bullying has on psychopathology outcomes, implying that school initiatives to reduce bullying (e.g., Smith, Pepler, & Rigby, 2004) will grant some benefit to gay students, regardless of other sources of distress. Additionally, the best interventions to reduce bullying are system-wide, and target not only teacher responses to bullying, but the reactions of other students (Smith et al.). Specifically, these interventions target the audience of students that typically aggregate around fights and

incidents of bullying. This change in the response of the student body to bullying may create a climate less supportive of stigmatizing cognitions, although there is no research in that area to date.

Another implication is that internalized homophobia likely requires a separate clinical response than simply a focus on bullying. Because these beliefs are likely internalized very early in life, school based intervention may be of limited efficacy, particularly if it does not begin until adolescence. Although there have been many proposed models of "affirmative" therapy for gay students (Ritter & Terndrup, 2002), there is a paucity of empirical data to support the efficacy of these approaches. Clinical trials that monitor sexual orientation have historically focused on establishing the generalizability of manualized treatments to gay and lesbian populations, but have not focused on changes in internalized homophobia (Martell, Safren, & Prince, 2003). Minority stress research indicates that it would be valuable to develop and empirically validate interventions specific to the treatment of self-stigma.

Interventions that target internalized homophobia might take many forms. Cognitive therapy suggests numerous techniques to challenge and change illogical or undesired cognitions (Beck, Rush, Shaw, & Emery, 1979). Moreover, third wave cognitive-behavioral therapies, such as mindfulness, acceptance and commitment therapy, or dialectical-behavioral therapy, teach skills that reduce reactivity and commitment to unwanted thoughts (Hayes, Follette, & Linehan, 2004). Experiential avoidance reflects an unwillingness to accept unpleasant thoughts and experiences and is specifically targeted by those third-wave cognitive-behavioral therapies. Although the

literature is incomplete, it may indicate one productive avenue for the development of interventions for self-stigma.

Further, minority stress theory implicates the value of separately assessing internalized homophobia and bullying events when conceptualizing interventions for gay youth. Specifically, the finding that there was no interaction effect between bullying and internalized homophobia suggests that the absence of prejudicial experiences does not indicate a lack of internalized homophobia. Likewise, the inverse would be true: The absence of internalized homophobia does not indicate a lack of prejudicial experiences, such as bullying, in a gay man's past. Assessing these domains separately will allow for more targeted and effective interventions. A similar warning could be made regarding the report of a supportive parental environment. Parental support did not correlate with the psychopathology outcomes, nor did it correlate significantly with bullying or internalized homophobia. The report of a supportive home environment should not preclude the assessment of prejudicial experiences or internalized homophobia in gay men.

Finally, this study demonstrates that, to some extent, self-reported PTG related to prejudice events may be related to a poor adjustment to PTSD symptoms among young, gay men. It is still unclear from the research whether different types of stressors are more likely to cause "true" growth or merely self-perceived growth (Zoellner & Maercker, 2006), or whether an initial appraisal of growth is a precursor to true growth (Helgeson et al., 2006). Additionally, however, there are increasing findings that PTG may be associated in many instances with avoidant coping styles and illusory, positive

reappraisal (Helgeson et al.). This misuse of PTG can be targeted and explored in a psychotherapeutic setting. Ultimately, the promotion of growth following prejudicial events should be interpreted with caution. Furthermore, the ethics of increasing PTG in survivors of trauma, at least as it is currently conceptualized (Calhoun & Tedeschi, 1999), needs to be examined; Zoellner and Maercker's (2006) Janus-face models would imply that there is a healthy side of PTG, and the possibility exists that therapists could encourage this process. This possibility merits extensive future research.

Implications for Future Research

This study highlights many areas where further research is needed. Replication with a larger sample size could bolster the findings summarized here. This would especially allow for path analysis along the lines of several of the paths noted in this study. Further, the hypothesis that minority stress begins to effect gay boys while in high school may be better tested by collecting data among boys that are still in high school, which would eliminate the possibility that these findings are an artifact of inaccurate retrospection. As noted above, this would carry the limitation that high school boys that are out may be unrepresentative of all gay boys.

In addition, greater research on the intersection of ethnicity and sexual orientation is needed among gay teens of color. Though limited in size, the gay African American men interviewed in this study often provided feedback that they were teased primarily for "acting white," and reported fewer instances of sexuality-specific teasing. Similar feedback was given by men that self-reported being overweight or obese during childhood. These boys indicated that teasing over "being fat" was much more typical of

their experiences. It is obvious that substantially more qualitative research is needed in this area to better guide the direction of future quantitative analyses. Also, the incorporation of parent measures is uncommon across research on the effects of bullying (e.g., Bond et al., 2001; Smith et al., 2004). This would be of particular interest in exploring the complexities of the parental relationship for gay men.

Finally, more basic research is needed on the development and internalization of anti-gay stigma in children. It is difficult to infer from the current literature when or how self-stigmatizing beliefs are established. There have been no longitudinal studies, for example, examining the establishment of bias toward homosexuals among children in general. Some qualitative analyses indicate that children may begin to recognize stereotypes related to homosexuality by middle childhood (Cossman, 2004; Renold, 2006). Both studies cited (i.e., Cossman, 2004; Renold, 2006), however, infer these biases indirectly: Cossman (2004) noted children's bias toward men with HIV/AIDS and its relationship with parental homophobia, and Renold (2006) observed hetero-centric discourse in childhood play. These phenomena warrant further investigation.

Conclusions

Taken as a whole, results suggest that prejudice in the form of bullying acts as an important stressor, but not through any contribution to internalized homophobia. Rather, the internalization of anti-homosexual attitudes and experiences with bullying are separate sources of distress with which young gay men must contend. Moreover, the current study provides evidence for theory and research suggesting that minority stress due to societal stigma and prejudice events impacts the functioning of gay men. These

findings suggest that the source of self-stigma among gay men has more complex origins than youthful prejudicial events or lack of parental support. This study also provides evidence that minority stress models might be improved through the assessment of cognitive coping strategies. The findings regarding PTG demonstrated that it played an important role in the relationship between bullying severity and psychopathological outcomes. Specifically, an understanding of intrapersonal factors predictive of later symptom severity, such as negative cognitive coping, may clarify the intersection of minority stress at the group level, and psychological distress at the individual level.

These findings contribute to a growing body of literature on minority stress. In particular, when individuals experienced either severe bullying or increased internalized homophobia, PTSD symptoms such as hypervigilance or somatic arousal were elevated. These variables each contributed independently, suggesting that when high levels of internalized homophobia and bullying co-occurred, PTSD symptoms were more likely to occur. Cognitive coping strategies that involve a reappraisal of traumatic events as positive were also related to ongoing PTSD symptoms. Findings underscore the importance of examining social sources of stigmatizing beliefs separate from prejudicial events as they occur, in part, in isolation from one another.

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APPENDIX A

CONSENT FORM

[Kent State University Psychology Department Letterhead]

Log #

Consent Form

I want to do research on the experiences gay men have had with bullying, as well as attitudes gay men have about themselves and the gay community. I will be looking at how that relates to social support and psychological health. I want to do this because it would benefit the gay community and community health workers if there were a better understanding of what contributes to the positive or negative well-being of gay men. If you decide to participate in this study, you will be asked to sit with an interviewer for an interview that will take approximately thirty minutes to complete.

Because of the sensitive nature of these questions you may experience some discomfort. However, please keep in mind that all of your responses will be totally anonymous. You will not be asked for your name or any identifying information, and so your answers will not be connected to you in any way. Should you experience any distress, please contact me at (330) 931-2754, or my advisor, Dr. Stevan Hobfoll, at (330) 672-2137. If you wish to talk to someone in more depth about issues that participating in this study may have raised for you, you can contact the Psychological Clinic at (330) 672-2372 or University Psychological Services at (330) 672-2487. In the Akron community, resources and support groups can be found at the Pride Center, (330) 253-2220, or inquire at (330) 375-2000 for the Men in Touch group.

Taking part in this project will benefit the community, and hopefully, thinking about these issues will benefit you, as well. Participation in this project is entirely up to you, and no one will hold it against you if you decide not to do it. If you do take part, you may stop at any time.

If you want to know more about this research project, please call Matthew Skinta at (330) 931-2754, or Dr. Stevan Hobfoll at (330) 672-2137. This project has been approved by Kent State University. If you have questions about Kent State University's rules for research, please call Dr. John L. West, Vice President and Dean, Division of Research and Graduate Studies, (330) 672-2704.

Keep a copy of this form for your records.

Sincerely,

_____
Matthew Skinta , M.A.
Project Director

_____
Stevan Hobfoll, Ph.D.
Distinguished Professor
Advisor

APPENDIX B

MEASURES

Section A : Demographics

How old are you?

What is the highest grade in school you completed?

What do you consider your ethnic background?
White
Black/African American
Hispanic
Asian
Native American
Other _____

Are you employed?
Yes No
Secretary/clerical
Food Service
Manufacturing
Sales
Professional (nurse, lawyer)
Other _____

With whom do you currently live?
Boyfriend/partner
Relatives
Parents
Friends
Alone

Are you currently in a relationship?
Yes No

What is your religion?
Protestant (including Baptist)
Jewish
Moslem
Catholic
Pagan/Wiccan
Other _____

Do you consider yourself to be religious?
Yes No

Do you regularly attend a place of worship?
Yes No

What is the estimated yearly income of your household?
Less than $10,000
$10,001 to $15,000
$15,001 to $25,000
$25,001 and up

Are you a college student? Yes No
At what age did you know you were gay? ____
At what age did you 'come out'? ____

Section B : Bullying

Were you ever bullied for being different when you were younger?
Yes No

Was this because you were gay, or perceived as gay?
Yes No Uncertain

How old were you when the bullying started?

Did bullying occur …
- At home?
- At school?
- In neighborhood?
- Other setting _____

Was the setting the same for gay-related bullying and other bullying? _____

Was this a one time incident, or did this last for days/weeks/months? ____
- If so, how long did the bullying continue? ____

Can you tell me how you were bullied?
- I was called names
- I was teased
- I was hit or kicked
- I became frightened when a particular person looked in my direction
- No one would speak to me
- Rumors were spread about me
- I was ridiculed in front of others
- I was sexually assaulted
- They took my belongings
- Other

(*If called names*) Were the names you were called related to being perceived as gay? ____

Did the name-calling occur …
- At home?
- In the corridors?
- In the classroom?
- In the school playground?
- In the changing rooms?
- On the way home?
- Other _____

Was anyone else present, or were you alone with the bully? _____
- If others were present, who were they? _____

Was this a once time incident, or did it last for days/weeks/months? ____
- only once or twice

sometimes
maybe once a week
several times a week

(*If more than once*) Was this always for the same reason? _____

Were you ever beaten up so badly that you required medical attention? _____
If so, how severe was it? _____

Were you ever forced to perform humiliating acts? _____

Did any bullies ever attempt to take sexual advantage of you? _____

If bullying was occurring in school :

In which year was the person or group of people who bullied you?
mainly in my year
mainly in the year above me
mainly several years above me
mainly in the year below me

How many pupils bullied you?
mainly one young man bullied me
several young men bullied me
mainly one young woman bullied me
several young women bullied me
both young men and young women bullied me

Did you tell your teacher(s) that you were being bullied at school?
No, I didn't tell them
I tried to tell them
Yes, I did tell them

Did you tell your teacher(s) why you were being bullied?
I didn't tell them I was being bullied
No, I didn't tell them why
Yes, I did tell them why

What happened when you told your teacher(s) about being bullied?
I didn't tell them I was being bullied
Nothing happened
The bullying stopped

Did you tell someone at home that you were being bullied at school?
I didn't tell someone at home
I tried to tell someone at home
Yes, I did tell someone at home

Did you tell someone at home why you were being bullied?
No, I didn't tell them I was being bullied
No, I didn't tell them why
Yes, I did tell them why

What happened when you told someone at home about being bullied?
I didn't tell them I was being bullied
nothing happened
the bullying stopped

Section C : Resolution of Bullying

Did anyone come to your aid, like friends or siblings?
Yes No

If so, who?

Could you go to anyone that would stop others from bullying you, like a parent or teacher?
Yes No

If so, whom? _____

When did the bullying end? _____

Why did it end? _____

Do you consider this a positive or negative outcome? _____

Section D : Adult victimization

Since you turned 18, have you had any experiences of harassment, or been the target of violence? _____

Was this because you were gay?

Yes No Uncertain

If harassed...

Where were you harassed?
At home
At work
In neighborhood
Other setting _____

Was the setting the same for gay-related harassment and other harassment? _____

Was this a one-time incident, or did it occur over days/weeks/months? _____

Can you tell me how you were harassed?
I was called names
I was teased
I was hit or kicked
I became frightened when a particular person looked in my direction

No one would speak to me
Rumors were spread about me
I was ridiculed in front of others
They took my belongings
Other

(*If called names*) Were the names you were called related to being perceived as gay? _____

If physically assaulted...

Where were you assaulted?
At home
At work
In neighborhood
Other setting _____

Were you assaulted by a stranger, or someone you knew? _____
If so, who? _____

Was the assault sexual in nature? _____

Were you injured seriously enough to warrant medical attention? _____
If so, please describe the nature of your injuries _____

Was this a one-time incident, or did this occur over days/weeks/months? _____

Section E : Resolution of Assault

Did anyone come to your aid, like a friend or stranger?
Yes No

If so, who? _____

How did the encounter end? _____

Do you consider this a positive or negative outcome? _____

Section F: Self-Efficacy

With the following statements, I'd like you to rate yourself, on a scale of 1 to 5, on how well you feel able to handle a number of situations related to your experiences with violence or harassment.

1. How well did you feel able to cope with violence/harassment directed at you from others?.

1 --- 2 --- 3 --- 4 --- 5

2. How well did you feel you could enlist the aid of adults when necessary to protect yourself?

1 --- 2 --- 3 --- 4 --- 5

3. How well did you feel you were able to avoid situations in which bullying/harassment were likely to occur?

1 --- 2 --- 3 --- 4 --- 5

4. How well did you feel you were able to personally protect yourself from others?

1 --- 2 --- 3 --- 4 --- 5

5. How well did you feel you were able to discourage bullies/perpetrators from bothering you in the future?

1 --- 2 --- 3 --- 4 --- 5

Section G : Internalized Homophobia

Next, I'd like to ask you to rank a number of attitude statements that are personal and intimate in nature. These statements pertain to sexual behavior and sexuality. Specifically, the statements fall into categories: (1) attitudes toward the fact of one's own sexuality, (2) attitudes toward homosexual men and homosexuality in general, and (3) attitudes toward other people's knowing of your own sexual orientation.

No two statements are exactly alike, so consider each statement carefully before responding. We would like you to use these statements in order to describe your own beliefs and attitudes. That is, we would like you to indicate, on a scale from "strongly disagree" to "strongly agree," how much you personally endorse each statement.

Example: SD D N A SA 1. Gay men should not be allowed to teach in elementary schools.

SD if you *strongly disagree* with this statement.

D if you *disagree* with this statement.

N if you are *neutral* in regard to this statement.

A if you *agree* with this statement.

SA if you *strongly agree* with this statement.

Some statements may depict situations that you have not experienced; please imagine yourself in those situations when answering those statementsAppendix b body.

1. When I am in a conversation with a gay man and he touches me, it does not make me uncomfortable.
2. Whenever I think a lot about being gay, I feel depressed.

3. I am glad to be gay.
4. When I am sexually attracted to another gay man, I feel uncomfortable.
5. I am proud to be a part of the gay community.
6. My homosexuality does not make me unhappy.
7. Whenever I think a lot about being gay, I feel critical about myself.
8. I wish I were heterosexual.
9. I have been in counseling because I wanted to stop having sexual feelings for other men.
10. I have tried killing myself because I couldn't accept my homosexuality.
11. There have been times when I've felt so rotten about being gay that I wanted to be dead.
12. I have tried killing myself because it seemed that my life as a gay person was too miserable to bear.
13. I find it important that I read gay books or newspapers.
14. It's important to me to feel part of the gay community.
15. Homosexuality is not as satisfying as heterosexuality.
16. Marriage between gay people should be legalized.
17. Homosexuality is a natural expression of sexuality in humans.
18. Gay men do not dislike women any more than heterosexual men dislike women.
19. Gay men are overly promiscuous.
22. Most problems that gay persons have come from their status as an oppressed minority, not from their homosexuality per se.
20. Gay persons' lives are not as fulfilling as heterosexuals' lives.
23. Children should be taught that being gay is a normal and healthy way for people to be.
24. Homosexuality is a sexual perversion.
25. I wouldn't mind if my boss knew that I was gay.
26. When I tell my *nongay* friends about my homosexuality, I do not worry that they will try to remember things about me that would make me appear to fit the stereotype of a homosexual.
27. When I am sexually attracted to another gay man, I do not mind if someone else knows how I feel.
28. When women know of my homosexuality, I am afraid they will not relate to me as a man.
29. I would not mind if my neighbors knew that I am gay.
30. It is important for me to conceal the fact that I am gay from most people.
31. If my straight friends knew of my homosexuality, I would be uncomfortable.
32. If men knew of my homosexuality, I'm afraid they would begin to avoid me.
33. If it were made public that I am gay, I would be extremely unhappy.
34. If my peers knew of my homosexuality, I am afraid that many would not want to be friends with me.
35. If others knew of my homosexuality, I wouldn't worry particularly that they would think of me as effeminate.

36. When I think about coming out to peers, I am afraid they will pay more attention to my body movements and voice inflections.
37. I am afraid that people will harass me if I come out more publically.

Section H : Quality of Support Inventory

Please answer the following questions regarding your relationship with your parents during your high school years? On a scale of 1 to 4, where 1 is "Not at all," 2 is "A little," 3 is "Quite a bit," and 4 is "Very Much" :

1. To what extent could you turn to your parents for advice about problems?
2. How often did you need to work hard to avoid conflict with your parents?
3. To what extent could you count on your parents for help with a problem?
4. How upset did your parents sometimes make you feel?
5. To what extent could you count on your parents to give you honest feedback, even if you did not want to hear it?
6. How much did your parents make you feel guilty?
7. How much did you have to "give in" in this relationship?
8. To what extent could you count on your parents to help you if a family member very close to you died?
9. How much did your parents want you to change?
10. How positive a role did your parents play in your life?
11. How significant was this relationship in your life?
12. How close will your relationship be with your parents in 10 years?
13. How much would you miss your parents if you could not see or talk with each other for a month?
14. How critical of you were your parents?
15. To what extent could you count on your parents to listen to you when you are angry at someone else?
16. How responsible did you feel for your parents' well-being?
17. How much did you depend on your parents?
18. To what extend could you count on your parents to listen to you when you were very angry at someone else?
19. How much would you like your parents to change?
20. How angry did your parents make you feel?
21. How much did you argue with your parents?

22. To what extent could you really count on your parents to distract you from your worries when you feel under stress?
23. How often did your parents make you feel angry?
24. How often did your parents try to control or influence your life?
25. How much more did you give than you get from this relationship?

Section I : PTSD symptoms - Lifetime

Directions: Have you ever had a period during your life where you felt very troubled or upset because of abuse or assault that you've experienced? Yes No

Please respond with the choice that best describes the **WORST** such time in your life when you were having the following thoughts and feelings (1 = rarely or none of these; 2 = some or little of the time; 3 = occasionally or a moderate amount of time; 4 = most or all of the time). Think specifically about the period of time in which you were bullied:

1. Did you have upsetting thoughts or images about being bullied or assaulted that came into your head when you didn't want them to
2. Did you have bad dreams or nightmares about being bullied or assaulted
3. Did you relive the bullying or assault, acting or feeling as if it were happening again
4. Did you feel very emotionally upset when you were reminded of being bullied or assaulted. For example, feeling scared, angry, sad, or guilty
5. Did you experience physical reactions when you were reminded of being bullied or assaulted. For example, breaking out in a sweat or your heart beating fast
6. Did you try not to think about, talk about, or have feelings about being bullied or assaulted
7. Did you try to avoid activities, people, or places that remind you of being bullied or assaulted
8. Were you unable to remember an important part of the bullying or assault
9. Did you have much less interest or participating much less often in important activities
10. Did you feel distant or cut off from people around you
11. Did you feel emotionally numb. For example, being unable to cry or unable to have loving feelings
12. Did you feel as if future plans or hopes will not come true. For example, you will not have a career, find a partner, have children or a long life
13. Did you have trouble falling or staying asleep
14. Did you feel irritable or have fits of anger
15. Did you have trouble concentrating? For example, drifting in and out of conversations, losing track of a story on television, or forgetting what you've read

16. Were you overalert. For example, checking to see who is around you or being uncomfortable with your back to a door
17. Were you jumpy or easily startled? For example, when someone walks up behind you.

Did any of these symptoms impair your day-to-day functioning? Y / N

Section J : PTSD symptoms - Current

Are you currently experiencing any of these symptoms? Yes / No

Please respond with the choice that best describes following thoughts and feelings you've had in the **LAST TWO WEEKS** (1 = rarely or none of these; 2 = some or little of the time; 3 = occasionally or a moderate amount of time; 4 = most or all of the time)**:**

18. Did you have upsetting thoughts or images about being bullied or assaulted that came into your head when you didn't want them to
19. Did you have bad dreams or nightmares about being bullied or assaulted
20. Did you relive the bullying or assault, acting or feeling as if it were happening again
21. Did you feel very emotionally upset when you were reminded of being bullied or assaulted. For example, feeling scared, angry, sad, or guilty
22. Did you experience physical reactions when you were reminded of being bullied or assaulted. For example, breaking out in a sweat or your heart beating fast
23. Did you try not to think about, talk about, or have feelings about being bullied or assaulted
24. Did you try to avoid activities, people, or places that remind you of being bullied or assaulted
25. Were you unable to remember an important part of the bullying or assault
26. Did you have much less interest or participating much less often in important activities
27. Did you feel distant or cut off from people around you
28. Did you feel emotionally numb. For example, being unable to cry or unable to have loving feelings
29. Did you feel as if future plans or hopes will not come true. For example, you will not have a career, find a partner, have children or a long life
30. Did you have trouble falling or staying asleep
31. Did you feel irritable or have fits of anger
32. Did you have trouble concentrating? For example, drifting in and out of conversations, losing track of a story on television, or forgetting what you've read
33. Were you overalert. For example, checking to see who is around you or being uncomfortable with your back to a door
34. Were you jumpy or easily startled? For example, when someone walks up behind you.
35. Do any of these symptoms impair your day-to-day functioning? Y/N

Section K:

Directions: Below is a list of ways you might have felt or behaved.

Please tell me how often you have felt this way during the PAST WEEK

(1 = rarely or none of these; 2 = some or little of the time; 3 = occasionally or a moderate amount of time; 4 = most or all of the time):

1. I was bothered by things that usually don't bother me
2. I had trouble keeping my mind on what I was doing
3. I felt depressed
4. I felt that everything I did was an effort
5. I felt hopeful about the future
6. I felt fearful
7. My sleep was restless
8. I was happy
9. I felt lonely
10. I could not get "going"

Section L:

Directions: Below is a list of ways you might have felt or behaved during high school, while bullied.

Please tell me how often you have felt this way during the WORST WEEK (1 = rarely or none of these; 2 = some or little of the time; 3 = occasionally or a moderate amount of time; 4 = most or all of the time):

11. I was bothered by things that usually don't bother me
12. I had trouble keeping my mind on what I was doing
13. I felt depressed
14. I felt that everything I did was an effort
15. I felt hopeful about the future
16. I felt fearful
17. My sleep was restless
18. I was happy
19. I felt lonely
20. I could not get "going"

Section M: Traumatic Growth

Next, I'd like to ask you to rank a number of attitude statements that relate to changes that occurred in your life as a result of this bullying or harassment. For this section:

1 = I did not experience this change as a result of the events

2 = I experienced this change to a *very small degree* as a result of my crisis

3 = I experienced this change to a *small degree* as a result of my crisis

4 = I experienced this change to a *moderate degree* as a result of my crisis

5 = I experienced this change to a *great degree* as a result of my crisis

6 = I experienced this change to a *very great degree* as a result of my crisis

1. My priorities about what is important in life

   1 --- 2 --- 3 --- 4 --- 5 --- 6 ---

2. An appreciation for the value of my own life.

   1 --- 2 --- 3 --- 4 --- 5 --- 6 ---

3. A feeling of self reliance.

   1 --- 2 --- 3 --- 4 --- 5 --- 6 ---

4. Knowing that I can count on people in times of trouble.

   1 --- 2 --- 3 --- 4 --- 5 --- 6 ---

5. A sense of closeness with others.

   1 --- 2 --- 3 --- 4 --- 5 --- 6 ---

6. Knowing that I can handle difficulties.

   1 --- 2 --- 3 --- 4 --- 5 --- 6 ---

7. Being able to accept the way things worked out.

   1 --- 2 --- 3 --- 4 --- 5 --- 6 ---

8. Appreciating each day.

   1 --- 2 --- 3 --- 4 --- 5 --- 6 ---

9. I discovered that I’m stronger than I thought I was.

   1 --- 2 --- 3 --- 4 --- 5 --- 6 ---

10. I learned a great deal about how wonderful people are.

1 --- 2 --- 3 --- 4 --- 5 --- 6 ---

APPENDIX C

DEBRIEFING BROCHURE

BROCHURE FORMAT

[COVER]

Bullying Project
Kent State University
2006

[FIRST FOLD]

Did you know:

- Up to 59% of gay men report being bullied in high school

Studies around the country show that gay boys might be picked on or bullied at nearly double the rate of heterosexual boys. This happens in spite of many gay boys being in the closet, or working hard to appear heterosexual.

- Bullying leads to long term risks for emotional and psychological distress

When the world appears to be a dangerous place, it's hard to relax and deal with even daily stress. Some studies have shown that being a victim of violence can lead to long term difficulties, and that in gay men this can be magnified by discrimination that occurs in the workplace or socially. When anti-gay policies are debated in the news or the classroom, this can also increase the risk of feeling down, or worried.

- Young gay men often lack family support to buffer the impact of bullying

Many gay boys do not feel that they can count on their parents for support. Even into adulthood, many young men worry that their family might reject them. This creates an added burden for young gay men, compared with their heterosexual peers that are able to use their parents for support.

- This research could help us better understand how bullying harms young gay men!

You might realize, looking at the different factors mentioned already, that there are many issues that face gay men. One goal of this study is to look at how these different factors relate, either to magnify or reduce the impact that bullying has later in life.

[SECOND FOLD]

It can be difficult to discuss experiences with violence or discrimination that may occur because of sexual orientation. Taking part in this study might have made you curious to further explore how your experiences with anti-gay attitudes or bullying have impacted you. For further reading, you might try one of the following:

The Gay and Lesbian Self-Esteem Book: A Guide to Loving Ourselves, by Kimeron N. Hardin

Loving Someone Gay, by Don Clark

Growth and Intimacy for Gay Men, by Christopher J. Alexander

Outing Yourself: How to come out as lesbian or gay to your family, friends, and coworkers, by Michelangelo Signorile

Already out and looking for places to get involved in the community? Contact these organizations for more information:

Kent

Pride!Kent
OCL 17, Student Center
Kent State University
330-672-2068

Cleveland

Gay, Lesbian and Straight Association, GLASA
Cleveland State University
2121 N. Euclid, UC 9
csu_glbtq@yahoo.com

[THIRD FOLD]

The success of this study depends on *you*, the participant!

If you have any gay male friends, between the ages of 18 and 23, that would like to share their experiences with us, please provide them with the contact information on this brochure.

Thank you,
Matthew Skinta
e-mail: mskinta@kent.edu
phone: 330-931-2754

Please include "bullying" in the subject line, or mention the bullying project in telephone messages.

APPENDIX D

RESPONSES TO SELECTED QUESTIONS ABOUT BULLYING

Appendix D

*Responses to Selected Questions about Bullying (*N = *90)*

Question	%[a]	*M*	*SD*
	All participants		
Were you ever bullied for being different when you were younger?			
Yes	88.9		
No	11.1		
Have you experienced harassment or been the target of violence as an adult?			
Yes	32.2		
No	67.8		
	Participants who were bullied		
[Were you bullied] because you were gay, or perceived as gay?			
Yes	71.3		
No	20.0		
Uncertain	8.8		
How old were you when the bullying started?		11.5	3.3
How old were you when the bullying ended?		16.8	2.1
Duration of bullying[b]		5.0	3.8
Did bullying occur primarily…			
At home?	5.0		
At school?	92.5		
In neighborhood?	2.5		
Other setting	0.0		
Was the setting the same for gay-related bullying and other bullying?			
Yes	85.0		
No	15.0		

Question	%[a]	*M*	*SD*
Was this a one time incident, or did this last for days/weeks/months?			
Days	5.0		
Weeks	8.8		
Months	86.3		
If so, how long did the bullying continue?			
1x	3.8		
Discrete interval	26.6		
Chronic (> 1 year)	69.6		
How were you bullied?			
Called names	96.3		
Teased	83.8		
Hit or kicked	31.3		
Given threatening looks	35.0		
No one would speak to me	31.3		
Rumors were spread	70.0		
Ridiculed in front of others	58.8		
Sexually assaulted	8.8		
Belongings stolen	27.5		
Other	21.3		
Did anyone ever come to your aid, like friends or a sibling?			
Yes	53.8		
No	46.3		
Could you go to anyone that would stop others from bullying you, like a parent or teacher?			
Yes	37.5		
No	62.5		

Question	%[a]	*M*	*SD*
Bullied participants who were called names			
Were the names you were called related to being perceived as gay?			
Yes	86.3		
No	13.8		
Did the name-calling occur…			
At home?	12.5		
In the corridors?	63.8		
In the classroom?	61.3		
In the school playground?	42.5		
In the changing rooms?	30.0		
On the way home?	42.5		
Other	10.0		
Was anyone else present?			
Yes	9.5		
No	90.5		
Was this a one time incident, or did this last for days/weeks/months?			
Days	8.3		
Weeks	0.0		
Months	91.7		
Was this always for the same reason?			
Yes	16.9		
No	83.1		
Were you ever beaten so badly you required medical attention?			
Yes	11.4		
No	88.6		
Were you ever forced to perform humiliating acts?			
Yes	16.3		
No	83.8		
Did any bullies ever attempt to take sexual advantage of you?			
Yes	8.8		
No	91.3		

Question	%[a]	*M*	*SD*
Bullied participants who were bullied at school			
In which year was the person or group of people who bullied you?			
Mainly in my year	65.8		
Mainly in the year above me	17.7		
Mainly several years above me	8.9		
Mainly in the year below me	7.6		
How many pupils bulled you?			
Mainly one young man bullied me	19.0		
Several young men bullied me	58.2		
Mainly one young woman bullied me	1.3		
Several young women bullied me	1.3		
Both young men and young women bullied me	20.3		
Did you tell your teacher(s) that you were being bullied at school?			
No, I didn't tell them	62.0		
I tried to tell them	7.6		
Yes, I did tell them	30.4		
What happened when you told your teacher(s) about being bullied?			
I didn't tell them I was being bullied	62.0		
Nothing happened	34.2		
The bullying stopped	3.8		
Did you tell someone at home that you were being bullied at school?			
No, I didn't tell them	51.9		
I tried to tell them	6.3		
Yes, I did tell them	41.8		
Did you tell someone at home why you were being bullied?			
I didn't tell them I was being bullied	51.9		
No, I didn't tell them why	21.5		
Yes, I did tell them why	26.6		

Question	%[a]	*M*	*SD*
What happened when you told someone at home about being bullied?			
I didn't tell them I was being bullied	51.9		
Nothing happened	41.8		
The bullying stopped	6.3		

[a]Percentages may not total 100% due to rounding. [b]Duration of bullying was derived from the bullying start and end ages.