Testimony of
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Briefing on Peer-to-Peer Violence and Bullying

U.S. Commission on Civil Rights

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Mr. Chairman and members of the Commission, I am pleased to have the opportunity to appear before you today to discuss social scientific knowledge related to peer-to-peer violence based on sexual orientation in K-12 public schools. Thank you for addressing your attention to this important matter.

My name is Gregory Herek and I am a Professor of Psychology at the University of California at Davis. I received my Ph.D. in Psychology, with an emphasis in Personality and Social Psychology, from the University of California at Davis in 1983. I was a Post-Doctoral Fellow in Social Psychology at Yale University from 1983 to 1985. I subsequently served as a Lecturer and Visiting Assistant Professor at Yale University, and then as an Assistant Professor at the City University of New York Graduate Center in the graduate program in Social and Personality Psychology. I returned to the University of California at Davis in 1989 as an Associate Research Psychologist, and was appointed a tenured full Professor in 1999.

I have been conducting original empirical research on topics related to sexual orientation for more than 30 years. A principal emphasis of my research program is societal stigma based on sexual orientation – its sources, manifestations, and effects. As reflected in my curriculum vitae (attached), I have published more than 100 papers and chapters in scholarly journals and books, most of them related to sexual orientation, HIV/AIDS, or stigma and prejudice. I also have edited or coedited five books and two special issues of academic journals on these topics, and I have

made more than 90 presentations at professional conferences and meetings. I have received numerous federal, state, and foundation grants for my research with combined budgets totaling more than $5 million. At the University of California, Davis, I regularly teach an upper-division undergraduate course on sexual orientation and also have taught graduate seminars on this and related topics.

In addition to my own research and teaching, my professional activities over the past three decades have included serving on multiple editorial boards and as an ad hoc peer reviewer for a large number of scientific and professional journals spanning a variety of disciplines. I have also reviewed grant proposals submitted to the National Institute of Mental Health, the National Science Foundation, and other funding agencies. Many of the papers and grant proposals for which I served as a reviewer focused on sexual orientation, stigma and prejudice, or violence. Recently, I was a member of an expert panel convened by the Institute of Medicine of the National Academy of Sciences to prepare a comprehensive report on the health of lesbian, gay, bisexual, and transgender people, which was released in March. These and other aspects of my professional service are detailed in my vita.

I am a Fellow of the American Psychological Association (APA) and the Association for Psychological Science, and a member or Fellow of several other professional organizations. I have received several professional awards and honors, including the 1996 APA Award for Distinguished Contributions to Psychology in the Public Interest. In 1986, I testified on behalf of the American Psychological Association (APA) for hearings on antigay violence conducted by the House Subcommittee on Criminal Justice. In 1997, I was an invited participant at President Clinton's White House Conference on Hate Crimes.

In my statement today, I summarize social science research findings related to violence and victimization based on sexual orientation in the United States, focusing on peer-to-peer

harassment and violence in K-12 public schools. To provide a foundation and context for that research, I begin with a brief discussion of sexual orientation and stigma.

Sexual Orientation

Terminology and Definitions

As commonly used, *sexual orientation* refers to an enduring pattern of or disposition to experience sexual, affectional, or romantic desires for and attractions to men, women, or both sexes. The term is also used to refer to an individual's sense of personal and social identity based on those desires and attractions, behaviors expressing them, and membership in a community of others who share them. Although sexual orientation ranges along a continuum from exclusively heterosexual to exclusively homosexual, it is usually discussed in terms of three categories: *heterosexual* (having attraction primarily or exclusively to members of the other sex), *homosexual* (having attraction primarily or exclusively to members of one's own sex), and *bisexual* (having a significant degree of attraction to both men and women).[1] The term *gay* is commonly used to refer collectively to men and women whose social identity is based on their homosexual orientation, that is, their sexual, affectional, or romantic attraction primarily to members of their own sex. *Lesbian* is also used to refer to women in this category, and sometimes *gay* is used to refer specifically to men.

Most social and behavioral research has assessed sexual orientation in terms of attraction, behavior, or identity, or some combination of these constructs. Which of these operational definitions is most appropriate for a particular study depends on the research goals. For example, studies of sexually-transmitted diseases among men who have sex with men would appropriately focus on sexual behavior. By contrast, for research on adults' employment experiences stemming

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[1] Institute of Medicine, 2011.

from their status as an openly gay, lesbian, or bisexual individual, sexual orientation would be best defined in terms of identity.

Sexual orientation is distinct from other components of sex and gender, including *biological sex* (the anatomical, physiological, and genetic characteristics associated with being male or female), *gender identity* (the psychological sense of being a man or boy, a woman or girl, or some other gender), *gender expression* (the manifestation of characteristics in one's personality, appearance, and behavior that are culturally defined as masculine or feminine), and *gender role conformity* (the extent to which an individual's gender expression adheres to the cultural norms prescribed for people of his or her sex).[2]

The term *transgender* has been defined in different ways, but it is usually understood to encompass individuals whose gender identity differs from the sex originally assigned to them at birth or whose gender expression varies significantly from what is traditionally associated with or typical for that sex (i.e., people identified as male at birth who subsequently identify as female, and people identified as female at birth who later identify as male), as well as other individuals who vary from or reject traditional cultural conceptualizations of gender in terms of a dichotomy between male and female.[3]

Lesbians, gay men, bisexual men and women, and transgender people are often discussed as though they constitute a single group (e.g., they are often referred to collectively with the acronym LGBT). However, each of these groups differs from the others in important ways. Relevant to my testimony, being lesbian, gay, or bisexual is a matter of sexual orientation, whereas being transgender is a matter of gender identity and expression. Transgender people can be heterosexual, homosexual, or bisexual in their sexual orientation. Some lesbians, gay men,

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2 Institute of Medicine, 2011.
3 Institute of Medicine, 2011.

and bisexuals are transgender; most are not.

I was invited to provide the Commission with information about peer violence based on sexual orientation. Accordingly, my testimony focuses on sexual orientation and people who are lesbian, gay, or bisexual, or have significant same-sex attractions or engage in same-sex sexual behavior. I will refer to these individuals collectively as *sexual minorities*. Some of the research I cite has also examined the experiences of transgender people as well as individuals who do not label themselves transgender but whose gender expression does not conform to the cultural norms prescribed for people of their sex. I refer to these individuals collectively as *gender minorities*. To repeat, sexual orientation and gender identity constitute distinct aspects of human experience. Some individuals belong to both sexual and gender minority populations.

The Relational Nature of Sexual Orientation

Sexual orientation is commonly discussed as a characteristic of the *individual,* like biological sex, race, or age. This perspective is not inaccurate but it is incomplete because sexual orientation is always defined in *relational* terms and necessarily involves relationships with other individuals. Sexual acts and romantic attractions are characterized as homosexual or heterosexual according to the biological sex of the individuals involved in them, relative to each other. Indeed, it is by acting with another person – or expressing a desire to act – that individuals express their heterosexuality, homosexuality, or bisexuality. This includes sexual behaviors as well as actions that simply express affection, such as holding hands with or kissing another person.

Thus, sexual orientation is integrally linked to the intimate personal relationships that human beings form with others to meet their deeply felt needs for love, attachment, and intimacy. These bonds encompass not only sexual behavior, but also feelings of affection between partners, shared goals and values, mutual support, and ongoing commitment. Consequently, sexual orientation is not merely a personal characteristic that can be defined in

isolation. Rather, one's sexual orientation defines the universe of persons with whom one is likely to find the satisfying and fulfilling relationships that, for many individuals, comprise an essential component of personal identity.

Homosexuality Is a Normal Expression of Human Sexuality

Mainstream mental health professionals and researchers have long recognized that homosexuality is a normal expression of human sexuality; that being gay, lesbian, or bisexual bears no inherent relation to a person's ability to perform, contribute to, or participate in society; that being gay, lesbian, or bisexual poses no inherent obstacle to leading a happy, healthy, and productive life; and that the vast majority of sexual minority individuals function well in society and in their interpersonal relationships. Such functioning includes the capacity to form a healthy and mutually satisfying intimate relationship with another person of the same sex and to raise healthy and well-adjusted children.

Empirical research conducted since the 1950s has consistently failed to provide an empirical or scientific basis for the once-common view of homosexuality as a mental disorder. While the American Psychiatric Association initially classified homosexuality as a disorder in 1952 when it published its first *Diagnostic and Statistical Manual of Mental Disorders* (DSM),[4] that classification was subjected almost immediately to critical scrutiny in research funded by the National Institute of Mental Health.[5] As empirical research results accumulated, professionals in

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4 American Psychiatric Association, 1952.

5 In what is now considered a classic study and one of the first methodologically rigorous examinations of the mental health status of homosexuality, Dr. Evelyn Hooker administered a battery of widely used psychological tests to groups of homosexual and heterosexual males who were matched for age, IQ, and education. The men were recruited from nonclinical settings; none of the men was in therapy at the time of the study. The heterosexual and homosexual groups did not differ significantly in their overall psychological adjustment, as rated by independent experts who were unaware of each man's sexual orientation. Hooker concluded from her data that homosexuality is not inherently associated with psychopathology and that "homosexuality as a clinical entity does not exist" (Hooker, 1957, p.

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medicine, mental health, and the behavioral and social sciences reached the conclusion that the classification of homosexuality as a mental disorder was in error. They recognized that it reflected untested assumptions based on once-prevalent social norms as well as clinical impressions from unrepresentative samples of patients seeking therapy and individuals whose conduct brought them into the criminal justice system.

The American Psychiatric Association removed homosexuality from the *DSM* in 1973, stating that "homosexuality *per se* implies no impairment in judgment, stability, reliability, or general social or vocational capabilities." The American Psychological Association adopted the same position in 1975, and urged all mental health professionals to help dispel the stigma of mental illness that had long been associated with a homosexual orientation.[6]

Like heterosexuals, sexual minority individuals benefit psychologically from being able to share their lives with and receive support from their family, friends, and other people who are important to them. In many studies, for example, lesbians and gay men have been found to manifest better mental health to the extent that they hold positive feelings about their own sexual orientation, have developed a positive sense of personal identity based on it, and have integrated it into their lives by disclosing it to others (such disclosure is commonly referred to as "coming out of the closet" or simply "coming out").[7] By contrast, lesbians and gay men who feel

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30). Hooker's findings were subsequently replicated and amplified by numerous studies using a variety of research techniques which similarly concluded that homosexuality is not inherently associated with psychopathology or social maladjustment (see, e.g., Gonsiorek, 1991).

6 The text of the 1975 American Psychological Association resolution can be found at http://www.apa.org/about/governance/council/policy/discrimination.aspx and in Conger, 1975. The Psychological Association's other resolutions addressing issues related to sexual orientation are posted at http://www.apa.org/pi/lgbt/resources/policy/index.aspx. The Psychiatric Association's official positions on those issues are posted at http://www.healthyminds.org/More-Info-For/GayLesbianBisexuals.aspx.

7 Herek & Garnets, 2007; Pachankis, 2007.

compelled to conceal their sexual orientation tend to report more frequent mental health concerns than their openly gay counterparts[8] and are also at risk for physical health problems.[9]

Moreover, like heterosexuals, gay people can be adversely affected by high levels of stress. The link between experiencing stress and manifesting symptoms of psychological or physical illness is well established in human beings and other species. To the extent that the portion of the population with a homosexual orientation is subjected to additional stress beyond what is normally experienced by the heterosexual population, it may, as a group, manifest somewhat higher levels of illness or psychological distress.[10] Much of the difference in levels of stress experienced by the heterosexual population and the homosexual population is attributable to the societal stigma directed at the latter.[11] As Prof. Ilan Meyer noted after reviewing the relevant scientific literature, lesbian, gay, and bisexual individuals "are exposed to excess stress due to their minority position and . . . this stress causes an excess in mental disorders."[12] In experiencing such excess stress, the gay and lesbian population is comparable to other minority groups that face unique stressors due to prejudice and discrimination based on their minority status.[13] Given the unique social stressors to which they are subjected, it is noteworthy that most gay men and lesbians effectively cope with these challenges and lead happy, healthy and well-

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8 Meyer, 2003; Herek, 1996.

9 Cole, 2006; Strachan, Bennett, Russo, & Roy-Byrne, 2007.

10 Consistent with this observation, several studies suggest that, compared to the heterosexual population, a somewhat larger proportion of the homosexual and bisexual population may manifest certain psychological symptoms (Herek & Garnets, 2007; Meyer, 2003).

11 I define the construct of stigma and discuss it at length below.

12 Meyer, 2003; see also Herek & Garnets, 2007.

13 Meyer, 2003, pp. 675-76, 690. In addition, lesbian, gay, and bisexual people face other stressors. For example, because the AIDS epidemic has had a disproportionate impact on the gay male community in the United States, many gay and bisexual men have experienced the loss of a life partner, and gay, lesbian, and bisexual people alike have experienced extensive losses in their personal and social networks resulting from the death of close friends and acquaintances; bereavement related to multiple losses is linked to higher levels of depressive symptoms (see Folkman, Chesney, Collette, Boccellari, & Cooke, 1996; Martin, 1988).

adjusted lives.

The Origins and Enduring Nature of Sexual Orientation

The factors that cause an individual to become heterosexual, homosexual, or bisexual are not well understood. A variety of explanations for the origins of adult sexual orientation have been proposed but no single theory enjoys unequivocal empirical support. Given the current lack of definitive knowledge about why some individuals develop a heterosexual orientation and others become homosexual, most social and behavioral scientists regard sexual orientation as being shaped by a complex interaction of biological, psychological, and social forces. They often differ, however, on the relative importance they attach to each.

Irrespective of the origins of sexual orientation, most gay men and lesbians report experiencing either no choice or very little choice in their sexual orientation. In a survey conducted during the 1990s with a nonprobability sample[14] of more than 2,200 gay, lesbian, and bisexual adults in the greater Sacramento area, I found that 87 percent of the gay men and 70 percent of the lesbians reported that they experienced "no choice at all" or "very little choice"

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[14] Researchers distinguish between probability and nonprobability samples. In a *probability* sample, all members of the population under study have some calculable chance of being included in the sample, and individual sample members are chosen through a process that includes some element of randomization. Probability samples are sometimes referred to colloquially as *representative* samples, reflecting the fact that statistical procedures can be applied to them to estimate their level of sampling error. In *nonprobability* samples, by contrast, some members of the population have no chance of being included in sample. For example, if a study relies solely on data from volunteers who respond to a newspaper advertisement, it inevitably excludes members of the population who didn't see the ad; this would be a nonprobability sample. To confidently describe the prevalence or frequency with which a phenomenon occurs in the population at large, it is necessary to collect data from a probability sample. By contrast, simply to document that a phenomenon ever occurs, case studies and nonprobability samples are often adequate. For comparisons of different populations, probability samples drawn from each group are desirable but not necessary and are often not feasible. Hence, researchers often rely on nonprobability samples that have been matched on relevant characteristics (e.g., educational level, age, income). Some groups are sufficiently few in number – relative to the entire population – that locating them with probability sampling methods is extremely expensive or practically impossible. In the latter cases, the use of nonprobability samples is often appropriate.

about their sexual orientation.[15] More recently, in a survey conducted with a national probability sample of more than 650 self-identified lesbian, gay, and bisexual adults, I found that 88 percent of the gay men reported they experienced "no choice at all" about being gay, and another 7 percent reported experiencing "a small amount of choice." Only 5 percent said they experienced "a fair amount" or "a great deal" of choice. Among lesbians, 68 percent reported that they experienced no choice, and another 15 percent reported experiencing a small amount of choice; only 16 percent experienced a fair amount or a great deal of choice.[16]

This finding is consistent with research showing that most people report having sexual attractions to and experiences with the members of only one sex. In the Kinsey studies of the 1940s and 1950s, for example, substantial numbers of respondents reported they had experienced sexual attraction to the members of only one sex, that is, they experienced either heterosexual or homosexual attractions, but not both.[17] More recent studies have reported similar findings.[18] I am not aware of empirical studies in which heterosexual men and women were directly asked whether or not they chose to be heterosexual. If such a study were to be conducted, however, I believe it is likely that most heterosexuals would report that they do not experience their heterosexuality as a choice.

Sexual orientation is highly resistant to change through psychotherapy or religious

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[15] Herek, Gillis, & Cogan, 2009.

[16] Herek, Norton, Allen, & Sims, 2010.

[17] In interviews with a nonprobability sample of more than 10,000 adults, Alfred Kinsey and his colleagues categorized respondents according to the extent to which their sexual behaviors and emotional attractions and fantasies after the onset of adolescence were heterosexual or homosexual (Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy, Martin, & Gebhard, 1953). The extent to which the percentages reported by Kinsey and his colleagues can be generalized to the current U.S. population has been a topic of controversy (e.g., Michaels, 1996). However, regardless of whether or not Kinsey's findings accurately describe the current distribution of heterosexuals, homosexuals, and bisexuals in the general population, they document the existence of a sizable number of individuals whose history of sexual attractions and behaviors is exclusively or almost entirely to one sex.

[18] e.g., Chandra, Mosher, Copen, & Sionean, 2011; Lauman et al., 1994.

interventions. Although some psychotherapists and religious counselors have reported changing their clients' sexual orientation from homosexual to heterosexual, empirical data are lacking to demonstrate that these interventions are either effective or safe. Most of the published empirical research that has claimed to demonstrate the efficacy of techniques intended to change a person's sexual orientation has been criticized on methodological grounds.

In response to public debates about these techniques, the American Psychological Association created a Task Force on Appropriate Therapeutic Responses to Sexual Orientation which reviewed the relevant research literature. The Task Force reported that it found "serious methodological problems in this area of research, such that only a few studies met the minimal standards for evaluating whether psychological treatments, such as efforts to change sexual orientation, are effective."[19] Based on its review of the studies that met these standards, the Task Force concluded that:

> "enduring change to an individual's sexual orientation is uncommon. The participants in this body of research continued to experience same-sex attractions following SOCE [sexual orientation change efforts] and did not report significant change to other-sex attractions that could be empirically validated, though some showed lessened physiological arousal to all sexual stimuli. Compelling evidence of decreased same-sex sexual behavior and of engagement in sexual behavior with the other sex was rare. Few studies provided strong evidence that any changes produced in laboratory conditions translated to daily life. Thus, the results of scientifically valid research indicate that it is unlikely that individuals will be able to reduce same-sex attractions or increase other-sex sexual attractions through SOCE."[20]

In addition, the Task Force found evidence to indicate that some individuals experienced harm or believed they had been harmed by these interventions.[21]

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[19] American Psychological Association, 2009a (p. 2).

[20] American Psychological Association, 2009a (pp. 2-3).

[21] The Task Force report provides a detailed discussion of this topic and an extensive review of relevant research. It is available at: http://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf.

Thus, interventions aimed at changing an individual's sexual orientation have not been demonstrated by empirical research to be effective or safe. Moreover, because homosexuality is a normal variant of human sexuality, the major mental health professional organizations do not encourage individuals to try to change their sexual orientation from homosexual to heterosexual. Indeed, such interventions are ethically suspect because they can be harmful to the psychological well-being of those who attempt them; clinical observations and self-reports indicate that many individuals who unsuccessfully attempt to change their sexual orientation experience considerable psychological distress.

For these reasons, no major mental health professional organization has sanctioned efforts to change sexual orientation, and virtually all of them have adopted policy statements cautioning the profession and the public about treatments that purport to change sexual orientation. These include the American Psychiatric Association, American Psychological Association, American Counseling Association, and National Association of Social Workers. In addition, reflecting the fact that adolescents are often subjected to such treatments, the American Academy of Pediatrics has adopted a policy statement advising that therapy directed specifically at attempting to change an adolescent's sexual orientation is contraindicated and unlikely to result in change.[22]

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[22] In response to the 2009 report of its Task Force on Appropriate Therapeutic Responses to Sexual Orientation, the APA passed a resolution that stated, in part, "the American Psychological Association concludes that there is insufficient evidence to support the use of psychological interventions to change sexual orientation" and "the American Psychological Association concludes that the benefits reported by participants in sexual orientation change efforts can be gained through approaches that do not attempt to change sexual orientation" (American Psychological Association, 2009b). See also the relevant policy statements by the American Psychiatric Association, the National Association of Social Workers, and the American Counseling Association. These policy statements are compiled in a publication titled *Just the Facts About Sexual Orientation and Youth: A Primer for Principals, Educators, and School Personnel*, which is available on the American Psychological Association's Web site: http://www.apa.org/pi/lgbt/resources/just-the-facts.pdf

Sexual Stigma

Although several different definitions of *stigma* can be found in the social science literature, researchers generally agree that it refers to an enduring condition, status, or attribute that is negatively valued by society, that fundamentally defines a person's social identity, and that consequently disadvantages and disempowers those who have it.[23] Social scientists have long recognized that stigma is not inherent in a particular trait or membership in a particular group; rather, society collectively identifies particular characteristics and groups, and assigns negative meaning and value to some of them, thereby "constructing" stigma. Thus, a classic work in this area characterized stigma as "an undesired differentness."[24] Exactly which differences are important, and which ones are designated as undesirable, is socially constructed and can change over time as social norms and mores change.

Social psychological research indicates that "differentness," to the extent that it creates perceptions of ingroups and outgroups, is associated with biased perceptions and differential treatment of individuals according to whether they are considered "us" or "them." People tend to hold positive feelings and display favoritism toward members of their own group, even in situations when group membership is based on a completely arbitrary criterion, such as the flip of a coin.[25]

Homosexuality remains stigmatized today in the United States: Significant portions of the heterosexual public harbor negative feelings and hostile attitudes toward sexual minorities.[26] Such stigma can be observed both in the institutions of society and among its individual members. In the former, stigma-derived differentials in status and power are legitimated and

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[23] See, e.g., Goffman, 1963; Link & Phelan, 2001.
[24] Goffman, 1963, p. 5.
[25] See, e.g., Devine, 1995; Dovidio & Gaertner, 1993.
[26] e.g., Herek, 2002; Herek & Capitanio, 1999; Schafer & Shaw, 2009.

perpetuated in the form of *structural stigma*. As a product of sociopolitical forces, structural stigma "represents the policies of private and governmental institutions that restrict the opportunities of stigmatized groups."[27]

By legitimating and reinforcing the "undesired differentness" of sexual minorities and by according them inferior status relative to heterosexuals, structural stigma gives rise to prejudicial attitudes and individual acts against them, including ostracism, harassment, discrimination, and violence. Large numbers of lesbian, gay, and bisexual people experience such acts of stigma because of their sexual orientation. For example, in my national survey of lesbian, gay, and bisexual adults, 21 percent of the respondents reported having been the target of a physical assault or property crime because of their sexual orientation since age 18. Gay men were the most likely to report they had been the targets of such crimes; 38 percent had experienced an assault or property crime because of their sexual orientation.[28] In the same survey, I found that 18 percent of gay men and 16 percent of lesbians reported they had experienced discrimination in housing or employment because of their sexual orientation.

Research indicates that experiencing stigma and discrimination is associated with heightened psychological distress – both among gay and lesbian adults[29] and adolescents.[30] Being the target of extreme enactments of stigma, such as an antigay criminal assault, is accompanied by greater psychological distress than is experiencing a similar crime not based on one's sexual orientation.[31] Fear of being a target for stigma makes some gay and lesbian persons feel compelled to conceal or lie about their sexual orientation. As noted above, experiencing barriers to integrating one's sexual orientation into one's life (e.g., not being able to disclose it to

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[27] Corrigan et al., 2005; see generally Link & Phelan, 2001.
[28] Herek, 2009a; see also Herek, Gillis, & Cogan, 1999; Herek & Sims, 2008.
[29] e.g., Meyer, 2003; Mays & Cochran, 2001.
[30] e.g., O'Shaughnessy, Russell, Heck, Calhoun, & Laub, 2004.
[31] Herek et al., 1999.

others) is often associated with heightened psychological distress and has negative implications for physical health.

In addition, to the extent that the threat of being stigmatized motivates some lesbians and gay men to remain in the closet, it further reinforces anti-gay prejudice among heterosexuals. Research has consistently shown that prejudice against minorities, including gay people,[32] is significantly lower among members of the majority group who knowingly have contact with minority group members.[33] Consistent with this general pattern, empirical research demonstrates that having personal contact with an openly gay person is one of the strongest and most consistent correlates of heterosexuals' tolerance and acceptance of gay people. Anti-gay prejudice is significantly less common among members of the population who report having a close friend or family member who is gay or lesbian.[34] Indeed, an extensive analysis of empirical studies examining the association between prejudice and personal contact between a wide range of stigmatized and nonstigmatized groups found that the link is stronger for sexual minorities than for other types of groups, including those defined by race, ethnicity, and mental illness.[35] Prejudice tends to be lower when a lesbian or gay friend or family member has directly disclosed her or his sexual orientation to a heterosexual person, compared to when the former's

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[32] Although the specific content of prejudice varies across different minority groups, the psychological dynamics of prejudice are similar regardless of the group toward which that prejudice is directed.

[33] A meta-analysis of more than 500 studies of contact and prejudice based on sexual orientation, nationality, race, age, and disability found a highly robust inverse relationship between contact and prejudice. Majority group members who had personal contact with one or more minority group members were consistently less prejudiced toward the minority group (Pettigrew & Tropp, 2006).

[34] Heinze & Horn, 2009; Herek & Capitanio, 1996; Vonofakou, Hewstone, & Voci, 2007. For a review, see Smith, Axelton, & Saucier, 2009.

[35] Based on their meta-analysis, Pettigrew & Tropp reported that ". . . the magnitudes of the contact–prejudice effect sizes vary in relation to different target groups. The largest effects emerge for samples involving contact between heterosexuals and gay men and lesbians . . . . These effects are significantly larger than are those for the other samples combined . . . ." (Pettigrew & Tropp, 2006, p. 763, statistics omitted).

sexual orientation is known but has not been directly discussed.[36]

Just as sexual orientation is inherently about relationships, so is the stigma associated with homosexuality. Although sexual stigma is often enacted against individuals (e.g., through ostracism, discrimination, or violence), it is based on those individuals' relationships (actual, imagined, or desired) with others of their same sex. Sexual minority individuals are stigmatized not only because their private desires are directed at people of their same sex, but also because of the nature of their intimate relationships (i.e., because their sexual or romantic partner is of their same sex). Indeed, a person's homosexuality or bisexuality often becomes known to others only when she or he enters into a same-sex relationship, regardless of whether that relationship involves a single sexual act or a lifelong commitment to another person. Consistent with this observation, psychological research has shown that heterosexuals' reactions to same-sex couples are typically more negative than their reactions to heterosexual couples, and this bias is often outside their conscious awareness or control.[37]

Sexual Orientation and Inter-Student Violence

With this general discussion of sexual orientation and stigma as background, I turn now to the issue of inter-student violence based on sexual orientation. When considering this issue, it is important to recognize that a person's sexual orientation is not readily apparent in most social interactions and perpetrators of harassment and violence often act on the basis of their assumptions about another student's sexual orientation. Those assumptions may or may not be accurate. Consequently, virtually anyone can be the target of antigay violence and harassment, regardless of their actual sexual orientation.

It is also important to recognize that children and adolescents whose behavior or

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[36] Herek, 2009b; Herek & Capitanio, 1996.
[37] e.g., Dasgupta & Rivera, 2006; Jellison, McConnell, & Gabriel, 2004.

appearance is perceived as atypical for their gender are frequently the targets of violence and harassment. In many cases, the perpetrators assume that gender nonconformity is a marker for homosexuality or bisexuality. In addition, gender nonconformity is itself stigmatized and some children and adolescents are targeted for harassment and violence entirely because of their gender atypicality.[38]

Research by social scientists and educators demonstrates that peer harassment and victimization based on sexual orientation is widespread in school settings, and that experiencing such harassment and victimization is associated with a variety of negative outcomes for sexual minority youth.

Harassment and Victimization Are Widespread

Children and adolescents are frequently harassed and victimized because they are perceived to be lesbian, gay, or bisexual, and these incidents often occur in school settings.[39] For example, in the 2001-2002 California Healthy Kids Survey (CHKS), 7.5 percent of the respondents – nearly 18,000 students – reported being harassed in middle or high school on the basis of their actual or perceived sexual orientation; this included two-thirds of the students who identified as lesbian, gay, bisexual, or transgender.[40] In a 1995 census of Seattle (WA) students (grades 9-12), 8.1 percent of the 8,406 respondents said they had been the targets of offensive comments or attacks at school or on the way to school because of their (perceived) sexual orientation; this included 34 percent of students who identified as gay, lesbian or bisexual, and 5 percent of heterosexual students.[41] In the 1997 Wisconsin Youth Risk Behavior Survey, 4.9

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[38] D'Augelli, Grossman, & Starks, 2006; Friedman, Koeske, Silvestre, Korr, & Sites, 2006; Toomey, Ryan, Diaz, Card, & Russell, 2010; see also Horn, 2007.
[39] D'Augelli et al., 2006.
[40] O'Shaughnessy et al., 2004.
[41] Reis & Saewyc, 1999.

percent of all students responding to the survey said they had been threatened or hurt because someone thought they were gay, lesbian, or bisexual (students were not asked their sexual orientation in this survey).[42] In a large national nonprobability sample of nonheterosexual youth surveyed in 2009 by the Gay, Lesbian and Straight Education Network (GLSEN), approximately 85 percent of the respondents reported they had been verbally harassed, and 19 percent said they had been physically assaulted at school during the previous year because of their sexual orientation.[43]

The problem of peer victimization in schools may be more extensive today than in the past because contemporary sexual minority youth appear to be recognizing their sexual orientation and coming out at earlier ages than was the case for previous generations. This is illustrated by the results of analyses I conducted with data from a 2005 national probability sample of sexual minority adults.[44] Comparing respondents who were 40 years or older with those under 40, I found significant generational differences in the mean ages associated with important developmental milestones. Gay and bisexual males who were 40 years or older reported they first became aware of their minority sexual orientation at an average age of 18 years, compared to approximately 14 years for males under 40.[45] For lesbian and bisexual females, the average ages were approximately 23 (for those 40 and over) and 17 (for those under 40). When asked when they first told someone else that they were gay, lesbian, or bisexual,

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[42] Reis & Saewyc, 1999.

[43] Kosciw, Greytak, Diaz, & Bartkiewicz, 2010; see also Kosciw, Greytak, & Diaz, 2009.

[44] These data are from a study reported in Herek, 2009a, and Herek et al., 2010. The findings reported here concerning age-related differences are derived from analyses conducted specifically for these hearings.

[45] Respondents were asked, "How old were you when you first knew or decided you were [gay/lesbian/bisexual]?" The specific wording was tailored to the respondent's self-identification, ascertained by an earlier question in the survey. Note that this question differs from questions in other studies that ask about the respondent's earliest sexual *attraction* (which typically occurs earlier than self-labeling).

younger males reported an average age of approximately 18 years whereas men over 40 reported an average age of about 23 years. For women, the average ages were approximately 19 years (for those under 40) and 26 years (for those over 40). Thus respondents under 40 experienced important milestones related to their sexual orientation at significantly younger ages than older respondents.

Because these data were obtained from a probability sample, they can be assumed to be representative of the U.S. lesbian, gay, and bisexual adult population. However, the sample was not large enough to permit examination of younger, more narrowly-defined age groups (e.g., respondents in their 20s). Other published data, however, suggest that the average ages associated with first recognition of one's minority sexual orientation and first disclosure to others are even lower for younger generations.[46]

The earlier average ages for first self-awareness and coming out probably reflect societal changes over the past 50 years, including greater visibility and increased acceptance of sexual minority individuals.[47] However, being identified as gay, lesbian, or bisexual in middle or high school clearly poses risks for sexual minority students. Sexual minority adults and adolescents are more likely to experience harassment and victimization to the extent that their sexual orientation is known to a greater number of others.[48] This may be especially the case in school settings because negative attitudes toward homosexuality and sexual minorities are common among heterosexual youth, especially in early adolescence.[49] Such attitudes are problematic not only because they are often expressed through harassment and victimization, but also because

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[46] Floyd & Bakeman, 2006; Ryan & Futterman, 1998; see also Herdt & Boxer, 1993; Russell, Ryan, Toomey, Diaz, & Sanchez, 2011.

[47] For a general discussion of changes in U.S. attitudes, see Herek, 2009b.

[48] Chesir-Teran & Hughes, 2009; D'Augelli, Pilkington, & Hershberger, 2002; Herek et al., 1999.

[49] Horn, 2006; Poteat, Espelage, & Koenig, 2009; see also Poteat, 2007; Poteat, 2008; Poteat & DiGiovanni, 2010

they create an environment in which sexual minority students lack friendship and emotional support from many of their peers at an important juncture in their development.[50]

Harassment and Victimization Are Associated With Negative Outcomes

Research indicates that experiencing bullying and peer victimization is associated with psychological distress and related problems. For example, data from the California Healthy Kids Survey indicated that, compared to students who were not harassed, students harassed on the basis of their actual or perceived sexual orientation were more than twice as likely to report depression, to report seriously considering suicide, or to report making a plan for suicide. They were also more likely than other students to use methamphetamines or inhalants and to smoke cigarettes, drink alcohol, or use other illicit drugs. And they were more likely to be victims of violence and to report having missed school in the previous 30 days because they felt unsafe.[51] Other studies similarly reveal a link between victimization based on one's sexual orientation and higher levels of psychological distress, suicidality, and risk behaviors.[52] Several studies have found that experiences with harassment and victimization based on sexual orientation account for much or all of the disparities between heterosexual and nonheterosexual students in mental health, substance use, truancy and poor school performance, and risk behaviors.[53]

Although bullying and victimization have negative consequences for all students who

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[50] Hansen, 2007.

[51] O'Shaughnessy et al., 2004.

[52] Almeida, Johnson, Corliss, Molnar, & Azrael, 2009; Birkett, Espelage, & Koenig, 2009; D'Augelli et al., 2002; Friedman et al., 2006; Poteat & Espelage, 2007; Swearer, Turner, Givens, & Pollack, 2008.

[53] Birkett et al., 2009; Toomey et al., 2010; Russell et al., 2011. In addition, an analysis of data from the 1995 Massachusetts and Vermont Youth Risk Behavior Surveys (YRBS) found that levels of at-school victimization of any form accounted for much of the difference between heterosexual and nonheterosexual youth in substance use, suicidality, and sexual risk behaviors; the YRBS did not directly assess whether victimization was related to the victim's sexual orientation (Bontempo & D'Augelli, 2002).

experience them, being targeted for bullying because of one's sexual orientation is associated with more problems and greater distress than is experiencing bullying or harassment that is not related to one's identity. In the California Healthy Kids Survey, the negative outcomes associated with harassment based on actual or perceived sexual orientation were found to be much more severe than outcomes associated with other harassment and bullying not based on race, ethnicity, national origin, religion, disability, gender, or sexual orientation. For example, students who were harassed based on their actual or perceived sexual orientation were more than twice as likely to binge drink or smoke and more than four times as likely to bring a weapon to school than students who experienced non-bias-related harassment. By contrast, students who experienced non-bias-related harassment reported levels of substance use and low grades that were nearly identical to students who were not harassed at all.[54] Although students of all sexual orientations can encounter antigay harassment, its impact appears to be greater for lesbian, gay, and bisexual students than for heterosexual students. A study of nearly 14,000 high school students in a Midwestern county found that experiencing antigay teasing or harassment was more strongly associated with depression and the use of alcohol and marijuana among nonheterosexual students, compared to heterosexual students who reported such teasing.[55]

The negative psychological effects of bullying and peer victimization appear to last after students leave high school. In a study of sexual and gender minority young adults (21-25 years old), experiencing school victimization during the teen years was associated with higher current levels of depression, more suicidal thoughts, lower self-esteem, and less life satisfaction.[56]

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[54] O'Shaughnessy et al., 2004.
[55] Espelage, Aragon, Birkett, & Koenig, 2008.
[56] Russell et al., 2011.

Institutional Practices and Policies May Help

More research is needed to systematically assess the impact of various interventions to eliminate and counteract the negative effects of peer victimization. However, the research that is currently available points to at least three policy strategies that may reduce victimization and increase students' safety and well-being. Using terminology from research on stigma, these strategies address various facets of structural stigma .[57]

First, institutional practices and policies may reduce peer victimization based on sexual orientation and mitigate its negative impact when it occurs. Having anti-bullying and nondiscrimination policies that explicitly include sexual and gender minority youth appears to reduce prejudicial behaviors among students, increase feelings of safety among sexual minority youth, and create safer climates.[58]

Second, schools in which teachers and staff are trained to stop and prevent harassment and victimization of sexual minority youth are likely to provide a safer environment for those youth.[59] A positive school climate (e.g., in which students report that they feel respected and cared about by adults in the school) also helps to buffer the negative impact of experiences with antigay harassment and victimization.[60]

Third, having resources and supportive groups and programs for sexual and gender minority students increases school safety.[61] A study in the Massachusetts schools, for example, found lower rates of victimization and suicide attempts among sexual minority adolescents in

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[57] For an extended discussion, see Russell, Kosciw, Horn, & Saewyc, 2010; see also Hansen, 2007.
[58] O'Shaughnessy et al., 2004; Russell et al., 2010; Szalacha, 2003.
[59] Chesir-Teran & Hughes, 2009; Szalacha, 2003.
[60] Birkett et al., 2009; Espelage et al., 2008.
[61] Chesir-Teran & Hughes, 2009; O'Shaughnessy et al., 2004; Szalacha, 2003.

schools with support groups than in schools without such groups.[62]

Gender Minority Youth and Inter-Student Violence

Because I was invited to provide the Commission with information about peer violence based on sexual orientation, I have only briefly addressed the related problem of violence against gender minority youth. As I noted earlier, gender identity and sexual orientation are distinct aspects of human experience. Moreover, some students belong to both gender and sexual minority populations. Sexual minority students are often targeted for harassment or violence because they are not perceived as conforming to traditional gender roles, and gender minority students are often assumed by perpetrators to be gay, lesbian, or bisexual.

Much of the research I have cited in relation to the problem of peer victimization in the schools has also addressed the victimization of gender minority youth. In addition, some studies have focused specifically on them.[63] Like sexual minority youth, gender minority youth face considerable stigma and routinely experience harassment and violence. Those experiences often have negative consequences for the victim. It is likely that policies and interventions to prevent the victimization of sexual minority youth will also benefit gender minority youth. However, a comprehensive approach to the problem of peer victimization in K-12 schools public schools will necessarily include explicit attention to the needs of gender minority youth.

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[62] Goodenow, Szalacha, & Westheimer, 2006.
[63] McGuire, Anderson, Toomey, & Russell, 2010; Grant, Mottet, & Tanis, 2011.

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