Mental Health Sequelae Of Bullying: A Review and Case Report

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ABSTRACT

This paper is a review of the effects of bullying on children and adolescents. We begin with a case report of a young male who presented at a children's hospital emergency room after being subjected to months of bullying. We then proceed to a review of relevant literature, and focus on a definition of bullying, the incidence of this problem, and the characteristics of bullies, victims and those who both bully and are bullied. The consequences of this behaviour, both for the perpetrator and victim, are also examined. We note that all individuals who participate in bullying, whether as perpetrators, victims, or those who have been both the perpetrators and the targets of this particular form of aggression, have in some way been psychologically affected by such experiences. It is hoped that the significance of bullying behaviour, and its psychological cost on the psychological well-being of the children and adolescents involved with bullying, will be a central theme of this review.

Introduction

What is bullying? Who does it involve? Why does it happen? What are the consequences? These are questions, which often arise in the study of bullying behaviour, and highlight issues of violence in our schools and homes, and of under reported victimization and questionable parenting. The tragedy of bullying behaviour is not only that it occurs, but that its effects are long-lasting and often unappreciated (or even ignored) by those who have primary responsibility for the care and welfare of children. Rappaport (2001) pointed out regarding the school site:

> The most overlooked dynamic in bullying is the role staff members may have in escalating a conflict. Often administrators, in the interest of being fair, hand out cookbook discipline that does not give students (and staff) an opportunity to be reflective about their actions but instead reinforces the coercive punitive intent of a staff member. Many times adults/staff are not held responsible for their actions in the context of a public school system that allows employment for life with limited accountability. This may contribute to our reluctance to examine in schools the parallel process, in which students act as bullies, implicitly mirroring the aggressive climate that is sometimes endorsed by teachers.

The following case presentation is a clinical account of the effect of bullying on one young teenager, and the issues identified in the case parallel those reviewed in the literature. The case acts as a springboard to examine the larger issues of bullying, its meaning, prevalence and consequences. Psychological profiles of both bullies and victims are presented, as well as the mental health sequelae for the children involved. We hope that this introduction to the topic will help to raise awareness regarding this all too-frequent behaviour, as well as to the immediate and long-term developmental costs to the children who are both its instigators and its victims.

Case Presentation – GS

GS is a thirteen year-old male and a Grade 9 student at an urban middle school. He presents at the children's emergency room of a tertiary care hospital with his mother, having been referred by his family doctor. The emergency psychiatry service is consulted because the family doctor is concerned about suicidal ideation expressed by the boy earlier in the week.

On enquiry, the boy states that two days prior, he was working on a computer at his school, when the "class bully" and two other boys approached him. GS was alone at the time. The bully told him that he was stupid, ugly and everyone hated him. The bully added that GS was a "waste of space", and concluded: "Why don't you just kill yourself, everyone thinks you're a joke". The other boys laughed and taunted the patient for several minutes before finally leaving him alone.

On his way home from school that day, the patient became increasingly upset, as he thought about what had happened. He began to feel that he was useless, and stupid, and alone. He was also enraged at himself for not responding or defending himself. Suddenly he had the urge to throw himself in front of a city bus, and actually walked to the curb

before turning away, stating: "I was too chicken". Instead, he found a payphone and called his mother at work. She told him to go home immediately and that she will meet him there. By the time she arrives at home, the suicidal feelings had passed.

The next afternoon, there was a meeting at the school attended by the patient, his mother, the vice-principal, the guidance counsellor, and the school psychologist, who was concerned about the possibility of a major depression. As a result, the family contacted the family doctor, who recommended that the patient be brought to the emergency room.

GS told the Psychiatry emergency team that he had been bullied by this boy for the entire school year. The bullying took various forms, including insults, enlisting other boys to taunt GS, physical humiliations such as being kicked or spat on, and painful attacks such as being stabbed with a pencil or geometry compass. The patient explained that when he has complained in the past, the school had done nothing more than reprimand the other boy, which "only makes things worse for me". GS described feeling sad, ugly and useless as a result of the bullying. He stated: "I just wither away in my own little world". He had initially sought help from the school guidance counsellor and subsequently from the school psychologist, whom he has seen bi-monthly for five months, at the school. His family doctor initiated Sertraline at a dose of 25 mg. daily five days before he was seen at Emergency. GS denied changes in sleep, appetite or concentration, or poor school performance.

GS denied prior contact with any mental health professional (apart from the school psychologist) and insisted that he has never before had suicidal thoughts. He was generally in good health, and on no medications apart from Sertraline. There was a significant family history of mood disorders: his maternal great-uncle committed suicide while depressed, and his maternal aunt suffered from depression as well. GS also stated that two of his paternal uncles committed suicide, but noted that: "One of them was involved with drugs and alcohol."

GS lived with his mother and his seven-year old brother. His parents had been divorced for about seven or eight years and he saw his father on weekends. He stated that his father had a gambling addiction, and used to abuse alcohol. GS denied any use of alcohol or street drugs. He stated that his interests included playing on the computer and playing games with Alex, his one friend. He denied any history of legal charges.

On examination, GS presented as a slender, 13 year-old male dressed in torn pants and a dirty jacket. He was not visibly agitated, nor was there evidence of psychomotor retardation. Although there was no notable facial dysmorphism, he did have prominent epicanthal folds and a thin upper lip, raising the question of Fetal Alcohol Effects. He made adequate eye contact throughout the assessment. Speech was normal in volume, rate and tone, and was not tangential. His mood was "sad" and his affect was somewhat flat. Thought processes were clear and logical. Thought content was notable for the absence of suicidal or homicidal ideation, and he described his brief thoughts of suicide as "a mistake, an over reaction. I don't want to be dead". There were no psychotic symptoms such as delusions or thought broadcasting, withdrawal or insertion. There was some evidence of depression, including endorsement of sadness, hopelessness and worthlessness. However, other neurovegetative signs and symptoms of depression were absent. There was no evidence of perceptual disturbances, and judgment and insight were both fair, with good reliability. GS was noted to be alert and oriented, and cognition appeared grossly intact.

The initial diagnostic impression was that of an adjustment disorder with features of depression and anxiety. As he was not suicidal, homicidal, psychotic nor severely depressed, he was not admitted. A referral was made to an outpatient program in the Child and Adolescent Mental Health Program. Both GS and his mother (present during the latter part of the assessment) indicated that they were satisfied with this outcome.

Definitions and Incidence of Bullying

Besag (1989) described bullying as being 'The repeated attack - physical, psychological, social or verbal - by those in a position of power, which is formally or situationally defined, on those who are powerless to resist, with the intention of causing distress for their own gain or gratification'. Olweus (1994) noted that bullying is characterized by aggressive behaviour or intentional "harm doing", which is carried out "repeatedly and over time", in an interpersonal relationship characterized by an imbalance of strength. He noted that there may be individual or group bullying (or victims), and that bullying may be direct or indirect. Indirect bullying includes slandering and spreading of rumours and manipulation of friendship relationships, which is more common among girls. Harassment with non-physical means (words, gestures, threats) is also the most common form of bullying among boys.

Bullying also includes name-calling. Teasing is ubiquitous in life, having both positive and negative effects. It may be playful and fun when done in sport or mischief. Important factors include individual attributional differences, social context and the relationship among participants, thus distinguishing between teasing that the recipient considers playful and teasing that is considered harmful. In addition, cultural differences may exist with respect to conduct that can be considered bullying, and thus unacceptable. For example, Boulton (1999) has found that there are significant differences between English and Swedish secondary pupils' attitudes towards, and conception of bullying. A significantly larger percentage of English than Swedish pupils indicated that name-calling is bullying, whereas the reverse was true for leaving somebody out.

The incidence of bullying varies with the location surveyed, but this behaviour is clearly a significant problem worldwide. In Canada, the incidence of being bullied amongst school-age children in Toronto has been estimated at 20% (Ziegler and Rosenstein-Manner, 1991). Fried and

Fried (1997) estimated that there are 2.1 million bullies and 2.7 million victims in U.S. schools and they stated that 60,000 children do not attend school each day because of fears of attack or intimidation. In Norway, Olweus (1994) found that 9% of school age children were bullied, and 7% bullied others regularly. In Australia (Forero et al, 1999), a survey of nearly 4000 school children showed that 23.7% bullied other students, 12.7% were bullied, 21.5% were both bullied and bullied others, and 42.4% were neither bullied nor bullies.

A British survey (Boulton and Underwood, 1992) of 8-9 year-olds and 11-12 year olds showed 21% reported being bullied, and 17% bullied others. Bullying was more common among boys than girls, and among younger than older children. The most common forms were teasing and hitting/kicking. Most boys were bullied by boys only, whereas girls were more likely to be bullied by either sex. The majority of victims had not spoken to teachers/family about being bullied. Finally, an Italian study (Baldry and Farrington, 1999) of 113 girls and 125 boys aged 11-14 in a Rome middle school suggested that over half of all students had bullied others in the 3 months prior to the survey. Boys bullied more than girls, and both boys and girls tended to be bullied by boys.

Bullies and Victims

Olweus (1994) has reported that bullies are more aggressive towards both peers and adults, and have a more positive attitude towards violence, characterized by impulsivity and a strong need to dominate others. They displayed little empathy towards victims. Male bullies tend to be generally stronger than boys of their own age, and especially stronger than victims. He concluded that bullies display an aggressive reaction pattern combined with (in boys) physical strength. There was a noted increased incidence of anti-social and "rule-breaking" (conduct disordered) behaviour patterns, with increased long-term risk of criminal behaviour and alcoholism.

Attempts have been made to categorize bullies. 'Anxious bullies' were the least confident perpetrators, and appear to have other difficulties such as problems at home or educational failure. A second category was the 'bully/victims', which consisted of 6% of those who were seriously bullied, and 18% of those who were bullied occasionally. This second group was seen to be less popular than the main group of bullies, and appeared to focus on younger children as more vulnerable targets. The third category was the 'passive bullies' (or 'henchmen'), who did not take the initiative for bullying activities. This was a fairly mixed group, which included some of the insecure and anxious students.

Gender differences have been noted. Olweus (1994) concluded that more boys than girls are both bullies and bullied, and that girls were more often subjected to indirect attacks (social isolation, exclusion) rather than direct physical attacks. However, boys and girls were equally exposed to indirect bullying, and boys carried out a large part of the bullying on girls. He also attempted to identify important factors which give rise to bullying behaviour, and described the development of an 'Aggressive Reaction Pattern' characterized by four contributory elements. The first is the emotional attitudes of the caregiver, in particular one who demonstrated a negative attitude, characterized by lack of warmth and involvement. This increased the risk of the child later showing aggressiveness and hostility to others. A second element is permissiveness towards aggressive behaviour: if there are no clear limits on aggressive behaviours towards peers, siblings and adults, aggression is likely to grow. Power-assertive child-rearing methods, such as the use of physical punishment or violent emotional outbursts increase the likelihood of aggression in children constitute the third element. Finally, the temperament of the child is considered, as an active and "hot-headed" child is more likely to develop aggression (and bullying behaviours).

Victims have also been described and categorized. Olweus (1994) expressed somewhat general conclusions that victims are more anxious and insecure, and are often cautious, sensitive and quiet. When attacked, they commonly react by crying when younger and by withdrawal at older ages. They tend to experience low self-esteem, a negative view of self and their situation, and feel that they are stupid, shameful and unattractive.

The first category of victims are the 'passive victims'. They are ineffectual in the face of attack, avoid aggression and confrontation and lack the confidence or skill to elicit support from their peers. They are lonely and abandoned, with few friends at school. They often have a negative attitude towards violence and (if boys) are physically weaker than others. They display helpless, futile anger when attacked. Their behaviour and attitudes signal to others that they are insecure and worthless and will not retaliate if attacked. The second category, 'provocative victims', are much less common and have both anxious and aggressive reaction patterns. They tease and taunt, but quickly complain if others retaliate. 'Colluding victims' take on the role of the victim to gain acceptance and popularity. They may mask true academic ability to avoid being outcast from their group. Finally, false victims complain unnecessarily about others in the group, usually as attention-seeking behaviour.

In addition, there are "special groups", who attract the attention of bullies due to obvious differences. In one study of bullied children in the U.K (Leff, 1999), 17% had learning disabilities, 33% had physical disabilities and 33% were neglected. A survey of 28 children who stutter (Langevin et al, 1998) showed that 59% were teased/bullied about speech, and 69% were teased or bullied about other things. As well, a British study (Voss et al, 2000) found that short boys were more than twice as likely to be victims than age-controlled peers of normal height, and much more likely to be upset by bullies.

Finally, in a recent study of children with Asperger's Disorder and Nonverbal Learning Disorder (Little, 2001), the annual peer victimization rate was 94%. Seventy-three percent of children had been hit by peers or siblings, 75% had

been bullied, 10% had been attacked by gangs, and 15% were victims of nonsexual genital assaults. Bullying remained high regardless of age, and gang attacks were the most frequent in middle and high school. Boys were at greater risk of being bullied than girls, and children with Asperger's were at greater risk of being assaulted than those with Nonverbal Learning Disorder.

The personality dimensions of both bullies and victims have also been studied. Mynard and Joseph (1997) describe 179 children (ages 8-13), who completed a battery of psychological tests. The results showed that 11% of children identified themselves as bullies, 20% as victims, and 18% as both bully and victim. Bullies scored lower on scales that measure lying, but higher on the psychoticism scale. Victims scored lower on the extroversion scale and higher on the neuroticism scale, while mixed bully/victims were characterized by low social acceptance, high neuroticism and high psychoticism.

Finally, a British survey (Boulton and Underwood, 1992) examined children, including bullies, victims and those not involved in bullying, and asked why children bully other children. According to the bullies, the most common reason given was that the victim provoked them, while one-fifth said they didn't know, and 8% said because the victim was smaller, weaker or didn't fight back. These results were reversed when their targets were surveyed. Victims reported that the most common reason for being victimised was that victims were smaller or weaker or didn't fight back, while one-quarter said there was no reason, and 8% agreed that the victim provoked the bully. Of non-involved children, 32% thought that other children were bullied because they were small or weak, or because they didn't stand up for themselves.

The Consequences Of Bullying

One Finnish study (Kumpulainen et al, 1998) surveyed nearly 6,000 elementary school children, their parents and their teachers. Bullies (8.1%), victims (11.3%) and bully/victims (7.6%) were compared to each other and to controls (73.1%). It was found that bully/victims scored highest in externalizing behaviour and hyperactivity, and self-reported feelings of ineffectiveness and personal problems. Victims scored highest in internalizing behaviour and psychosomatic symptoms, anhedonia and negative self esteem (males) and negative mood (females). Bullies scored quite high in externalizing behaviour and hyperactivity. "Psychological disturbance" was found in nearly 25% of victims, using the Children's Depression Inventory (CDI). However, it was the bullies (in particular male and female bully/victims) who were most frequently referred for psychiatric consultation. The reason for this is unclear.

An Australian survey (Forero et al, 1999) of almost 4,000 students aged 12, 14 and 16 asked questions about effects of bullying, including psychosomatic symptoms (headache, stomach ache, backache, irritability, anxiety, and insomnia) and mental health (mood, loneliness, contact, self-esteem). A significant association was found between bullying behaviour, psychosomatic symptoms and smoking, with bully/victims reporting the greatest symptoms. A British survey (Salmon et al, 1998) of 904 students aged 12-17 in two coeducational schools found that bullied children are more anxious, and bullies are equally or less anxious than non-bullied children. Older boys with low scores on anxiety and lying scales and high scores on depression scales were most likely to be bullies.

A Finnish report (Kaltiala et al, 1999) studied 16,410 participants aged 14-16, who completed a questionnaire incorporating the Beck Depression Inventory. Researchers found an increased prevalence of depression and severe suicidal ideation amongst victims and bullies, with depression most common in bully/victims, and suicidal ideation most common in bullies. A companion study (Kumpulainen et al, 1999) reviewed 1268 eight year-old children, who were assessed twice four years apart. The Rutter A-2 and B-2 Scales and the Children's Depression Inventory (CDI) were utilized. Bully/victims were most likely to persist in bullying behaviour four years after the initial survey. The researchers concluded that children involved in bullying have significantly more psychiatric symptoms than those not involved

Discussion

Our case report illustrates the effect of bullying, namely how it marginalizes and traumatizes the victims, while (in some cases) rewarding the bully with increased self-esteem and improved social status. Our patient, GS, is an outsider, alienated from many of his peers. As such, he is an easy target. He displays certain characteristics of a victim. He signals that he will not strike back, is anxious and withdrawn, and with few social supports. His appearance, while not noticeably disfigured, is sufficiently different from his peers that it sets him apart.

The bully in his case, described as a "blowhard", appears in some ways to represent the bully/victim portrayed in the literature. He is not truly dominant, preferring to back away from those who challenge him, and identifying those who will not fight back. He enlists others in his conduct, thus increasing his own status at the expense of his victim. He does not have an independent source of popularity and he is able to identify the needs of the peer group to attack, harangue and alienate a vulnerable individual. He appears to serve a social need, acting out the collective will of the group to identify and punish a scapegoat.

The school, too, is an active participant. On the sole occasion that GS dared to respond to his attacker, both boys were punished with detention. Conversely, the unprovoked and constant harassment that GS endures is to some extent tolerated by the school. If he complains, he is a "rat" and deserving of punishment. If he doe not complain, the bullying can continue unimpeded. In either alternative, GS is potentially condemned to a continuation of his victimization.

GS presents with brief, transient suicidal ideation and evidence of an adjustment disorder. It is difficult and perhaps dangerous to ignore the psychological and physical suffering that GS does endure. A consequence of his predicament is yet further social isolation and withdrawal, the effects of

which are as yet unclear. However, the effect of bullying on this boy's personality formation, his ability to function in social settings, and his capacity to trust and form meaningful relationships is clearly described by his own words: "I just wither away in my own little world".

From an objective distance, and through the screen of conventional psychiatric diagnostic criteria, the long-term effects of bullying are somewhat difficult to accurately assess or predict. However, in subjective proximity to those involved, the consequences of such behaviour and its covert acceptance are indeed frightening. Further study is indicated to assess the incidence of psychiatric morbidity in bullies, victims, and in those who are both perpetrators and targets. Finally, it is essential to identify temperamental and personality characteristics of the children involved, as well as to examine for dimensions of psychological distress, including depression, suicidality, anxiety, obsessive-compulsive traits, aggressive traits and psychotic symptoms. Such study will further promote development of our understanding of bullying and its sequelae at individual, interpersonal and systemic levels, and further inform our treatments of the bullies, bullying recipients and the systemic, community milieus where the bullying occurs.

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