STATEMENT OF ILAN H. MEYER, PH.D.

BEFORE THE UNITED STATES COMMISSION ON CIVIL RIGHTS

BRIEFING ON PEER-TO-PEER VIOLENCE AND BULLYING: EXAMINING THE FEDERAL RESPONSE

MAY 13, 2011

QUALIFICATIONS

1. My background, experience, and list of publications are summarized in my curriculum vitae, which is attached as Exhibit A to this report.

2. I am a Professor of Clinical Sociomedical Sciences and Deputy Chair for Masters Programs in Sociomedical Sciences at Columbia University, Mailman School of Public Health. In 1993, I received my Ph.D. in Sociomedical Sciences and Social Psychology from Columbia University's Mailman School of Public Health. My doctoral dissertation, titled *Prejudice and pride: Minority stress and mental health in gay men*, received *distinguished* designation, awarded to the top 10% of Columbia University doctoral dissertations, as well as the *Marisa De Castro Benton Dissertation Award* for outstanding contribution to the sociomedical sciences, and an honorable mention for the mental health section of the American Sociological Association's award for best dissertation. I was a predoctoral National Institute of Mental Health Fellow in Psychiatric Epidemiology at Columbia University from 1987 to 1992. I was a postdoctoral Fellow in Health Psychology at The Graduate Center at The City University of New York from 1993 to 1995 and a National Institute of Mental Health Research Fellow in Psychiatry, with a focus on AIDS, at Memorial Sloan-Kettering Cancer Center from 1995 to 1996. I returned to Columbia University's Mailman School of Public Health in 1994 and served as an Assistant Professor of Clinical Public Health; beginning in 1998, I served as an Assistant Professor of Public Health in the Department of Sociomedical Sciences. I was appointed as an Associate Professor of Clinical Sociomedical Sciences in 2003 and Deputy Chair for Masters Programs in the Department of Sociomedical Sciences in 2004. From 2006 to 2007, I was a Visiting Scholar at the Russell Sage Foundation. I was appointed as a Professor of Clinical Sociomedical Sciences in 2010.

3. My study of the health of lesbian, gay, and bisexual (LGB) populations can be classified in an area of study that is called *social epidemiology*. Social epidemiology is concerned with social patterns of disease and risks for disease. "Social epidemiology is about how society's innumerable social arrangements, past and present, yield differential exposures and thus differences in health outcomes. . . ." (Oakes & Kaufman, 2006, p. 3). I study the role of social stress related to prejudice and discrimination on mental health outcomes, with a focus on United States populations defined by gender (men and women), race/ethnicity (African Americans, Latinos and Whites), and sexual orientation (LGB and heterosexuals).

4. My original theoretical and empirical research focuses on the relation of social status, minority identity, prejudice and discrimination to mental health outcomes. I have studied, in particular, sexual minorities and the intersection of sexual orientation, race/ethnicity and gender. Through these studies, I have developed a model of social stress. This model has become the most commonly used framework for the study of mental health in LGB individuals (Herek & Garnets, 2007) and has generated several hundred scientific papers. For this work, I have received the American Psychological Association Division 44 Distinguished Scientific Contribution Award.

5. As reflected in my curriculum vitae, I have published more than 60 original, peer-reviewed articles, chapters, reviews, and editorials in scholarly journals and books. Most of these publications relate to stress and illness in minority populations and, in particular, to the relationship of minority status, minority identity, prejudice and discrimination and mental health outcomes in the LGB population. I also have co-edited a book and two special issues of academic journals on these topics, including the first special issue on lesbian, gay, bisexual, and transgender (LGBT) health of the *American Journal of Public Health*, published in 2001. I have

made numerous presentations at professional conferences and meetings (some of them listed in my CV). For example, I was the Keynote Speaker at the National Institutes of Health's 11th Annual Noon-in-June Program: An Observance of Gay, Lesbian, Bisexual & Transgender Pride Month at the National Institutes of Health, in Bethesda, MD. I have received grants for my research from federal, state, and private funders and am currently a recipient of the prestigious Robert Wood Johnson Foundation's Investigators Award in Health Policy Research.

6. I am a member of the American Public Health Association, the American Psychological Association, and the American Sociological Association. I have received several professional awards and honors, including the Association of Lesbian & Gay Psychologists' Mark Freedman Award for outstanding research on lesbian/gay issues.

7. I currently serve on the editorial board of the *Journal of Health and Social Behavior* and routinely serve as a reviewer for many other professional journals. Over the past 10 years, I have reviewed numerous manuscripts for many of the top scientific and professional journals in the fields of public health, psychology, sociology, and medicine. I co-edited a book, published in 2007 by Springer, entitled *The health of sexual minorities: Public health perspectives on lesbian, gay, bisexual and transgender populations*. From 1993 to 2002, I served as co-chair of the Science Committee of Division 44 of the American Psychological Association, the Society for the Psychological Study of Lesbian, Gay, Bisexual and Transgender Issues. From 2000 to 2001, I served as Guest Editor for the *American Journal of Public Health*'s Special Issue on lesbian, gay, bisexual and transgender (LGBT) health, published in June 2001. In 2004, I served as Leader of the Working Group on Stigma, Prejudice and Discrimination for The Robert Wood Johnson Health and Society Scholars Program at Columbia University's Mailman School of

Public Health. In 2006, I served as co-editor of the *Social Science & Medicine* Special Issue on prejudice, stigma, and discrimination in health, published in 2008.

8. As Deputy Chair for Masters Programs in Sociomedical Sciences at Columbia University's Mailman School of Public Health, I administer our MPH and MS programs of over 200 students. I also teach graduate-level courses on research methods; stigma, prejudice, and discrimination; and gay and lesbian issues in public health. I regularly sponsor students' doctoral and masters theses and dissertations.

THE NATURE OF SCIENTIFIC EVIDENCE

9. In this report I rely on my reading and interpretation of current scientific literature in different disciplines including psychology, sociology, epidemiology, and public health. My analysis follows established social science rules of evidence. Social science evidence relies on the following: (a) theory (b) hypotheses posed based on theory, (c) empirical associations that assess these hypotheses using quantitative and qualitative methods, and (d) conventions and rules about causal inference developed in these disciplines over decades of methodological writings.

10. No one article or study is determinative, and all studies have methodological limitations. Indeed, a good scientific article should provide the reader with a thorough review of the study's limitations, as well as suggestions for further study. The existence of methodological limitations in any one study, or even in a group of studies, does not by itself discredit the study or area of investigation. A scientist uses his or her judgment about the significance and potential impact of the limitations to form conclusions about the questions under study.

11. For these reasons, like most scientists, I base my conclusions on an analysis of the cumulative evidence, a critical review of the theoretical basis for a study, the hypotheses tested, the methodology used, inference conventions and rules, and my years of experience as a researcher in the field.

12. My decisions about which articles to review, how many articles to consult, and what weight to give to any one article were based solely on scientific merit. In making those decisions, I relied on my experience and judgment about the best methods to assess the question under study. Thus, in choosing which literature to consult, I judge the quality of evidence, including, for example, but not exclusively, the type and prestige of the journal where an article was published, the purpose of the article (e.g., review vs. original research), and the quality and rigor of the methodology used.

13. In this report I refer to lesbian, gay, bisexual (LGB) individuals and groups, also referred to as *sexual minorities*, as a catchall term that denotes non-heterosexual orientation or identity. In that, I also include what has been referred to as *questioning*—youth who are not clear about their sexual orientation or identity but who perceive some difference between themselves and completely heterosexual peers and therefore explore questions about their sexuality. I use these terms recognizing that youth and adults may use various other terms and labels (e.g., *queer*) to refer to their non-heterosexual sexuality. In using these terms I do not suggest that all youth who are sexual minorities have a settled sexual orientation or identity, rather they may be in a process of understanding and organizing their perceptions and ideas about their sexuality. The term *transgender* refers to youth who are perceived as gender nonconforming (that is, feminine boys and masculine girls) in the way they look, the way they dress, their mannerisms, or their vocational or recreational interests.

STIGMA

14. My professional work has focused on the role of stigma, particularly as it relates to minority groups. Stigma is "a function of having an attribute that conveys a devalued social identity in a particular context" (Crocker, Major & Steele, 1998, p. 506).

15. *Structural* (or *institutional)* stigma is "formed by sociopolitical forces and represents the policies of private and governmental institutions that restrict the opportunities of stigmatized groups" (Corrigan et al., 2005, in Herek, 2009a, p. 67). Structural stigma restricts the liberty and dignity of members of a stigmatized group by erecting barriers to their success.

16. One important function of stigma is that it legitimizes the unequal treatment of some groups in society. "People of higher status may stigmatize those of lower status to justify [the higher status people's] advantages" (Crocker, Major, & Steele, 1998, p. 509). When acted upon, antigay stigma is expressed as prejudice, discrimination and violence against LGB people (Herek, 2009a, 2009b).

17. Laws are perhaps the strongest of social structures that uphold and enforce stigma. "Law can . . . be a part of the problem by enforcing stigma" (Burris, 2006, p. 530). Laws can also eradicate and dismantle stigma. "Law can be a means of preventing or remedying the enactment of stigma as violence, discrimination, or other harm; it can be a medium through which stigma is created, enforced, or disputed; and it can play a role in structuring individual resistance to stigma" (Burris, 2006, p. 529).

18. Because of the effectiveness of structural interventions, such as the law, public health structural interventions often use law to enhance the nation's health. In using law to advance

public health goals, public health officials and legislators consider the impact of the law on reducing, maintaining, or propagating stigma. From a social science perspective, irrespective of their legal functions or standing, laws both reflect and shape social values and attitudes and enhance or diminish stigma. Indeed, the role of law in shaping stigma is so well understood to public health professionals that they explicitly debate the ethics of using law that promote stigma even when such laws have undeniable benefits to the public's health by preventing morbidity and mortality such as in the context of restrictions on smokers (Bayer, 2008).

19. Recognizing the important role of law in promoting or reducing stigma, legislators propose laws with clear and explicit purpose of removing stigma. For example, California has laws that aim to reduce stigma and discrimination by enhancing, through education, its citizens' understanding of the historical contribution to society of groups that have been subject to stigma and discrimination such as African Americans. "California has a history of prohibiting discriminatory bias in education, dating back to 1965 when the first statutory prohibition against curricula and books reflecting bias against persons because of national origin and ancestry was enacted" (Bill Analysis, SB 48, accessed online 4/30/11 http://www.leginfo.ca.gov/bilinfo.html).

20. In Senate Bill 48 California legislators sought to extend this to lesbian, gay, bisexual and transgender (LGBT) populations, noting that "The historically inaccurate exclusion of LGBT Americans in social sciences instruction as well as the spreading of negative stereotypes in school activities sustains an environment of discrimination and bias in school throughout California" (Bill Analysis, SB 48, accessed online 4/30/11 http://www.leginfo.ca.gov/bilinfo.html).

21. Stigma has a serious impact on the health of LGBT people in the United States by causing stress and disease. This has been recognized by public health authorities including *Healthy People 2010* and *Healthy People 2020*, which set health priorities for the United States (U.S. Department of Health and Human Services, 2000, 2010, available online www.healthypeople.gov/). *Healthy People 2010* identified the "gay and lesbian population," among groups targeted to reduce health disparities in the United States. In explaining the reason for the inclusion of the gay and lesbian population as one of the groups requiring special public health attention, the Department of Health and Human Services noted: "The issues surrounding personal, family, and social acceptance of sexual orientation can place a significant burden on mental health and personal safety."

MINORITY STRESS

22. This burden has most clearly been articulated in the literature on *minority stress,* a theoretical perspective that builds on stress theory to understand the unique burden of stigma on minority and otherwise socially disadvantaged groups (see Institute of Medicine, *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding,* March 2011, available online www.iom.edu).

23. Stress can be defined as "any condition having the potential to arouse the adaptive machinery of the individual" (Pearlin, 1999, in Meyer 2003, p. 675). Using engineering analysis, stress can be described as the load relative to supportive surface (Wheaton, 1999, in Meyer 2003, p. 675). Like a surface that may break when load weight exceeds its capacity to withstand the load, so has psychological stress been described as reaching a breaking point beyond which an organism may reach "exhaustion" and even death (Selye, 1993). Stress has been shown to cause

mental disorders, including anxiety, depression, suicide, substance use, and many physical disorders, such as cardiovascular disorders.

24. Stress exposures include major life events (e.g., loss of a loved one), chronic conditions (e.g., unemployment), and minor events and instances (e.g., traffic in rush hour in a big city). Such stressors are ubiquitous—all individuals in modern societies are exposed to them. I have referred to these as *general* stressors (Meyer, Schwartz, & Frost, 2008).

25. In addition, people in disadvantaged social statuses are exposed to unique added stressors—I have referred to this as *minority* (also *social)* stress. Minority stress stems from social disadvantage related to structural stigma, prejudice, and discrimination. "*Minority stressors* . . . strain individuals who are in a disadvantaged social position because they require adaptation to an inhospitable social environment, such as the LGB person's heterosexist social environment" (Frost & Meyer, 2009, p. 97).

26. By definition, minority stress is unique, in that it affects and requires special adaptation by LGB people but not by heterosexuals. Therefore, minority stress confers a unique risk for diseases that are caused by stress. Exposure to minority stress is chronic in that it is attached to persistent social structures, but it can impact LGB individuals as both acute (e.g., a life event, such as victimization by antigay violence or firing from a job because of one's gay identity) and chronic stress (e.g., heightened vigilance required to prevent victimization by antigay violence).

27. Against minority stress, LGB people individually, as well as the LGB community as a group, mount coping efforts and build resources that may buffer the toll of stress. Personal coping includes, for example, a sense of mastery and strong social support; community-level coping refers to the LGB person's mobilization of supportive services, including, for example,

his or her sense of connectedness and affiliation with the gay community (Meyer, 2003; Kertzner, Meyer, Frost, & Striratt, 2009). Coping and social support ameliorate the impact of stress so that the total effect of stress on the etiology of illness results from the combined opposing influences of stress on one hand and coping and social support on the other.

28. In my research I have described four pathways through which social stigma is manifested in the lives of people who are members of stigmatized groups. I referred to these as *minority stress processes* and described them as: (a) chronic and acute prejudice events and conditions, (b) expectation of such events and conditions and the vigilance required by such expectation, (c) internalization of social stigma (internalized homophobia), and (d) concealing or hiding of one's LGB identity. Below, I describe in greater detail these minority stress processes and discuss how they can inform the discussion of bullying, violence, and harassment of sexual minority students in K-12 schools.

PREJUDICE EVENTS

29. Prejudice events refer to antigay discrimination and violence. Prejudice events include the *structural* exclusion of LGBT individuals from resources and advantages available to heterosexuals, such as their exclusion from the institutions of marriage and from protection against employment discrimination, or rules prohibiting LGBT students from forming student groups and clubs in schools and colleges.

30. Structural stigma predisposes LGBT people to experience prejudicial *interpersonal* events, perpetrated by individuals either in violation of the law (e.g., hate crimes, harassment) or within the law (e.g., lawful but discriminatory employment practices). There are numerous

accounts of the excess exposure of LGBT people to such prejudice events (e.g., Meyer, Schwartz, & Frost, 2008; Herek, 2009a, 2009b; Stotzer, 2009; Greytak, Kosciw, & Diaz, 2009).

31. Studies have also shown that unlike other minority groups, rejection can occur at home, and antigay events can be perpetrated by family members, of LGBT children and youth (D'Augelli, Hershberger, & Pilkington, 1998; Diamond, Shilo, Jurgensen, et al., 2011; Ryan, Huebner, Diaz, & Sanchez, 2009). For example, in one study I conducted, a gay man recalled being raped and brutally beaten to unconsciousness at age 13 by a family member who, in the respondent's words "raped me because I was gay and to teach me what a faggot goes through" (Gordon & Meyer, 2007, p. 62). Studies also report of boys and girls who were thrown out of their homes to become homeless because of their family's rejection of their homosexuality (Ryan, Huebner, Diaz, & Sanchez, 2009). In one probability study of high school students conducted in Massachusetts, 16% of sexual minority youth as compared with 3% of heterosexual youth were homeless (Fournier, Austin, & Samples, 2009; from various reasons, not necessarily because of being thrown out of their homes by family).

32. Hate crimes—perpetrated by family or strangers—are a particularly painful type of prejudice event because they inflict not only the pain of the assault itself, but also the pain associated with the social disapproval of the victim's stigmatized social group. The added pain is associated with a symbolic message to the victim that he or she and his or her kind are devalued, debased, and dehumanized in society. Such victimization affects the victim's mental health because it damages his or her sense of justice and order (Garnets, Herek, & Levy, 1990 in Meyer, 2003; Herek, Gillis, & Cogan, 1999). It is not only the pain of the assault but the pain reverberated through the act of the entire community's disapproval, derision, and disdain. One

perpetrator may perpetrate a hate crime, but it is the message of hate of a larger community that makes hate crimes especially painful.

33. The added symbolic value that makes a hate crime more damaging than a similar crime not motivated by hate exemplifies an important quality of minority stress: Prejudice events or even everyday instances of prejudice (often referred to as *everyday discrimination)* can have a powerful impact "more because of the deep cultural meaning they activate than because of the ramifications of the events themselves . . . a seemingly minor event, such as a slur directed at a gay man, may evoke deep feelings of rejection and fears of violence [seemingly] disproportionate to the event that precipitated them" (Meyer, 1995, p. 41-42). Therefore, stress related to stigma is not assessed solely by its intrinsic characteristics but also by its symbolic meaning within the social context: even a minor event or instance can have symbolic meaning and thus create pain and indignity beyond its seemingly low magnitude.

34. Surveys of sexual minority youth report that they are more likely than their peers to encounter chronic harassment, such as being called derogative names. Indeed, such name-calling is commonplace experience for sexual minority youth. A recent survey by the Gay, Lesbian, and Straight Education Network (GLSEN) shows that as many as 85% of sexual minority students were called names or threatened at school (Kosciw, Greytak, Diaz, & Bartkiewicz, 2010). These and similar *everyday discrimination* instances can be damaging even if they are not major events because of the symbolic message of rejection that they convey. Such instances are not acute and do not qualify as life events because they are seemingly minor by any objective measure (in stress language, these incidents bring about little objective change and, therefore, require little adaptation). Nevertheless, they can have a great impact. In the context of school climate such seemingly minor experiences, especially when chronic, can color the entire

social environment sending a message of rejection and disdain to the victim (Dupper & Meyer-Adams, 2002). This message is exacerbated when teachers and school personnel ignore instances of harassment such as name calling (O'Conor, 1993), implicitly joining the perpetrator in rejecting the LGBT youth and sending a message that LGBT youth are to be scorned.

Expectations of Rejection and Discrimination

35. Expectation of rejection and discrimination is another form of minority stress. An expectation of rejection and discrimination is a stressor because of the almost constant vigilance required by members of minority groups to defend and protect themselves against potential rejection, discrimination, and violence (Meyer, 2003). Unlike the concept of prejudice events, where a concrete event or situation—a major or minor life event or a chronic stressor—was present, expectations of rejection and discrimination are stressful even in the absence of an immediate or concrete prejudice experience.

36. Vigilance is not only about physical safety, it is also about embarrassment and awkward social transactions, especially when such transactions can be damaging, for example, affecting school performance. Considering the chronic exposure to prejudice, discrimination, and violence at schools, is not surprising that sexual minority youth would experience great anxiety about even attending school. Indeed, LGBT youth are more likely than their heterosexual peers to report not going to school because they felt unsafe (Coker, Austin, Schuster, 2010; Rosario & Schirmshaw, in press). It is likely that such anxiety, and the vigilance required because of expectations for harm, is responsible for the poorer academic performance and truancy of LGBT youth (Dupper & Meyer-Adams, 2002; Birkett, Espelage, & Koenig, 2009; McGuire, Anderson, Toomey, & Russell, 2010).

CONCEALMENT OF STIGMATIZING IDENTITY

37. Concealing their LGB sexual identity is a way in which some LGB people cope with stigma and related prejudice, discrimination, and violence. By concealing their LGB sexual identity, some LGB individuals hope to protect themselves from the effects of stigma. Despite offering some protections—for example, people who do not conceal their LGB identity are more likely to be victims of antigay violence than are people who conceal their LGB identity (Rosario, Hunter, & Maguen, 2001)—concealing one's LGB identity is itself a significant stressor for at least three reasons I describe below.

38. First, people must devote significant psychological resources to successfully concealing their LGB identity. Concealing requires constant monitoring of one's interactions and of what one reveals about his or her life to others. Keeping track of what one has said and to whom is very demanding and stressful, and leads to psychological distress. Among the effects of concealing are preoccupation, increased vigilance of stigma discovery, and suspiciousness (Pachankis, 2007). For example, researchers studying the cognitive efforts required to conceal stigmatizing conditions described the person who attempts to conceal his or her stigma as living in a "private hell" (Smart & Wegner, 2000, in Meyer, 2003, p. 681). Concealing, and the required cognitive efforts, can lead to significant distress, shame, anxiety, depression, and low self esteem (Frable, Platt, & Hoey, 1998).

39. Second, concealing has harmful health effects by denying the person who conceals his or her LGB identity the psychological and health benefits that come from free and honest expression of emotions and sharing important aspects of one's life with others. Health psychology research has shown that expressing and sharing emotions and experiences can have a

significant therapeutic effect by reducing anxiety and enhancing coping abilities (Meyer, 2003; Pachankis, 2007). In contrast, repression and inhibition can induce health problems. For example, Cole and colleagues found that HIV-related disease advanced more rapidly in a group of gay men who concealed their sexual identity than in a group of gay men with similar HIV infection who did not conceal their sexual identity (Cole et al., 1996a). In another study, these authors showed a similar pattern among HIV-negative men regarding health outcomes unrelated to HIV (Cole et al., 1996b).

40. Third, concealment prevents LGB individuals from connecting with and benefiting from social support networks and specialized services for LGB individuals. Protective coping processes can counter the stressful experience of stigma (Meyer, 2003). Coping processes include the group's effort to counter negative societal structures by creating alternative norms and values and providing role models and social support. Access to and use of such community resources is beneficial to stigmatized minority group members whose experiences and concerns are not typically affirmed in the larger community. For example, LGB communities have provided role models of successful same-sex intimate couples, have provided alternative values that support LGB families, and, in general, counter homophobic messages and values (Weston, 1991). To avoid being discovered LGB people who conceal their sexual identity avoid such institutions as gay or lesbian media, a gay community center, and other gay or lesbian community venues such as a gay pride day celebration.

41. In addition, LGB people who need supportive services, such as competent mental health services, may receive better care from sources in the LGB community (e.g., a specialized gay clinic; Potter, Goldhammer, & Makadon, 2008). But individuals who conceal their LGB identity are likely to fear that their sexual identity would be exposed if they approached such sources.

More generally, concealing can lead to social isolation as the person who conceals his or her sexual identity may avoid contact with other LGB persons but also feel blocked from having meaningful honest social relations with non-LGB individuals.

42. Confronted with a hostile environment or unsupportive adults, it is likely that sexual minority youth would attempt to conceal their identity in an attempt to protect themselves from harm and rejection (D'Augelli, Hershberger, & Pilkington, 1998; D'Augelli, Grossman, & Starks, 2008). Being open about one's sexual orientation in school can lead to hostile reactions including antigay verbal harassment, discrimination, and physical violence as well as increased school absenteeism (Huebner, 2004; Frost & Bastone, 2007). Concealment is often the only coping available to youth, who lack resources and are developmentally and legally dependent on parents and caretakers and therefore cannot change (or flee) a hostile environment. Worries about being discovered can cause great stress and are exacerbated in youth, in part, because of the dependence of children on parents and other adults (Diamond, Shilo, Jurgensen, et al., 2011).

INTERNALIZED HOMOPHOBIA

43. Perhaps the most insidious damage that a hostile school environment generates is the message that homosexuality is to be rejected, that it is shameful, or that it limits or would harm one's prospects for a healthy and happy future. Such messages—especially when propagated by teachers and other respected adults in the community—can be internalized by youth who question their sexual identity and, thus, inflict great pain.

44. Internalized homophobia (also described as *internalized stigma, internalized heterosexism*, *homonegativity*, and *self-stigma*) refers to the internalization of negative societal attitudes about LGB people toward oneself. Internalized homophobia is an insidious stressor

because it is unleashed by the person toward him- or herself due to years of socialization in a stigmatizing society (Meyer, 2003, Herek, 2009a). Both heterosexual and LGB individuals internalize the prejudice and stigma of homosexuality but the effects of this internalization is quite severe for LGB persons who, upon identifying as—or even suspecting they may be—LGB, must learn to dissociate their sense of self from what they have learned as members of society about homosexuality. In what psychologists call the *coming out process*, the LGB person—typically in adolescence and early adulthood—must unlearn these negative values and prejudicial attitudes and adopt new, healthier attitudes and self-perceptions.

45. One of the core stigmas about homosexuality has been the denial of intimacy for LGB couples, the notion that LGB individuals cannot achieve or do not even desire satisfying intimate relationships, and that if they do have intimate relationships they are not as valuable as those of heterosexuals. Such attitudes are refracted by current debates around marriage for gay couples. Other attitudes or perceptions that make up negative stigma of LGB people include that being gay is a disease; that being gay would lead one to become HIV infected or have AIDS; that boys and men are not masculine enough, and girls or women are not feminine enough, to qualify for service in certain professions that are seen as gendered, or conversely, that they can only serve in certain professions; etc.

46. An important aspect of one's self that is affected by internalized homophobia is the *possible self* (Markus & Nurius, 1986)—the view of the self not only as it is but as it can become in the future. Possible selves are an important aspect of one's aspiration and motivation. Possible selves determine not only future success but also current hope and well-being. But possible selves are formed from one's perception of current social norms, values, and

expectations for the future. Among the important sources of possible selves are social conventions, social institutions, role models, and expectations and aspirations of others.

47. Upon realizing and accepting that one is or may be gay, an LGB person must therefore chart a new possible life course that is different from the possible life course of heterosexuals. Indeed, gay youth "recognize that they will not have the same course of life as their parents and heterosexual peers. They will not have a heterosexual marriage; they may not have children or grandchildren. . . . In a society such as ours, where much store is placed in competing and keeping up with one's friends and neighbors, such an identity crisis can unhinge not only sexuality but belief in all future life success" (Herdt & Boxer, 1996, p. 205).

48. For example, in a study of gay youth in Chicago, Herdt and Boxer (1996) noted that coming out begins a process of imagining a possible future. But the researchers found that gay youth had a harder time than heterosexuals imagining life beyond their mid-thirties. That is because when asked to foresee their futures, gay and lesbian youth had foreseen fewer relationship events, such as getting married or becoming a parent than heterosexual youth. The researchers concluded that "one of the great developmental tasks of gay and lesbian youth . . . is the construction of a new set of future expectations of the gay and lesbian life course in the . . . presence of negative stereotypes from the mainstream [heterosexual culture]" (p. 229).

49. Internalizing stigma has grave consequences for the health and well-being of LGB people. Because internalized homophobia disturbs the gay person's ability to overcome stigmatized notions of the self and envision a future life course, it is associated with mental health problems and impedes success in achieving intimate relationships (Meyer, 1995; Meyer & Dean, 1998; Frost & Meyer, 2009).

50. Empirical evidence has demonstrated that LGB people who have higher levels of internalized homophobia are less likely than LGB people with lower levels of internalized homophobia to sustain intimate relationships and, when in a relationship, they have poorer quality of relationships (e.g., Meyer, 1995; Meyer & Dean, 1998; Frost & Meyer, 2009; Balsam & Szymanski, 2005; Otis, Rotosky, Riggle, & Hamrin, 2006).

MINORITY STRESS AS A CAUSE OF ADVERSE MENTAL HEALTH OUTCOMES

51. Exposure to these minority stressors is a risk for mental disorders (including substance use), suicide, risk taking behavior (such are related to HIV or smoking), and other adverse health outcomes.

52. To show causal relationships stemming from minority stress hypotheses, investigators need to demonstrate that LGBT individuals are (a) exposed to greater stressors than their heterosexual peers, (b) that they have worse health outcomes, and (c) that the health outcomes are explained by the exposure to excess stressors (Schwartz & Meyer, 2010). Although causal relationships are difficult to prove in public health research, results from studies of LGBT youth provide solid and irrefutable support for the minority stress hypothesis—showing that social stressors resulting from stigma and prejudice against LGBT populations exposes them to unique stress that, in turn, causes health problems.

53. It has been shown in numerous scientific publications that LGBT individuals, especially youth, have more stressful experiences than their heterosexual peers because of their exposure to stigma and prejudice (e.g., Meyer, Schwartz, & Frost, 2008). Results concerning LGBT youth are abundant and overwhelming in their evidence—indeed, of the numerous published scientific studies conducted on LGBT youth, many with large probability samples, conducted in the United

States, Canada and other nations, I know of *not one* study that shows significant contradictory evidence. LGBT youth at home, at school, and the community at large significantly more frequently than their heterosexual peers experience adverse events. At school, LGBT youth more frequently than heterosexual peers experience bullying, including physical assault; being injured, threatened, and harassed; and having their property stolen or damaged. In general, out of school, sexual minority youth compared with heterosexuals are more often victims of violence, homelessness, physical and sexual abuse, verbal and physical sexual harassment, and forced sex and dating violence (Saewyc, 2011; Coker, Austin, & Schuster, 2010; Rosario & Schrimshaw, in press).

54. Such findings of health disparities between sexual minorities and heterosexuals have been found in both adults and youth. In a recent review of adolescent studies Saewyc (2011, p. 262) noted, "Results on such studies of disparities between LGBT and heterosexual peers have been remarkably consistent, given the diversity of sampling methods, the dimensions of sexual orientation measured, the regions and countries, and across time: within nearly all population-based studies, a higher prevalence of sexual minority youth indicate emotional distress, depression, self harm, suicidal ideation, and suicide attempts than do their heterosexual peers." Such consistencies across studies that vary in methodologies suggest that the findings describe very robust underlying phenomena. That is, convergence of finding from various studies is testament to the strong validity of the conclusion that health disparities between sexual minorities and heterosexuals exist.

55. Studies that assess mental health outcomes provide conclusive evidence that LGBT populations, including youth, have higher prevalence of disorders and adverse health outcomes compared with heterosexuals. Youth is a time that can be particularly stressful to young LGB

people; a time when they realize they are gay and often disclose their minority LGB identity to parents, siblings and other family members, teachers, and/or friends and colleagues (Flowers & Buston, 2001). Minority stress is also associated with a higher incidence of suicide attempts among LGB compared with heterosexual individuals (e.g., Cochran & Mays, 2000; Gilman et al., 2001; Russell & Joyner, 2001; Safren & Heimberg, 1999; Fergusson, Horwood, & Beautrais, 1999; Herrell, Goldberg, True, et al., 1999). This is increase in suicidality is mostly related to minority stress encountered by youth due to coming out conflicts with family and community (Ryan, Huebner, Diaz, & Sanchez, 2009).

56. For example, studies using meta analysis—a quantitative method for summing data from multiple studies—found that the LGB population has about 1.5 to 3 times as many disorders as heterosexuals, including mood, anxiety, and substance use disorders—the three classes of psychiatric disorders typically studied in community surveys—and they are more than twice as likely to have suicide ideation and deliberate self harm (Meyer, 2003; King, Semlyen, Tai, et al., 2008; Marshal, Friedman, Stall, et al., 2008). Other studies have found that LGB people are more likely than heterosexual peers to have eating disorders, (Austin, Ziyadeh, Fisher, et al., 2004; Feldman & Meyer, 2007) and a variety of risky health behaviors, such as HIV risk taking and tobacco use (e.g., Austin, Ziyadeh, Fisher, et al., 2004).

57. Although less often studied, studies also show that LGB individuals have lower levels of well-being than heterosexuals because of exposure to minority stress, such as stigma and discrimination experiences (Frable, Wortman, & Joseph, 1997; Kertzner, Meyer, & Dolezal, 2003; Riggle, Rostosky, & Danner, 2009). This is not surprising because well-being, especially *social well-being*, reflects the person's relationship with his or her social environment—"the fit between the individuals and their social worlds" (Kertzner, Meyer, Frost, & Stirratt, 2009, p. 1).

58. Because of these disparities in health outcomes between LGB people and heterosexuals, sexual orientation, together with race/ethnicity, social class, and other categories, was identified by the U.S. Department of Health and Human Services as a focus for health research and intervention *(U.S. Department of Health and Human Services, 2010)*. A goal of *Healthy People 2020* is to eliminate such disparities in the nation's health. Similarly, the Institute of Medicine—an independent, nonprofit organization that works outside of government to provide unbiased and authoritative advice to decision makers and the public—reviewed of the literature on LGBT health. The review concurs with my testimony here, concluding that minority stress is an essential perspective to understanding causes of adverse health outcomes of LGBT populations (see Institute of Medicine, *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding,* March 2011, available online www.iom.edu).

COPING AND SOCIAL SUPPORT

59. An integral and important part of the stress model is the role of coping and social support. Coping and social support refer to the person's use of resources—either those used by one's self (coping) or those provided by others (social support). Coping and social support act as important moderators of the impact of stress (Aldwin, 2007). Stress theory and research show that coping and social support can reduce the adverse effect of stress on health outcomes. That is, in the face of the same stress—e.g., being bullied or harassed—a person with greater coping and social support resources will fare better than a person without such resources.

60. In the context of minority stress, coping and social support take on an additional unique meaning. For example, while general support may measured as the number of people who provide assistance and the type and quality of the assistance, minority stress related support must

also in various ways support the person in combating negative social attitudes. That is, coping and social support must have an affirmative function—supporting the person as a *gay* person (Meyer, 2003; Crocker & Major, 1989). For example, a seemingly supportive family or church that in the name of support impels their child to abandon homosexuality does not, in fact, provide support for minority stress; indeed they convey a message of rejection and derision of the child's sexual identity and thus add stress.

61. For these reasons, and because families and other community institutions, such as the church, are not always supportive and are sometimes rejecting and even harmful, it is important for schools and community organizations to provide LGBT youth support to counter the many sources of minority stress described above. Many studies, in various settings and using a variety of methods, have shown conclusively that social support from family, teachers, and peers is important in protecting youth from the adverse health effects of minority stress (Bos, Sandfot, de Bruyn, & Hakvoort, 2008; D'Augelli, 2003; Mustanski, Newcomb, & Garofalo, 2011; Williams, Connolly, Pepler, & Craig, 2005; Eisenberg & Resnick, 2006; McGuire, Anderson, Toomey, & Russell, 2010). Collectively, these studies show that when families, friends, and school environments are supportive, much of the observed adverse effects of minority stress on health and school performance outcomes decline.

PUBLIC HEALTH AND POLICY INTERVENTIONS

62. The overwhelming observations on the relationship of stress exposures and health and academic performance outcomes, and the ameliorative effects of coping and social support, has led many schools and national advocacy organizations to create supportive services to LGBT students. A leader in this has been the Massachusetts Board of Education, which in 1993

established the Safe Schools Program for Gay and Lesbian Students. The program provides recommendations to the State's schools aimed at developing school policies that gay and lesbian students from harassment, violence, and discrimination and support the establishment of school-based student support groups (Szalacha, 2003).

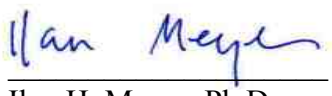
63. Such programs generally aim at increasing sensitivity and awareness of staff and students by using culturally relevant, inclusive teaching materials, introducing (or allowing) student support groups (such Gay Straight Alliance, GSA) in schools. For example, GSAs have been established across the United States to support LGB students and their straight allies by sponsoring social events and initiating changes in schools that enhance understanding and familiarity with and reduce prejudice and hostility toward sexual minorities students (Goodenow, Szalacha, & Westheimer, 2006).

64. Studies of the effectiveness of such programs span over a decade now, they have been conducted in different states and locales and using a variety of methods. These studies consistently indicate that such programs have been effective in improving school environment—including reduced dating violence, threats, and violence and increased sense of safety by LGBT youth—and improving health and educational outcomes such as reducing truancy, injuries at school, and suicide attempts (Goodenow, Szalacha, & Westheimer, 2006; Hatzenbuehler, 2011; Szalacha, 2003).

SUMMARY

65. In summary, a social environment characterized by antigay stigma and prejudice is damaging to the health of LGBT people in that it brings about life events—large and small—and other conditions that are stressful, including antigay harassment and violence. It is an

environment that demands of its LGBT youth vigilance as they watch to protect themselves from such potential events and conditions; an environment where, in an attempt to protect themselves from the stress of this stigma, LGB youth are moved to conceal their LGB identity; and where stigma and stereotypes are internalized by these youth, teaching them to reject their own selves. These stressors cause harm in the form of injuries from violence, suicide, mental health problems, general psychological distress, and lowered well-being among LGBT youth. Coping and social support resources, when they are made available to LGBT youth in schools, have been effective in reducing the harm of minority stressors, including significant reduction in youth suicide.



Ilan H. Meyer, Ph.D.

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EXHIBIT A: CURRICULUM VITAE

Personal Data

Name: Ilan H. Meyer

NIH eRA commons: MEYERL

Academic Training

Tel Aviv University, Tel Aviv, Israel -- B.A. Psychology, Special Education, 1981

New School for Social Research, New York, NY -- M.A. Psychology, 1987

Columbia University, School of Public Health New York, NY – Ph.D. Sociomedical Sciences/ Social Psychology 1993,

Dissertation title: *Prejudice and Pride: Minority Stress and Mental Health in Gay Men*. Bruce G. Link, Ph.D. Sponsor

Traineeship

1987-1992: Pre-doctoral NIMH Fellow in Psychiatric Epidemiology - Columbia University (T32 MH 13043)

1993 -1995: Postdoctoral Fellow, Health Psychology, The Graduate Center at CUNY

1995 -1996: NIMH Research Fellow in Psychiatry (AIDS), Memorial Sloan-Kettering Cancer Center

Professional Affiliations

American Public Health Association

American Psychological Association

American Sociological Association

New York State Psychiatric Institute, HIV Center for Clinical and Behavioral Studies

Center for Population Research in LGBT Health, The Fenway Institute

Academic Appointments

Assistant Professor of Clinical Public Health (part-time), Mailman School of Public Health, Columbia University, November 1994

Assistant Professor of Clinical Public Health, (full-time), Mailman School of Public Health, Columbia University, November 1996

Assistant Professor of Public Health, Sociomedical Sciences (full-time), Mailman School of Public Health, Columbia University, September 1998

Associate Professor of Clinical Sociomedical Sciences, Mailman School of Public Health, Columbia University, July 2003

Deputy Chair for Masters Programs, Department of Sociomedical Sciences, Mailman School of Public Health, Columbia University, February 2004

Professor of Clinical Sociomedical Sciences, Mailman School of Public Health, Columbia University, July 1010

Honors

Distinguished Dissertation - Columbia University, Graduate School of Arts and Sciences

Barbara Snell Dohrenwend Award for published/publishable paper

Marisa De Castro Benton Dissertation Award for outstanding contribution to the Sociomedical sciences - Columbia University

Honorable Mention, Best Dissertation - American Sociological Association, Mental Health Section

Mark Freedman Award for outstanding research on lesbian/gay issues - Association of Lesbian & Gay Psychologists

Distinguished Scientific Contribution Award -- American Psychological Association Division 44.

2006 – 2007 Visiting Scholar, Russell Sage Foundation, New York, NY

May 2010 -- Inaugural Faculty Mentoring Award – Department of Sociomedical Sciences, Columbia University's Mailman School of Public Health

Fellowship and Grant Support

Ongoing Research Support

1. Project title: On the content of our character: The myth of meritocracy and African American health.

Project #, PI, and dates: July 1, 2009 – June 30, 2012

Source and support: Robert Wood Johnson Foundation Investigator Award in Health Policy

Role: Co-PI

Project description: The proposed study aims to investigate some of the ill health effects of meritocratic ideology (MI). We propose to describe the distribution and variation of MI in the United States across historical periods and geographic regions and to assess the relationship between MI ideologies and other ideologies that more explicitly advance inequality. We then aim to describe narratives of MI among African Americans and assess their impact on their physical and mental health.

2. Project title: Minority HIV/AIDS Research Initiative (MARI): Sexual risk-taking among young Black men who have sex with men: exploring the social and situational contexts of HIV risk, prevention, and treatment

Project #, PI, and dates: U01 PS 000700-01 (Wilson) 9/30/07 – 9/29/2011

Source and support: CDC, $592,720

Project description: The 3-year project will research contextual risk and protective factors linked to HIV risk among young Black men who have sex with men (BMSM).

Role: Mentor, Co-investigator

3. Project title: HIV Center for Clinical and Behavioral Studies

Project #, PI, and dates: P30 MH43520 (Ehrhardt) 02/01/08 - 01/31/13

Source and support: NIMH $1,483,545

Project description: This large multidisciplinary AIDS research center focuses on HIV prevention science among neglected populations at risk for HIV infection, with a commitment to underserved inner-city populations and innovative research based on new scientific approaches to prevention that emphasize sexual risk and its broader context of gender,

ethnicity, and culture. Research also focuses on interventions with HIV-infected populations, including those for stress, coping, and medical adherence.

Role: Co-investigator, member Interdisciplinary Research Methods Core

Completed Research Support

1. Project Title: Random Digit Dialing Survey of Gay/Bisexual Men

   Project #, PI, and dates: Meyer, 5//1/95 – 5/1/96

   Source and support amount: American Suicide Foundation, New York State Psychiatric Institute, $5,000

   Role: Principal Investigator

2. Project title: Decreasing the Need for Emergency Asthma Care in Harlem

   Project #, PI, and dates: 5R01HL051492, Ford, 9/1/96 – 7/31/99

   Source and support amount: National Heart, Lung, and Blood Institute $1,800,000 (est.)

   Role: Project Director

3. Project Title: Community Outreach for Asthma Care in Harlem

   Project #, PI, and dates: Meyer, 8/1/99 – 10/1/00

   Source and support amount: New York State Department of Health, $350,000

   Role: Principal Investigator

4. Project Title: Survey of Women's Health and Sexuality

Project #, PI, and dates: Meyer, 3/1/00 – 3/1/01

Source and support amount: Gay and Lesbian Medical Association, Lesbian Health Fund, $7,500

Role: Principal Investigator

5. Project Title: Head Start for Asthma

Project #, PI, and dates: Ford, 9/30/99 – 9/ 29/02

Source and support amount: Centers for Disease Control and Prevention (CDC), $350,000 (annual)

Role: Co-Investigator

6. Project Title: Columbia Center for Children's Environmental Health

Project #, PI, and dates: Perrera, 8/1/98 – 7/ 31/03

Source and support amount: National Institute for Environmental Health Sciences, $901,730 (annual)

Role: Co-Investigator

7. Project Title: Vulnerabilities and strengths in the face of sexual prejudice in lesbians, gay men, and bisexuals

Project #, PI, and dates: Meyer, 10/31/01 – 10/30/03

Source and support amount: American Psychological Association, $50,000

Role: Principal Investigator

8. Project Title: Measurement of Major Stressful Events over Life Courses

Project #, PI, and dates: R01MH059627, Dohrenwend, 2/1/03 – 2/ 31/04

Source and support amount: National Institute of Mental Health, $276,000 (annual)

Role: Co-Investigator

9. Project Title: Prejudice as Stress – writing manuscript

Project #, PI, and dates: 5 G13 LM007660, Meyer, 9/30/02 – 9/29/05

Source and support amount: National Library of Medicine, $163,500

Role: Principal Investigator

10. Project title: Stigma, prejudice and discrimination in public health.

Project #, PI, and dates: Meyer, 9/1/04 – 5/31/06

Source and support amount: The Robert Wood Johnson Health & Society Scholars at Columbia University, $42,000

Role: Principal Investigator

11. Project Title: Stress, Identity, and Mental Health in Diverse Minority Populations

Project #, PI, and dates: R01 MH066058, Meyer, 4/1/03 – 3/31/07

Source and support amount: National Institute of Mental Health, $1,861,700

Role: Principal Investigator

12. Project Title: Diversity supplement doctoral student, Natasha Davis

Project #, PI, and dates: Supplement to 5 R01 MH066058, Meyer, 4/22/05 – 3/31/07

Source: National Institute of Mental Health, $42,000 (est. annual)

Role: Principal Investigator

13. Project Title: Cultural and Contextual Determinants of Alcohol Use Among African American Women: A Multidisciplinary Approach to Breast Cancer Risk

Project #, PI, and dates: BC031019, Kwate, 9/1/04 – 8/31/07

Source and support amount: Department of Defense, Breast Cancer Research Program, $402,206

Role: Mentor to Dr. Kwate, PI.

14. Prejudice and stress in minority populations

Project #, PI, and dates: Meyer, 9/1/07 – 7/31/07

Source of support and amount: Russell Sage Foundation,

Role: Visiting Scholar

Departmental and University Committees

Doctoral Admissions Committee – Present

Coordinator, MPH Research Track – till 2002

Coordinator, MPH Admissions 2002 – 2003

MPH Committee 2003 – Present

Curriculum committee 2003 – Present

School MPH Admissions Committee 2002 – Present

Department of Sociomedical Sciences Steering Committee 2007 – Present

- Department of Sociomedical Sciences Subcommittee on Revenue Generation 2008

Mailman School of Public Health Steering Committee, elected 2008 – 2010

Teaching Experience and Responsibilities

Courses

Introduction to Health Psychology (1995 - 2003)

Research Seminar in Gay and Lesbian Issues in Public Health (1997 – Present)

Stigma, Prejudice and Discrimination as Social Stressors (2004 - Present)

Masters Integrative Project (2005 - Present)

Survey Research Methods in Sociomedical Sciences (2009 - Present)

Dissertation sponsor

Lesley Sept (completed 2002) – *Evaluation of a tailored HIV prevention web site*

Parisa Tehranifar (completed 2004) – *African American adolescents perceptions of everyday racism and their psychological responses—D*istinguished Dissertation; Best Dissertation ASA

Paul Teixeira (defense 2007) – *Condom use among gay men: The impact of reactance and affect on safer sex practices*

Alicia Lukachko (defense 2009) – *Racial identity, discrimination, discrimination and religiosity and use of mental health services among African Americans*

Mentorships -- Post-doctoral fellows/Faculty

Naa Oyo Kwate: Research Scientist, Postdoctoral Award, Department of Defense, Breast Cancer Research Program, Department of Defense

Jennifer Stuber: Scholar, Robert Wood Johnson Foundation Health and Society Scholars

Kimberley Balsam, University of Washington. Consultant, NIMH K-Award application

Carolyn Wong, Ph.D. University of Southern California. Consultant, K-Award application.

José A. Bauermeister, MPH, PhD, University of Michigan, Mentor, K-Award application.

Huso Yi, Columbia University, HIV Center, Mentor, K-Award application.

Rahwa Haile, Columbia University, HIV Center for Clinical and Behavioral Studies, Mentor.

Tracy McFarlane, Columbia University, Psychiatric Epidemiology Training Program, Mentor.

Mentorships -- Pre-doctoral

John Blosnich. West Virginia University, Public Health Sciences, Social & Behavioral Theory. Mentor through Center for Population Research in LGBT Health (Fenway Institute, Boston, MA).

Richard Nobles. Department of Psychology, University of Washington. Consultant on NIMH individual NRSA grant.

Keren Lehavot. Department of Psychology, University of Washington. Consultant on NIMH individual NRSA grant.

Natasha Davis. Columbia University Teachers College. Mentor on supplemental diversity NIMH grant (MH066058).

Edward Alessi (NYU) – Dissertation: *Association of stressful life events and with posttraumatic stress disorder (PTSD) in a racially and ethnically diverse sample lesbian, gay, bisexual (LGB), and heterosexuals*.

David Frost (CUNY Graduate Center) – Dissertation: *Stigma, intimacy, and well-being: A personality and social structures approaches*

David Barnes -- Columbia University Mailman School of Public health, Department of Epidemiology, Psychiatric Epidemiology Training program.

Professional Activities, Consultations, Public Interest

American Civil Liberties Union: Position paper on Gender Identity Disorder and Psychiatric Diagnosis (with Sharon Schwartz)

Gay Men's Health Crisis: Oral Sex & HIV Risk Among Gay Men (with David Nimmons)

1993 – 2002 Co-Chair - Science Committee, American Psychological Association, Division 44 (Lesbian and Gay Issues)

1993 – present Ad hoc reviewer for leading scientific journals, including (partial list), AIDS Education and Prevention: An interdisciplinary Journal, American Journal of Public

Health, Archives of General Psychiatry, Epidemiology, Journal of Health and Social Behavior, Journal of Consulting and Clinical Psychology, Journal of Counseling Psychology, Sex Roles: A Journal of Research, Women and Health, Self and Identity, Developmental Psychology

1999 – 2000 Member, working group preparing a white paper on LGBT health disparities for consideration by US HHS of inclusion of sexual orientation in Healthy People 2010

1999- 2000 Member Healthy People 2010 workgroup on sexual orienation

2000 – 2001 Guest Editor, American Journal of Public Health, Special Issue on LGBT Health, published June 2001

2001 – present Faculty, the Center for Gender, Sexuality and Health, Department of Sociomedical Sciences, Mailman School of Public Health, Columbia University

2003 Member, Working Group -- Workplace discrimination research and prevention, National Institute of Occupational Safety and Health (NIOSH), Cincinnati, OH, September 29-30

2003 Member, Working Group – Men who have sex with men (MSM) of color summit, Los Angeles, CA, May 29-30

2004 – present Faculty, The Robert Wood Johnson Foundation Health & Society Scholars Program at Columbia University

2004 Leader, Working Group on Stigma, prejudice and discrimination. The Robert Wood Johnson Health and Society Scholars Program at Columbia. Mailman School of Public Health, Columbia University

2006 Co-editor, Social Science & Medicine, Special Issue on Prejudice, stigma, and Discrimination in Health

2008 – present Faculty, The Center for the Study of Social Inequalities and Health, Mailman School of Public Health, Columbia University

2009 – 2012 Editorial Board – Journal of Health and Social Behavior

2009 Interview with Dr. Van Nuys
http://www.mentalhelp.net/poc/view_index.php?idx=119&w=9 or

http://tinyurl.com/br6ojl

2009 – 2010 Expert witness for plaintiffs in Perry v. Schwartzenegger, United States District Court for the Northern District of California, San Francisco, CA.

2010 Expert witness – Written testimony in application for asylum, withholding of removal, and/or withholding under the convention against torture. Removal proceedings before Immigration Judge, United States Department of Justice, Executive Office for Immigration Review.

Publications

Original, peer reviewed articles

1. Cournos, F., Empfield, M., Horwath, E., McKinnon, K., Meyer, I., Schrage, H., Currie, C., & Agosin, B. (1991). HIV seroprevalence among patients admitted to two psychiatric hospitals. *The American Journal of Psychiatry, 148*, 1225-1230. PMID: 1883002

2. Meyer, I., Cournos, F., Empfield, M., Agosin, B., & Floyd, P. (1992). HIV prevention among psychiatric inpatients: a pilot risk reduction study. *Psychiatric Quarterly 63*, 187-197. PMID: 1488461

3. Meyer, I., Cournos, F., Empfield, M., Schrage, H., Silver, M., Rubin, M., & Weinstock, A. (1993). HIV seroprevalence and clinical characteristics of severe impatient mentally ill homeless. *Journal of Social Distress and the Homeless, 2*, 103-116. doi: 10.1007/BF01074224

4. Empfield, M., Cournos, F., Meyer, I., McKinnon, K., Horwath, E., Silver, M., Schrage, H., & Herman, R. (1993). HIV seroprevalence among homeless patients admitted to a psychiatric inpatient unit. *The American Journal of Psychiatry, 150*, 47-52. PMID: 8417579

5. Meyer, I., McKinnon, K., Cournos, F., Empfield, M., Bavli, S., Engel, D., & Weinstock, A. (1993). HIV seroprevalence among long-stay patients in a state psychiatric hospital. *Hospital & Community Psychiatry, 44*, 282-284. PMID: 8444444

6. Muenzenmaier, K., Meyer, I., Struening, E., & Ferber, J. (1993). Childhood abuse and neglect among women outpatients with chronic mental illness. *Hospital & Community Psychiatry, 44*, 666-670. PMID: 8192738

7. Cournos, F., McKinnon, K., Meyer-Bahlburg, H., Guido, J. R., & Meyer, I. (1993). HIV risk activity among persons with severe mental illness: Preliminary findings. *Hospital & Community Psychiatry, 44*, 1104-1106. PMID: 8288184

8. Meyer, I., Empfield, M., Engel, D., & Cournos, F. (1995). Characteristics of HIV-positive chronically mentally ill inpatients. *Psychiatric Quarterly, 66*, 201-207. PMID: 7568528

9. Meyer, I. H. & Dean, L. (1995). Patterns of sexual behavior and risk taking among young New York City gay men. *AIDS Education & Prevention, 7*, 13-23. PMID: 8664094

10. Dean, L. & Meyer, I. (1995). HIV prevalence and sexual behavior in a cohort of New York City gay men (aged 18-24). *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology, 8*, 208-211. PMID: 7834405

11. Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior, 36*, 38-56. PMID: 7738327

    REPRINTED: Meyer, I. H. (2003). Minority stress and mental health in gay men. In L. Garnets & D. C. Kimmel (Eds.), *Psychological perspectives on lesbian and gay male experiences* (2nd Ed., pp. 699 - 731). New York: Columbia University Press.

12. Meyer, I. H., Muenzenmaier, K., Cancienne, J., & Struening, E. (1996). Reliability and validity of a measure of sexual and physical abuse histories among women with serious mental illness. *Child Abuse and Neglect, 20*, 213-219. PMID: 8734551

13. Meyer, I. H. & Dean, L. (1998). Internalized homophobia, intimacy, and sexual behavior among gay and bisexual men. In G.M. Herek (Ed.), Stigma and sexual orientation: Understanding prejudice against lesbians, gay men, and bisexuals (pp. 160-186). *Psychological Perspectives on Lesbian and Gay Issues*, Series Editors B. Greene & G.M. Herek. Thousand Oaks, CA: Sage.

14. Siegel, K., Lune, H. & Meyer, I.H. (1998). Stigma management among gay/bisexual men with HIV/AIDS. *Qualitative Sociology, 21*, 3-24. doi: 10.1023/A:1022102825016

    REPRINTED: D.H. Kelly and E.J. Clarke (Eds.), Deviant behavior: A text-reader in the sociology of deviance (pp. 263 – 281). NY: Worth Publishers.

15. ** Siegel, K. & Meyer, I. H. (1999). Hope and resilience in suicide ideation and behavior of gay and bisexual men following notification of HIV infection. *AIDS Education & Prevention, 11*, 53-64. PMID: 10070589

16. Meyer, I. H. & Colten, M. E. (1999). Sampling gay men: Random digit dialing versus sources in the gay community. *Journal of Homosexuality, 37*, 99-110. PMID: 10482333

17. ** Dean, L., Meyer, I. H., Sell, R. L., Sember, R., Silenzio, V., Bowen, D. J., Bradford, J., Rothblum, E. D., Scout, White, J., Dunn, P., Lawrence, A., Wolfe, D., & Xavier, J. (2000). Lesbian, gay, bisexual, and transgender health: Findings and concerns. *Journal of the Gay and Lesbian Medical Association, 4*, 102-151. doi: 10.1023/A:1009573800168

18. Ford, J.G. Meyer, I.H., Sternfels, P, Findley, S.E., McLean, D.E., Fagan, J.K., & Richardson, L. (2001). Patterns and predictors of asthma-related emergency department use in Harlem. *Chest, 120*, 1129-1135. PMID: 11591549

19. Meyer, I.H., Sternfels, P., Fagan, J.K., Copeland, L., & Ford, JG. (2001). Characteristics and Correlates of Asthma Knowledge Among Emergency Department Users in Harlem. *Journal of Asthma, 38*(7), 531-539. PMID: 11714075

20. Perera, F.P., Illman, S.M., Kinney, P.L., Whyatt, R.M., Kelvin, E.A., Shepard, P., Evans, D., Fullilove, M., Ford, J.G., Miller, R.L., Meyer, I., & Rauh, V. (2002). The challenge of preventing environmentally related disease in young children: Community-based research in New York City, *Environmental Health Perspectives, 110*(2), 197-204. PMCID: PMC1240736

21. Northridge, M.E., Meyer, I.H., & Dunn, L. (2002). Overlooked and Underserved in Harlem: A population-based survey of adults with asthma. *Environmental Health Perspectives, 110*, Supplement 2, 217-220. PMCID: PMC1241166

22. Meyer, I.H., Sternfels, P., Fagan, J.K., & Ford, J.G. (2002). Asthma-related limitations in sexual functioning: An important but neglected area of quality of life. *American Journal of Public Health, 92*, 770-772. PMCID: PMC1447159

23. Lewin, S. & Meyer, I.H. (2002). Torture and ill-treatment based on sexual identity: the roles and responsibilities of health professionals and their institutions. *Health and Human Rights, 6*(1), 161-176.

24. Meyer, I. H., Rossano, L., Ellis, J., & Bradford, J. (2002). A brief telephone interview to identify lesbian and bisexual women in random digit dialing sampling. *Journal of Sex Research, 39*, 139-144. PMID: 12476246

25. Meyer, I.H., Whyatt, R.M., Perera, F.P., & Ford, J.G. (2003). Risk for asthma in 1-year-old infants residing in New York City high-risk neighborhoods. *Journal of Asthma, 40* (5), 545 – 550. PMID: 14529104

26. Meyer, I.H. (2003). Prejudice as stress: Conceptual and measurement problems. *American Journal of Public Health, 93*, 262-265. PMCID: 1447727

27. Meyer, I.H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*, 674–697. PMCID: 2072932

28. Pesola, G. R., Xu, F., Ahsan, H., Sternfels, P., Meyer, I.H., & Ford, J.G. (2004). Predicting asthma morbidity in Harlem emergency department patients. *Academic Emergency Medicine, 11*(9), 944-950. PMID: 15347544

29. **Young, R. & Meyer, I.H. (2005). The trouble with “MSM” and “WSW”: Erasure of the sexual-minority person in public health discourse. *American Journal of Public Health, 95*, 1144-1149. PMCID: 1449332

30. **Feldman, M. B., & Meyer, I. H. (2007). Eating disorders in diverse lesbian, gay, and bisexual populations. *International Journal of Eating Disorders, 40,* 218 – 226. PMCID: 2080655

31. **Feldman, M.B. & Meyer, I.H. (2007). Childhood abuse and eating disorders in gay and bisexual men. *International Journal of Eating Disorders, 40,* 418 – 423. PMCID: 2042584

32. Gordon, A. & Meyer, I.H. (2007). Gender nonconformity as a target of prejudice, discrimination and violence against LGB individuals. *Journal of LGBT Health Research, 3(3)*, 55–71. PMID: 19042905

33. Stirratt, M. J., Meyer, I. H., Ouellette, S. C., & Gara, M. (2008). Measuring identity multiplicity and intersectionality: Hierarchical Classes Analysis (HICLAS) of sexual, racial, and gender identities. *Self & Identity, 7 (1)*, 89 – 111. doi: 10.1080/15298860701252203

34. *Meyer, I.H., Dietrich, J.D., & Schwartz, S. (2008). Lifetime prevalence of mental disorders and suicide attempts in diverse lesbian, gay, and bisexual populations. *American Journal of Public Health, 98*, 1004 – 1006. PMID: 17901444

35. Meyer, I. H., Schwartz, S., & Frost, D. M. (2008). Social patterning of stress and coping: Does disadvantaged social statuses confer more stress and fewer coping resources? *Social Science & Medicine, 67*, 368-79. PMCID: 2583128

36. Kwate, N.O. & Meyer, I.H. (2009). Association between residential exposure to outdoor alcohol advertising and problem drinking among African American women in New York City. *American Journal of Public Health. 99,* 228-30. PMID: 19059857

37. Narváez, R. F., Meyer, I.H., Kertzner, R.M., Ouellette, S.C. & Gordon, A.R.(2009). A qualitative approach to the intersection of sexual, ethnic, and gender identities. Identity, *9*(1), 63-86. doi: 10.1080/15283480802579375

38. Frost, D.M., & Meyer, I.H. (2009). Internalized homophobia and relationship quality among lesbians, gay men, and bisexuals. *Journal of Counseling Psychology, 56,* 97–109. PMC Journal – In Process. PMCID: PMC2678796

39. Meyer, I.H. & Wilson, P. (2009). Sampling lesbian, gay, and bisexual populations. *Journal of Counseling Psychology, 56,* 23–31. doi:10.1037/a0014587 PMC Journal – In Process

40. Kertzner, R. M., Meyer, I. H., Frost, D. M., & Stirratt, M. J. (2009). Social and psychological well-being in lesbians, gay men, and bisexuals: The effects of race, gender, age, and sexual identity. *Journal of Orthopsychiatry, 79(4), 500-510.* PMID: 20099941; PubMed - in process. PMCID: PMC2853758.

41. Kwate, N.A. & Meyer, I.H. (2009). Individual and group racism and problem drinking among African American women. *Journal of Black Psychology*. OnlineFirst, published on December 11, 2009 as doi:10.1177/0095798409355795. PMC Journal – In Process.

42. Meyer, I.H. (2010). Identity, stress, resilience in lesbians, gay men, and bisexuals of color. *The Counseling Psychologist, 38(3*), 442-454 *.* doi: 10.1177/0095798409355795. PMC Journal – In Process.

43. Schwartz, S. & Meyer, I.H. (2010). Mental health disparities research: The impact of within and between group analyses on tests of social stress hypotheses. *Social Science & Medicine,* 70(8), 1111-1118*.* PMID: 20100631.

44. Feldman, M.B., & Meyer, I.H. (2010). Comorbidity and age of onset of eating disorders in gay men, lesbians, and bisexuals. *Psychiatry Research*. doi:10.1016/j.psychres.2009.10.013, PMC Journal – In Process. PMID: 20483473.

45. Kwate, N.O. & Meyer, I.H. (2010). The Myth of meritocracy and African American health. *American Journal of Public Health.* (Published online ahead of print August 19, 2010: e1-e4. doi:10.2105/AJPH.2009.186445). PMID: 1883002.

46. O'Donnel, S., Meyer, I.H., & Schwartz, S. (2011). Increased risk for suicide attempts in Black and Latino lesbians, gay men, and bisexuals. *American Journal of Public Health.* Published online ahead of print April 14, 2011: e1-e4. doi:10.2105/AJPH.2010.300032

47. Kwate, N.O. & Meyer, I.H. (2011). On sticks and stones and broken bones stereotypes and African American health. *Du Bois Review: Social Science Research on Race, 8 (1)*, 191 – 198.

48. Frost, D.M. & Meyer, I.H. (2011). Measuring Community Connectedness among Diverse Sexual Minority Populations. *Journal of Sex Research.* First Published Online April 19, 2011 (iFirst) DOI: 10.1080/00224499.2011.565427.

Reviews, Chapters and Editorials

1. Meyer, I.H. (1992). Book Review: Inventing AIDS by Cindy Patton. *Women & Health, 18*(1), 137-142.

2. Nimmons, D. & Meyer, I.H. (1996). *Oral sex & HIV risk among gay men: Research summary*. NY: Gay Men's Health Crisis report.

3. Meyer, I.H. (1998). Oral sex – Fellatio. In Raymond A. Smith (Ed.) *Encyclopedia of AIDS: A social, political, cultural, and scientific record of the HIV epidemic* (p. 384 – 386). Chicago: Fitzroy Dearborn Publishers.

4. ‡ ** Meyer, I. H. & Schwartz, S. (2000). Social issues as public health: Promise and peril. *American Journal of Public Health, 90*, 1189-1191. PMCID: PMC1446330

5. Meyer, I. H. (2001). Why lesbian, gay, bisexual, and transgender public health? *American Journal of Public Health, 91*, 856-859. PMCID: PMC1446455

6. ‡ ** Lewin, S. & Meyer, I.H. (2001). Torture, ill-treatment, and sexual identity. *The Lancet, 358*, Dec 1, 1899-1900. PMID: 11741651

7. ‡ * Meyer, I.H. (2002). Smearing the queer: Medical bias in the health care of gay men by Michael Scarce (Essay Review). *International Journal of Epidemiology, 31*(2), 501-503. doi: 10.1093/ije/31.2.501

8. ‡ Kertzner, R., Meyer, IH., & Dolezal, C. (2003). Psychological Well-Being in Midlife Older Gay Men. In G. Herdt & B. de Vries (Eds.) *Gay and Lesbian Aging Research and Future Directions* (pp 97-115). NY: Springer Publishing Company.

9. ‡ *Meyer, I.H. (2005). Book review: Lesbian and gay psychology: New perspectives by Adrian Coyle and Celia Kitzinger. *Culture, Health & Sexuality: An International Journal for Research, Intervention and Care, 7*(2), 179 - 182.

10. ‡ * Meyer, I.H. (2007). Prejudice and discrimination as social stressors. In I.H. Meyer and M.E. Northridge (Eds.), *The health of sexual minorities: Public health perspectives on lesbian, gay, bisexual and transgender populations* (pp. 242 – 267). New York: Springer.

11. Stuber, J.S., Meyer, I.H., & Link, B.G. (2008). Stigma, prejudice, discrimination and health. An introduction to special issue, *Social Science & Medicine.* 67, 351- 7. PMID: 18440687

12. ‡*Meyer, I.H. & Ouellette, S.C. (2009). Unity and purpose at the intersections of racial/ethnic and sexual identities. In Phillip L. Hammack and Bertram J. Cohler (Eds.), *The story of sexual identity: Narrative perspectives on the gay and lesbian life course* (pp. 79 – 106). NY: Oxford University Press.

13. Schwartz, S. & Meyer, I.H. (2010). Reflections on the stress model: A response to Turner. *Social Science & Medicine, 70(8), 1121-1122.* doi:10.1016/j.socscimed.2009.11.038

14. Meyer, I.H. (2010). The right comparisons in testing the minority stress hypothesis: Comment on Savin-Williams, Cohen, Joyner, and Rieger. *Archives of Sexual Behavior.* Published online: August 2010. doi: 10.1007/s10508-010-9670-8.

15. Meyer, I.H. (in press). The health of sexual minorities. In: *Handbook of Health Psychology (2nd Edition).*

Note: ‡ Peer reviewed

Books

Meyer, I.H. & Northridge, M.E. (Eds.). (2007). The health of sexual minorities: Public health perspectives on lesbian, gay, bisexual and transgender populations. New York: Springer.

Manuscripts in Press

In Review

In Preparation

Meyer, I.H. Intersectionality of Identity in Stress and Health.

Meyer, I.H. *Prejudice and stress in diverse disadvantaged populations (Working title)*. Book.

Abstracts, Proceedings, and Papers Presented at Conferences (partial list)

Meyer, I.H. Experience from a community-based asthma intervention. Working Together to Combat Urban Asthma. Proceedings of a Conference hosted by the Center for Urban Epidemiologic Studies at the New York Academy of Medicine. New York, May 4 and 5, 1998.

Meyer I.H., Copeland L., Findley S., McLean D.E., Richardson L., Ford J.G.: The Harlem asthma knowledge questionnaire. Paper presented at the International Conference of the American Thoracic Society, Chicago, IL. April 24 - 29, 1998

Meyer, I.H., Richardson, L., Findley, S., McLean, D., Trowers, R., Ford, J.G. (1999). Predictors of frequent asthma-related emergency department use in Harlem. American Journal of Respiratory and Critical Care Medicine, 159: (3) A129-A129, Suppl. S.

Ford, J.G., Li, Y., Meyer, I.H., Dave, C., DeGraffinreidt, D. (1999). beta(2)-adrenoreceptor B16 and B27 polymorphisms and asthma severity. American Journal of Respiratory and Critical Care Medicine, 159: (3) A31-A31, Suppl. S.

Meyer I.H. Reducing Disparities in Asthma Care: Are We Doing Enough?. The 96th International Conference of the American Thoracic Society, Toronto, Canada. May 5 –10, 2000

Meyer I.H., Fagan J., Sternfels P., Foster K., Dave C., Ford J: Asthma-Related Limitation in Sexual Functioning among Emergency Department Users. The 96th International Conference of the American Thoracic Society, Toronto, Canada. May 5 –10, 2000

Meyer, I.H. Minority stress and mental health in lesbian and gay populations. Paper presented at the 26th Annual Meeting of the International Academy of Sex Research, Paris, France. June 21 –24, 2000.

Meyer, I.H. Epidemiology of mental health in gay men: What do we know and what do we need to know? Paper presented at the Gay Men's Health Summit, Boulder, Colorado. July 19 – 23, 2000.

Meyer, I.H., Community outreach for asthma care in Harlem: Broad based community, clinic, and research collaboration. Paper presented at the Annual Meeting of the American Association of Public Health, Washington, DC, November 13, 2000.

Meyer, I.H., Gay and bisexual men's health: What we know, what we need to know, what we need to do. Paper presented at the Annual Meeting of the American Association of Public Health, Washington, DC, November 15, 2000.

Meyer, I.H., Rossano, L., Ellis, J., & Bradford, J. Use of a brief telephone interview to identify lesbian and bisexual women in random digit dialing sampling. Paper presented at the 56th Annual Conference of the American Association of Public Opinion Research, Montreal, Canada, May 17 – 20, 2001.

Meyer, I.H. (2003). Prejudice as stress: Conceptual and measurement problems. Paper presented at the Eighth International Conference on Social Stress Research, Portsmouth, NH, April 2002.

Meyer, I.H. (2003). Minority stress and mental health in lesbians, gay men, and bisexuals. Paper presented at the annual meeting of the American Psychiatric Association, San Francisco, May 17 – 20, 2003.

Meyer, I.H. (2004). Expectations of stigma as a stressor in minority populations. Paper presented at the Ninth International Conference on Social Stress Research, Montreal, Canada, May 28 – 31, 2004.

Meyer, I.H. (2005). LGBT health research: Theoretical issues and research ethics. Enhancing the Health and Well-being of LGBT Individuals, Families and Communities: Building a Social Work Research Agenda. Symposium of the Institute for the Advancement of Social Work Research, Washington, D.C., June 23-24, 2005

Meyer, I. H. (2005, August). *Intersectionality in LGB health research*. Paper presented at the annual convention of the American Psychological Association (APA), Washington, DC.

Meyer, I. H. (2006, March). *Stress and mental health lesbian, gay, and bisexual individuals.* Paper presented at Temple Concord, Binghamton, NY (co-sponsored by Binghamton University, Pride and Joy Families, and the Temple Concord Outreach Committee).

Meyer, I. H. (2006, March 23). *Social stress, identity, and mental health in diverse lesbian, gay, and bisexual populations.* Paper presented at Binghamton University, Binghamton, NY.

Meyer, I. H. (2006, May 18). *Race, gender, and sexual orientation variability in exposure to stress related to prejudice.* Paper presented at the Psychiatric Epidemiology Training Seminar, Mailman School of Public Health, Columbia University.

Meyer, I, H., Schwartz, S., Stirratt, M. J., & Frost, D. M. (2006, August). *Identity, stress, and coping in lesbian, gay, and bisexual populations*. Paper presented at the annual convention of the American Psychological Association (APA), New Orleans, LA.

Frost, D. M., & Meyer, I. H. (2006, August). *Internalized homophobia as a predictor of intimacy-related stressors among gay, lesbians, and bisexual individuals*. Poster presented at the annual convention of the American Psychological Association (APA), New Orleans, LA.

Meyer, I.H. (2006, October). *Social stress related to prejudice and discrimination as a cause of mental disorders: Conceptual issues and research findings*. Paper presented at the Yale University Psychology Colloquium.

Meyer, I. H., Dietrich, J., & Schwartz, S. (2006, November). *Prevalence of DSM-IV disorders in diverse lesbian, gay, and bisexual populations.* Paper presented at the annual convention of the American Public Health Association (APHA). Boston, MA.

Frost, D. M., Dietrich, J., Narvaez, R. F., & Meyer, I. H. (2006, November). *Improving community sampling strategies of diverse lesbian, gay, and bisexual populations*. Paper presented at the annual convention of the American Public Health Association (APHA). Boston, MA.

Gordon, A. R., & Meyer, I. H. (2006, November). *Gender nonconformity as a target of prejudice, discrimination, and violence against LGB individuals*. Paper presented at the annual convention of the American Public Health Association (APHA), Boston, MA.

Kertzner, R. M., Meyer, I. H., Frost, D. M., & Stirratt, M. J. (2006, November). *Psychological and social well-being in lesbians, gay men, and bisexuals: The effects of age, sexual orientation, gender, and race.* Paper presented at the annual convention of the American Public Health Association (APHA), Boston, MA.

Meyer, I.H. (2008, July) Social stress and mental health outcomes in lesbians, gay men and bisexuals. Paper presented at the XXIX International Congress of Psychology, Berlin, Germany.

Meyer, I.H. (2008, August). Random versus venue-based community sampling of lesbians, gay men, and bisexuals, Paper in a symposium titled *Innovative research methodologies for advancing LGBT scholarship*. American Psychological Association 2008 Annual Convention, Boston MA

Frost, D.M. & Meyer, I.H. (2008, August). Social Support Networks among Diverse Sexual Minority Populations. Poster presented at the American Psychological Association 2008 Annual Convention, Boston MA

Invited Presentations (partial list)

Meyer, I.H. (2004, March 26). *Minority Stress: The Impact of Stigma, Prejudice, and Discrimination on the Mental Health of LGB populations*. Gay Men's Health Center, New York, NY.

-- (2004, September 28). *Stress, identity, and mental health in minority populations.* Sociomedical Sciences Seminar, Mailman School of Public Health, Columbia University.

-- (2004, October 7). *Prejudice, Identity, and Resilience in Minority Mental Health*. Rutgers University.

-- (2006, February 7). *Stress, identity, and mental health: overview*. Sociomedical Sciences Seminar, Mailman School of Public Health, Columbia University.

-- (2006, March). *Stress and mental health lesbian, gay, and bisexual individuals.* Temple Concord, Binghamton, NY (co-sponsored by Binghamton University, Pride and Joy Families, and the Temple Concord Outreach Committee).

-- (2006, March 23). *Social stress, identity, and mental health in diverse lesbian, gay, and bisexual populations*. Binghamton University, Binghamton, NY.

-- (2006, May 18). *Race, gender, and sexual orientation variability in exposure to stress related to prejudice*. Psychiatric Epidemiology Training Seminar, Mailman School of Public Health, Columbia University.

-- (2006, October 12). Clinical lunch talks, Department of Psychology, Yale University.

-- (2006, November 1). *Social stress related to prejudice and discrimination as a cause of mental disorders*. Temple University, Philadelphia, PA.

-- (2007, February 11). Russell Sage Foundation, Scholars Seminar. *Stress related to prejudice as a cause of mental disorders*. Russell Sage Foundation, New York, NY

-- (2007, September 20). *Stress, Identity, and Health in Diverse NYC LGB Communities.* HIV Center for Behavioral Studies, New York State Psychiatric Institute, New York, NY

-- (2007, June 5). Invited Keynote Address, The NIH 11th Annual Noon-in-June Program: An Observance of Gay, Lesbian, Bisexual & Transgender Pride Month at the National Institutes of Health. *The impact of prejudice on the mental health of lesbians, gay men, and bisexuals.* Bethesda, MD

-- (October, 2007). *Stress, Identity, and Mental Health in Diverse NYC LGB Communities?* St. Luke-Roosevelt Hospital, New York, NY

-- (2007, November 14). *Stress exposure and mental health outcomes: Are women disadvantaged?* Johns Hopkins University, Baltimore, MD.

-- (2007, November 29). Invited speaker: AAPOR NY symposium on lesbian and gay men. *The Impact of Prejudice and Discrimination on the Mental Health of LBG Populations.* Hunter College, New York, NY

-- (2008, January 6). Trevor Project suicide prevention helpline . *Staff training: Minority stress and health of LGB persons*. New York, NY

-- (2008, April 25). Invited speaker: *Minority stress and LGBT public health.* Breaking the Silence: LGBT Research at Columbia and Beyond, Columbia University, New York, NY

-- (2008, May 29). Keynote Speaker, Maine LGBTI Health Summit: Challenges, Opportunities, Change. *Social Stress and Health Disparities of LGBTI populations.* Augusta, ME

-- (2008, September 17) Personality/Social Psychology Colloquia. *Social Psychology and Minority Stress Models.* Graduate Center of the City University of New York. New York, NY.

-- (2008, October 17). *Prejudice, Social Stress and Mental Health.* Psychiatry Grand Rounds. Memorial Sloan-Kettering Cancer Center, New York, NY.

-- (2009, February 27). *LGBT public health.* UNC Minority Health Conference. UNC Gillings School of Global Public Health, Chapel Hill, NC

-- (2009, March 18). *Minority (Social) Stress.* Drexel University, Philadelphia, PA.

-- (2009, May 1). Keynote Speaker. Queer Health Task Force Conference, Columbia University, Mailman School of Public Health.

-- (2009, September 22). Gender, Sexuality, and Health seminar. *Social stress as a cause of mental disorder: research findings and reflections on a theory.* Columbia University, Mailman School of Public Health, Department of Sociomedical Sciences. New York, NY

-- (2009, October 8). Robert Wood Johnson Foundation Investigator Awards in Health Policy Research, 2009 Annual Meeting. With Naa Oyo Kwate. *On the content of our character: The myth of meritocracy and African American health.* San Diego, CA

-- (2009, December 1). Keynote Speaker. World AIDS Day Symposium *Minority Stress Theory, Findings, and Implications for HIV/AIDS Prevention with Racial/Ethnic Minority Gay and Bisexual Men.* University of California San Francisco, Parnassus Campus. San Francisco, CA

-- (2009, December 3). *Social stress as a cause of mental disorders: Research findings and reflections on a theory*. Palo Alto University, Palo Alto, CA

-- (2010, March 22). Invited address. *Mental Health: Stress and Protective Factors.* Institute of Medicine, Board on the Health of Select Populations. Committee on Lesbian, Gay, Bisexual, and Transgender Health: Issues and Research Gaps and Opportunities. Washington, DC

-- (2010, April 27). Invited address. *Bring gay back to the MSM health crisis.* Invited address, The Sexual Health of Gay Men and other MSM: HIV/STD Prevention Plus Conference, The Fenway Institute, Fenway Health, Boston, MA.

-- (2010, May 5). Keynote Speaker. LGBT Resiliency: From Trauma To Policy, Boston College, Boston, MA

-- (2010, May 7). Invited Speaker. *Sexual Orientation and Disparities in Mental Health.* Kellogg School of Management, Northwestern University, Chicago, IL.

-- (2010, June 28 – July 1). Lecturer. National Sexuality Resource Center at San Francisco State University Summer Institute. San Francisco, CA.

-- (2010, August 11). Lecturer. Boston University/Fenway Health Summer Institute, Boston, MA

-- (2010, August 13). Invited Speaker. *Marriage Inequality, Structural Stigma, and Health: Lesbian, Gay, and Bisexual People.* American Psychological Association, Presidential program on Marriage Equality. San Diego, CA

-- (2011, April 8-10). Invited Speaker: *Research, Advocacy, and the Constitutional Challenge to the Prop 8 Ban on Gay Marriage in California*. 2011 Pride and Joy Families Weekend Conference, Rochester, NY.

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* Lead author

** Authors contributed equally