

# Recollections of Bullying at School and Their Long-Term Implications for Lesbians, Gay Men, and Bisexuals

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**Abstract:** This study explores the relationship between experiences of bullying at school, adult mental health status, and symptoms of posttraumatic stress among a sample of 119 UK residents who identified as lesbian, gay, or bisexual. Participants completed a series of questionnaires that focused upon school experiences, suicide ideation at school, sexual history, relationship status and negative affect, recent positive and negative life-events, internalized homophobia, and symptoms associated with posttraumatic stress. The results suggested that posttraumatic stress was a potential issue for 17% of participants who also scored significantly higher for depression, and reported having had more casual sexual partners than their peers. However, those who were found to exhibit symptoms of posttraumatic stress were also more accepting of their sexual orientation. A small number of participants used prescription or nonprescription drugs, or alcohol to help them cope with memories of bullying. It is suggested that posttraumatic stress may be a feature of the adult lives of men and women who experienced frequent and prolonged bullying at school as a result of their actual or perceived sexual orientation.

**Keywords:** Bullying, homophobia, lesbian, gay, bisexual, memories.

## Introduction

Nightmares and flashbacks are most readily associated with posttraumatic stress among survivors of natural disasters or extraordinary negative life events (Yule, 1991; Yule & Udwin, 1991). However, research conducted in the United States has shown that symptoms often associated with posttraumatic stress can also be found within school-age populations where young people have experienced the unexpected bereavement of a peer, often through suicide (Mauk & Rodgers, 1994).

In their review of research on postintervention support following an adolescent suicide at school, Mauk and Rodgers (1994) suggested that posttraumatic stress manifests itself among peer survivors in the form of risk-taking behaviors, sexual recklessness, feelings of shame and guilt, withdrawal or hypermania, intrusive thoughts and nightmares, depression, and eating disturbances. The authors made little distinction between victims and so-called "survivors" when considering adolescent suicide and posttrau-

matic stress (p. 118). As they pointed out, while a young person can take her/his life as a consequence of a traumatic experience or event, those who are left behind have to deal with the emotional consequences of such an action. This is a view shared by Figley (1985), who suggested that in order to recover, survivors of any form of trauma have to learn to "make peace" with their memories:

The process of recovering from traumatic events is the transformation from being a victim to being a survivor. Victims and survivors are similar in that they both experience a traumatic event. But while the victim has been immobilized and discouraged by the event, the survivor has overcome the traumatic memories and become mobile. The survivor draws on the experience of coping with a catastrophe as a source of strength, while the victim remains immobilized. What separates victims from survivors is a conception about life, an attitude about safety, joy, and mastery of being a human being. Being a survivor, then, is making peace with the memories of a catastrophe and its wake (p. 399).

While Figley's (1985) comments suggest that recovery is intrinsically linked to the ability of an individual take control of her/his life and move forward, for those who are victims of violence or harassment in the home, school, or place of employment, the ability to consign negative experiences to the past and move on is often not feasible due to the fact that they may be unable to extricate themselves from the abusive environment without losing their social networks and/or financial security (see Leymann & Gustafsson, 1996). Indeed, various researchers have noted the presence of features associated with posttraumatic stress among adult psychiatric patients who were sexually abused as children and who report having received little if any support in coming to terms with their experiences until much later (Craine et al., 1988; Famularo et al., 1989).

## Sexual Orientation Bullying and Mental Health

Many of the symptoms cited by Mauk and Rodgers (1994) have also been found in young lesbians, gay men, and bisexual men and women experiencing difficulties coming to terms with their sexual orientation. For example, feelings of self-loathing and worthlessness (often described as *internalized homophobia*) have been associated with difficulties in forming and maintaining lasting intimate relationships (Friedman, 1991; George & Behrendt, 1988), unsafe sexual practices (Shidlo, 1994), avoidant coping strategies with AIDS among HIV sero-positive gay men (Nicholson & Long, 1990), and ultimately, suicide (Pilkington & D'Augelli, 1995). Additionally, researchers have demonstrated that the combined effects of bullying or alienation by peers, and difficulties in accepting one's sexual orientation, are correlated with the onset of a number of mental health problems among lesbian, gay, and bisexual youth. Such problems have included violent behavior, alcoholism and substance abuse, eating disorders, and, again, suicidal ideation (see Buhrich & Loke, 1988; Gonsiorek, 1988; Hershberger & D'Augelli, 1995; Otis & Skinner, 1996; Rothblum, 1990; Remafedi et al., 1991; Remafedi et al., 1998; Pilkington & D'Augelli, 1995; Shaffer et al., 1995).

Among lesbian, gay, and bisexual youth, one relatively recent study conducted in the United States, found that the best predictor of mental health was self-acceptance (Hershberger & D'Augelli, 1995). In their study, Hershberger and D'Augelli found that 42% of their sample of 194 lesbian, gay, and bisexual youth had attempted suicide on at least one occasion as a result of being victimized or otherwise alienated by peers, family, or community members. In the UK, Warren (1984) found that 20% of the teenagers he surveyed had contemplated or attempted suicide because of their sexual orientation. Although Hershberger and D'Augelli (1995) were cautious about linking the number of attempted suicides with peer, family, and community intolerance directly, they also found that self-acceptance

was associated with the receipt of family support, but only for those who had experienced low levels of bullying. For those who had experienced high levels of bullying, support from family members did not militate against the onset of mental health problems or, indeed, thoughts of suicide.

The above data suggest that when an individual is unable to escape harassment and accept her/his sexual orientation the potential for recovery is reduced considerably. Indeed, based upon the observations of Leymann and Gustafsson (1996) in their study of work-based bullying, those who are unable to escape the abusive environment, or, indeed, those who are culturally stigmatized are much more likely to suffer mental health problems, and experience a host of symptoms leading to posttraumatic stress, because of the unremitting nature of their bullying.

## Rationale for the Present Study

This study aimed to explore further the association between the experiences of a sample of lesbians, gay men, and bisexual men and women from the UK who reported prolonged bullying at school by peers because of their actual or perceived sexual orientation, and its long-term impact upon their lives, focusing specifically upon the incidence of symptoms associated with posttraumatic stress, and their relationship to other variables, such as relationship status, sexual behavior, internalized homophobia, negative affect, and suicide ideation.

## Method

A purposive sample of UK residents who self-identified as lesbian, gay, or bisexual participated in a 3-year retrospective study focusing upon their experiences of bullying at school and its impact upon their lives. The study consisted of three key elements: a survey of bullying at school ( $n = 190$ ), a survey of life postschool ( $n = 119$ ), and a series of interviews ( $n = 16$ ; see Cowie & Rivers [2000] for a discussion of some of the findings from the interviews). Participants were selected using a multimethod sampling approach including advertisements placed in the local and regional newspapers in the South East of England and in the national gay press (*Gay Times*, *The Pink Paper*, *Attitude*), liaison with community groups and gay support networks (London, Edinburgh, Cardiff, and Belfast), and via four university lesbian, gay, and bisexual student associations.

Following the initial survey, 119 participants completed an extensive battery of questionnaires that focused upon school experiences, adolescence, suicide ideation, first sexual experiences (same and opposite sex), academic background, occupational status, relationship status and security (Pinto & Hollandsworth 1984), negative affect (depression, anxiety, and hostility; Zuckerman & Lubin, 1965), recent positive and negative life-events (Dohrenwend et

al., 1978), internalized homophobia (divided into three subscales: self acceptance, willingness to disclose, and general attitudes toward homosexuality; Nungesser, 1983; Shidlo, 1994), and symptoms associated with posttraumatic stress (see Rivers, 2001b).

Symptoms associated with posttraumatic stress were assessed using a questionnaire derived from the criteria listed in the *Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition* (American Psychiatric Association, 1994). Symptoms were divided into three categories: recollections of bullying at school (distressing memories, flashbacks, nightmares); reports of current and persistent avoidance of stimuli or feelings of numbness in responding to people or events associated with bullying at school (activity avoidance, emotional inhibition, social isolation); and reports of current and persistent symptoms of arousal (dysomnia, poor concentration, substance use/abuse). Participants were asked to rate the frequency of each symptom they had experienced on a scale of 1 (Never) to 5 (Always). They were also asked to estimate the duration of persistent symptoms on a second scale of 1 (0–6 months) to 5 (5 years or more). Internal consistency for this instrument was found to be good ( $\alpha = .90$ ) and estimates of construct validity with other measures of negative affect were also found to be satisfactory with correlation coefficients ranging from .27 to .31 ( $p = .005$ ). Further analyses of the concurrent validity of this measure with other measures of posttraumatic stress are currently being undertaken.

## Results

The sample consisted of 92 gay and bisexual men and 27 lesbian and bisexual women resident in the UK who self-identified as “victims” of homophobic bullying behavior at school, providing both quantitative and qualitative evidence of their former victim status (through recollections of the nature and severity of the bullying experiences they suffered, together with examples of the names and labels used when they were bullied). Twenty-three potential participants who did not provide evidence that the bullying they experienced at school was homophobic in origin were not included in this study. The sample’s ages ranged from 16–54 years (16–54 years for men and 16–44 years for women; mean = 28 years). At the time of data collection 105 participants indicated that they were “open” about their sexual orientation (mean age for disclosure or “coming out” was 18.5 years), while 14 had not disclosed their orientation to anyone. Eighty-four percent (100) attended state schools until the age of 16 years while 16% (19) attended public or private schools in the UK. The average age when participants first recalled being victimized because of their actual or perceived sexual orientation was 10.5 years, and the average length of time they recalled being victimized was 5 years.

In terms of the sample’s demographic characteristics,

the majority lived in urban locations (85%) in the UK. Some 36% of the sample came from London and the South East of England, 20% from the North West, 20% from the Midlands, 6% from the South West, and 5% from the North East. Another 7% came from Scotland, and 2% from Wales. A further 3% lived in Northern Ireland, and one person lived overseas. At the time the survey was conducted 56% were in gainful employment, 26% were attending college or university, 10% were unemployed, and a further 8% were unable to work on the grounds of long-term illness or disability. Of those in employment (66), 30 described themselves as “professional” (solicitor, lecturer, teacher, nurse, priest), 15 described themselves as office/clerical/secretarial, 14 described their occupation as “skilled-technical” or “semiskilled,” 4 worked in retail, and 3 described their work as “manual/unskilled.” The majority (116) identified as “White European” (90 males and 26 females), two as “Asian or South-East Asian” (1 male and 1 female), and one male as “African-Caribbean.”

## Stability of Recall for Bullying Behavior

Stability of recall was assessed using a subsample of 60 participants who received the survey of bullying in schools twice at a 12–14 month interval. Participants’ recollections of bullying were found to remain stable in terms of their assessment of when the bullying began and its duration. They were also found to be consistent in terms of their recollection of its nature and location (see Rivers, 2001a).

## Symptoms Associated with PTSD

Approximately one quarter (26%) of participants indicated that they had been or continued to be distressed regularly by recollections of bullying in school. The majority reported distressing or intrusive memories of those events (21%) and indicated that they experienced psychological distress when in situations which reminded them of their school days and being victimized (26%). Very few (only 4%) reported having dreams or nightmares about being bullied at school, however slightly more (9%) recalled having experienced “flashbacks” (illusions, hallucinations, and dissociative episodes) or a feeling of reliving events while awake.

Table 1 illustrates the number of participants (in %) who reported the current and persistent avoidance of certain stimuli or a feeling of numbness in responding to people or events surrounding them, which they associated with being bullied at school.

Table 2 illustrates the number of participants (in %) who reported current and persistent symptoms of arousal.

In order to explore the interrelationship between the symptoms described in Tables 1 and 2, and those factors associated with experiences of abuse and/or bullying, re-

INIE = Table 1. Percentage of participants reporting current and persistent avoidance of stimuli associated with trauma (school) or numbing of general responsiveness ( $n = 119$ ).

Associative features	Never	Not often	Sometimes	Often	Always
Do you find yourself trying to avoid thoughts and feelings which remind you of the event(s)?	34	17	29	14	5
Do you avoid activities or situations which may remind you of the event(s)?	34	17	26	14	9
Do you find it difficult to recall important aspects of the event(s)?	37	20	28	9	6
Do you find it difficult to continue being interested in things you did before the event(s) took place?	60	9	21	6	4
Do you ever feel like an outsider in social situations?	6	10	38	33	13
Do you find it difficult to show emotions to others?	15	15	37	26	7
Do you ever feel as if you have no real future (i.e., no prospect of having a partner, career, or long life)?	21	19	27	21	13

Table 2. Percentage of participants reporting current and persistent symptoms of arousal associated with bullying at school ( $n = 119$ ).

Symptoms of Arousal	Never	Not often	Sometimes	Often	Always
Do you ever have difficulty going to sleep or staying asleep?	16	14	38	22	10
Do you feel irritable?	4	11	43	36	6
Do you ever have outbursts of anger?	8	26	44	21	2
Do you ever feel as if you cannot express yourself?	13	20	33	30	5
Do you ever feel as if you are losing control?	13	23	35	22	7
Do you ever have difficulty concentrating on what you are doing?	3	18	40	35	4
Do you become very wary of meeting new people or facing new situations?	10	20	31	21	18
Do you over-react?	6	22	39	27	6
Do you become nervous in situations which remind you of the event(s)?	27	15	27	18	13
Do you overindulge in alcohol to help you cope with memories of the event(s)?	61	12	19	4	3
Do you ever take prescription drugs to help you cope with memories of the event(s)?	81	9	6	1	3
Do you ever take nonprescription drugs to help you cope with memories of the event(s)?	80	7	8	4	1

sponses to all 24 items on the questionnaire were recoded with "0" (zero) scores being entered for those participants who responded "Never," "Not often," and "Sometimes"; and "1" being entered for those who responded "Often" and "Always." Only those participants who reported experiencing at least one of the five recollective items for a period of 6 months or more were included. Overall, 20 participants (14 gay and bisexual men, and 6 lesbian and bisexual women; 17%) were found to have a profile similar to that set out by DSM relating to posttraumatic stress (having experienced at least one recollective symptom for a period of no less than 6 months, together with at least three current and persistent associative features, and at least two persistent symptoms of increased arousal). Three borderline cases were omitted from the analyses.

Comparison was made between those participants

whose profile suggested posttraumatic stress (Group 1,  $n = 20$ ) with those whose profile did not (Group 2,  $n = 96$ ) on a number of other measures collected during the survey that are considered sequelae of long-term exposure to bullying.

Table 3 provides summary data from one-way analyses of variance (ANOVA) and, subsequently, one-way analyses of covariance (ANCOVA) controlling for recent positive and negative life events (see Dohrenwend et al., 1978) and experiences of bullying or harassment in adulthood (estimated according to number of incidents and/or duration post 18 years of age). In accordance with Leymann and Gustafsson's (1996) recommendation, duration of bullying (measured in years) was used as an index of severity. As the data illustrates, scores for depression,  $F(1, 115) = 6.28$ ,  $p < .05$ ; number of casual sexual partners,  $F(1, 115) = 4.03$ ,  $p < .05$ ; and the self-acceptance subscale of internalized

Table 3. Comparison of groups on associated measures of negative affect, internalized homophobia, and sexual behavior.

Measure	Group	Mean	ANOVA	ANCOVA
<b>Duration of bullying</b>				
Years	1 ( <i>n</i> = 20)	6.0	1.48	
	2 ( <i>n</i> = 96)	4.0		
<b>Coming out</b>				
Age	1	16.4	2.49	
	2	18.9		
<b>Posttraumatic stress</b>				
Total score	1	64.0	33.84**	32.19**
	2	32.0		
<b>Negative affect</b> (Dohrenwend et al., 1978)				
Depression	1	22.6	6.26*	6.28*
	2	17.8		
Anxiety	1	10.6	1.54	
	2	9.2		
Hostility	1	12.4	0.84	
	2	11.3		
<b>Internalized homophobia</b> (Nungesser, 1983; Shidlo, 1994)				
Willingness to disclose	1	34.0	2.23	
	2	30.4		
General acceptance	1	16.1	0.04	
	2	15.8		
Self-acceptance	1	34.0	5.02*	4.74*
	2	28.6		
<b>Relationships/sexual behavior</b> (Pinto & Hollandsworth, 1984)				
Number of casual partners	1	90.0	5.78*	4.03*
	2	22.8		

Note: \* $p < .05$ ; \*\*  $p < .001$

homophobia,  $F(1, 115) = 4.74$ ,  $p < .05$ ; were found to be significantly higher (and, thus, it is argued, negatively affected) for Group 1 when compared to Group 2.

Subsequently scores for both groups were compared with respect to reports of self-harming behavior as a result of bullying, and a range of other self-destructive behaviors such as alcohol consumption, and the use of prescription and nonprescription drugs. In this study, 53% of the 119 participants reported contemplating self-harm or suicide as a result of bullying, with 40% of the total sample attempting self-harm or suicide at least once and three quarters of those (30% of the total sample) on more than one occasion. All members of Group 1 reported having contemplated or attempted self-harm or suicide on at least one occasion at school (mean 1.9 attempts) as compared to members Group 2 (mean 0.7). Reports of alcohol consumption were also slightly inflated but were not found to be significant at  $p = .05$ . The use of prescription and nonprescription drugs was also compared between groups, with those with a profile suggesting PTSD reporting more frequent use of prescription and nonprescription drugs to counter recollections,

nightmares, and flashbacks. Both comparisons were, however, not significant at  $p = .05$ .

## Discussion

In this study, symptoms of posttraumatic stress were found in only 17% (20) of participants who reported having been bullied at school as a consequence of their actual or perceived sexual orientation at the time. Although this suggests that posttraumatic stress may not be a factor that affects the majority of former victims of school-based bullying, where it is indicated a number of other health-related factors come into play.

The analysis of covariance (controlling for recent life-events and bullying in adulthood) indicated that participants who exhibited symptoms of posttraumatic stress were also more likely to suffer from depression and had significantly more casual sexual partners than their peers (ratio: 4/1). These findings are similar to research focusing upon

the long-term impact of sexual abuse in childhood and revictimization in adulthood, which also shows a propensity for survivors to have a large number of transient sexual partners (Wyatt et al., 1992). However, according to Bech (1997) it is difficult to draw conclusions about perceived sexually reckless behavior when participants are lesbian, gay, or bisexual due to the sexually charged nature of much of gay culture. One of the difficulties in estimating the importance of this result relates to the fact that we know very little about normative sexual behavior among lesbian and gay populations: much of their socialization as young adults has taken place in venues involving alcohol, drugs, and sexual promiscuity (Skinner & Otis, 1996). Given that women made up only one quarter of the sample due to the difficulties of gaining access to this under-researched group within the population, any anti-normative conclusions drawn from the higher rates of sexual activity among this sample may be misleading and only relevant to gay and bisexual men.

It is also interesting to note that those who reported symptoms of posttraumatic stress also reported being much more accepting of their homosexuality or bisexuality, scoring significantly lower than members of Group 2 on the RHA self-acceptance subscale. At face value, these results would seem to be contradictory to expectations, especially given that members of Group 1 were slightly more insecure (i.e., possessiveness scores) in relationships than Group 2. It can be argued that those who had been much more negatively affected by their experiences of bullying had perhaps come to terms with their sexual orientation much earlier as a result of its constant reinforcement by peers. Indeed, this hypothesis may be partially confirmed by the fact that the results indicate that members of Group 1 had disclosed their sexual orientation earlier than Group 2 ("Coming Out" at 16.4 years and 18.9 years, respectively).

Generally, examination of the reports of individual symptoms indicated that a number of participants continue to be troubled by recollections of bullying long after they had left school. For a small number, the use of prescription and nonprescription drugs "sometimes" or "more often" as a coping strategy or, indeed, alcohol, suggests that experiences of bullying at school may be a contributory factor in a number of chronic conditions not readily associated with bullying.

An alternative argument offered by Helzer et al. (1987) is that symptoms associated with posttraumatic stress can be found within the general population, among individuals who have never experienced an extraordinary negative life event. In their study of 2500 residents of St. Louis, Missouri, Helzer et al. found that 15% of their sample reported symptoms of posttraumatic stress, in particular, nightmares and jumpiness, but less than 1% met the criteria for diagnosis. However, Helzer et al. also found that women were more prone to posttraumatic stress than men, and that participants who experienced symptoms associated with the disorder also reported high rates of truancy at school, alcohol abuse, and running away from home as adoles-

cents—factors also associated with lesbian, gay, and bisexual youth who suffer bullying (Hershberger & D'Augelli, 1995; Pilkington & D'Augelli, 1995; Rivers, 2000a).

The case is further reinforced in that members of Group 1 were slightly more likely to report the use of prescription drugs to help them cope with memories of bullying than Group 2, and, concordant with previous research on lesbian, gay, and bisexual bullying (Hershberger & D'Augelli, 1995), members of Group 1 were also found to have a history of self-harm when compared to Group 2.

## Conclusion

This study provides a useful framework for the development of prospective studies focusing upon the welfare of young lesbians, gay men, and bisexual men and women who may have experienced particular hardship during their educational career. It identifies symptoms usually associated with posttraumatic stress as a feature of the adult lives of men and women who experienced frequent and prolonged bullying at school as a result of their actual or perceived sexual orientation. Over one quarter of participants in this study reported continuing to experience psychological distress when they recalled their school days and one in ten reported regularly experiencing flashbacks. Regular use of alcohol, prescription and nonprescription drugs was found to affect approximately one in twenty participants. It is hoped that this article provides some additional guidance for health care professionals working with patients from sexual minority groups who have mental health problems.

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