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Bullying and Victimization Among Children

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Abstract

Bullying among children is a significant public health problem world-wide. Bullying is most commonly defined as repeated, intentional aggression, perpetrated by a more powerful individual or group against a less powerful victim. Trends in victimization and moderate to frequent bullying may be decreasing slightly in the United States, but over 20% of children continue to be involved in bullying. Direct bullying consists of physical and verbal aggression, whereas indirect bullying involves relational aggression. Cyber bullying is an emerging problem which may be more difficult to identify and intervene with than traditional bullying. Bullies, victims, and bully-victims are at risk for negative short and long-term consequences such as depression, anxiety, low self-esteem, and delinquency. Various individual, parental, and peer factors increase the risk for involvement in bullying. Anti-bullying interventions are predominantly school-based and demonstrate variable results. Healthcare providers can intervene in bullying by identifying potential bullies or victims, screening them for co-morbidities, providing counseling and resources, and advocating for bullying prevention.

Keywords

ullying; aggression; prevention; intervention; risk factors

INTRODUCTION

Definition of Bullying

Bullying is an important public health problem, affecting one in three US children. The most commonly used definition of bullying was developed by Daniel Olweus in the 1970's and 80's.[1,2] Olweus describes bullying as "intentional, repeated, negative (unpleasant or hurtful) behavior by one or more persons directed against a person who has difficulty defending himself or herself."[1] This definition applies to such aggressive behavior inflicted by a person or group with seemingly more power on a person or group with less power.[1,3,4] The power

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differential may be due to physical size, psychological/social power, or other factors.[5] The key elements are listed in Box 1 below.[3,5,6]

Types of Bullying

Bullying includes direct and indirect forms of aggression (Table 1).[2,6,7] Physical and verbal aggression are direct forms of bullying, consisting of an overt expression of power. Physical bullying includes any type of physical assault, such as hitting, pushing, kicking, choking, and forcefully taking something from the victim.[4,7–9] Verbal bullying includes verbal harassment or intimidation in the form of name-calling, threatening, taunting, malicious teasing, and psychological intimidation using words to harm victims.[4,5,7–9] Stealing, vandalizing, and making faces or obscene gestures also are ways in which children are bullied.[4,8]

Indirect bullying primarily consists of relational aggression, which includes social exclusion of victims through the manipulation of social relationships by bullies or injuring the reputation of the victims.[5,8,9] Gossiping, slandering, sabotage, and convincing peers to exclude victims are forms of relational bullying.[7–9] Bullying most often occurs in areas with little adult supervision, such as playgrounds and school hallways.[8] Verbal and relational bullying can be more difficult to identify than physical bullying.[8] Relational bullying is more common among girls and can lead to feelings of rejection at a critical time in social development.[8]

Cyber bullying is an emerging form of bullying and is defined as harm inflicted through threatening, harassing, taunting, and/or intimidating a peer using an electronic medium, such as computers, cell phones, and other electronic devices (Table 1).[6,7,10]. Similar to definitions of traditional bullying, cyber bullying definitions include that the behavior is aggressive, with the intent to harm.[6] Unlike traditional bullying, however, cyber bullying definitions do not include a power differential between the bully and victim, and not all cyber bullying definitions include that the behavior is repetitive.[6] This is a particularly insidious form of bullying as it can occur at school and at home, is difficult to detect and verify, quickly reaches a wide audience, and is easily accessible for over 80% of adolescents who have access to media technology.[6,7,11] The most commonly used electronic media for cyber bullying are listed in Box 2.[6]

Cyber bullies use these media by sending cruel or threatening messages, taking over the victims' email account and sending embarrassing or vicious messages to others which appear as if they have come from the victim, creating websites with pictures or jokes about victims and inviting other classmates to participate in ridiculing victims online, and tricking victims to reveal sensitive information through email or instant messaging and then forwarding it to others.[6]

Physical and cyber bullying peak in middle school, then decrease, whereas verbal bullying may continue to be elevated throughout high school.[6,10,12] More than half of cyber bullying victims are not bullied off-line.[6] Involvement in cyber bullying can, however, signal involvement in other types of bullying perpetration and victimization.[12,13] Those who are physically or cyber bullied are more likely to be verbally or relationally bullied as well.[13]

Characteristics of Bullies

Bullying consists of three main types of participants: bullies, victims, and bully-victims (Table 2).

Bullies are not a homogenous group. Some bullies have well-developed social skills and use bullying to gain or maintain dominance in their peer group.[8,14] Bullies may have a positive

attitude toward violence and lack empathy for their victims.[8] Approximately 10% of bullies exhibit consistently high rates of bullying over time.[15] Thirteen percent of students bully in early adolescence but are no longer bullying by the end of high school.[15] Boys are more likely to be classified as bullies than girls.[16] Bullies are more likely to manifest defiant behavior and negative attitudes toward school, and to use drugs.[16] Bullies also may exhibit co-morbid conditions, such as attention-deficit disorder, depression, and oppositional-conduct disorder.[8]

Characteristics of Bully-Victims

Bully-victims are those who bully others and are bullied themselves; they also are known as reactive bullies or provocative/aggressive victims.[8] These may be impulsively aggressive children who respond with aggression to being bullied, or victims who transition from victimization to bullying behavior over a period of time.[14,17] There is less information about bully-victims compared with the other groups, although this group seems to have the most severe and broadest range of adjustment problems.[16,18,19] Children in this group may have attention problems, low self-esteem, and especially high rates of depression and oppositional-conduct disorder.[8,14] They are more anxious and less popular than bullies, have poor social skills and problem-solving, tend to annoy peers, and may, therefore, not be well-liked by peers or teachers.[8,14] They are more likely to come from families with inconsistent or poor parenting, low warmth, and may learn aggressive behavior from home.[8]

Characteristics of Victims

The majority of bullying victims are passive or submissive victims (vs. provocative/aggressive). They may be physically smaller, less assertive, more anxious, insecure, or sensitive than bullies.[8,17] Victims of bullying also may have difficulty making friends and may relate better with adults than peers.[8] They also may have lower self-esteem, which may result in their being less likely to report victimization from bullying.[8] Compared with bullies and bully-victims, victims report the highest levels of loneliness and anxiety, whereas bullies report the lowest.[16] Victims have the lowest social status among peers and bullies have the highest, however, bully-victims are most avoided by classmates.[16]

Characteristics of Cyber Bullies and Victims

Cyber bullies and victims display some unique behaviors. Bullies are not necessarily stronger than their victims, they are usually anonymous, and are not able to see the distress caused by their bullying.[6] Cyber bullying occurs at school and at home and may be more difficult to identify and intervene with than other forms of bullying.[6] Cyber bullying also is more difficult to trace, therefore, bullies have less fear of being identified.[6] The majority of cyber bullying incidents occur outside of the school day.[20] Cyber bullying at school is most commonly via texting and victims are unlikely to report these incidents due to rules prohibiting cell phone use during school.[20] Although students report that they know how to circumvent school website filters to access social networking sites at school, they do not use these sites often during the school day.[20]

Cyber bullies are more likely to be aggressive, to display delinquent behavior, have delinquent peers, and be involved in substance use.[6] They also report poor parental monitoring, worse relationships with parents, and poor emotional bonding with their parents, compared with children uninvolved in cyber bullying.[6] More than one-third of cyber bullies report cyber bullying for fun, one-fourth state that they bully in retaliation, and a small number state that they bully because they felt bad about themselves.[6] Cyber bullies may be victims or perpetrators of traditional off-line bullying. The majority of cyber bullies know their victims, however, less than one-third of victims know their bullies in person.[6]

Victims of cyber bullying often do not know who is cyber bullying them and are hesitant to report bullying to parents for fear of losing electronic media privileges.[6,20] Victims are even less likely to report cyber bullying to school officials than to parents.[20] Children who cyber bully others, who are victims of traditional forms of bullying, and have social problems are more likely to be victims of cyber bullying.[6]

Risk and Protective Factors for Bullying Perpetration

Child, parental, peer, and community risk factors which increase the risk of bullying perpetration are listed in Box 3.

Maternal and paternal depression also may influence child bullying perpetration. Maternal depression is associated with bullying.[36] This relationship may be mediated by poorer quality of interactions between depressed mothers and their children, or decreased maternal attachment to the child, which are associated with bullying.[30,37] Interactions between depressed mothers and their children are more likely to be irritable, critical, and hostile.[38,39] Chronic depression also is associated with poor parenting behaviors[40] and negative child outcomes.[36,39] The relationship between paternal depression and child bullying perpetration is less clear. Some studies suggest that depression in fathers is associated with worse socioemotional development in the child[38] and more internalizing and externalizing behaviors.[41] One study found that fathers who bullied when they were in school were more likely to have children who bullied.[42]

Living in a two-parent family,[43] maternal warmth,[23,30] parental involvement with their child,[23,27,28,30,44] positive adult role models,[24] and high parental support[10,37] are protective against bullying perpetration.

Risk and Protective Factors for Victimization

Factors that increase the risk of victimization are listed in Box 4.

Children who have few friends, no reciprocal best friend,[2] or friendships which are low in supportiveness and protection are more likely to experience rejection and isolation by peers and be victimized by bullies.[2,45] Children with these types of peer relationships are more likely to be marginalized, making it easier and more socially acceptable for bullies to target them.[2] On the contrary, among those children who have personal characteristics that increase the risk for victimization, such as internalizing problems, but have more friends and protective peer relationships, these relationships can be protective against victimization.[2] This is especially true when these peer relationships are with prosocial or physically stronger peers.[2] Teachers' warm and caring behavior towards all students in the class also is protective against child victimization.[2]

Risk Factors for Bully-Victimization

Several factors, listed in Box 5, are associated with higher risk of being a bully-victim.

PREVALENCE AND TRENDS IN BULLYING AND VICTIMIZATION

World Wide Trends in Bullying and Victimization

Studies show variability in the prevalence of bullying and victimization across countries, ranging from 15% to over 50%.[46] Early estimates of bullying prevalence in Norway in the 1980's found that 15% of Norwegian students in elementary or middle school were involved in bullying; 9% as victims, 6–7% as bullies, and 1.5% as both bullies and victims.[1] In a study comparing trends in bullying and victimization from 1994–2006 in 27 European and North American countries, most showed significant decreases, with the United Kingdom and

North America showing no change or slight increases.[46] In a 2005–2006 study of 40 countries, 26% of children in 6th–10th grade were involved in bullying, 10.7% as bullies, 12.6% as victims, and 3.6% as bully-victims.[47]

Bullying and Victimization Trends in the United States

The prevalence of bullying in the US changed throughout the 1990's and early 2000, with slight decreases in occasional and chronic bullying and victimization from 1994–2006.[46] Nearly 30 percent of US children in 6th–10th grades surveyed in 1998–1999 reported being involved in moderate or frequent bullying;[3,8] 13% as bullies, 10.6% as victims, and 6.3% as bully-victims (Figure 1).[3] This translates to almost 6 million students directly involved in bullying at the time of the survey.[3,8] A 1996 study showed that one out of two middle and high school students reported knowing that bullying has occurred at their school and over 40% had personally witnessed bullying.[48] In 2001, bullying involvement among US children in 6th-10th grades had decreased to 21%, with 9% as bullies, 9% as victims, and 3% as both bullies and victims (Figure 1).[29] A 2005–2006 study which examined different types of bullying showed that 21% of 6th-12th grade students were involved in occasional physical bullying, 53% in verbal bullying, 51% in relational bullying, and 14% in cyber bullying (Figure 2).[10] Victimization from physical bullying has decreased from 2003 to 2008, however, victimization from emotional bullying is not significantly changed.[49] Variations in the prevalence of bullying among studies may be, in some part, attributable to variability in how bullying is measured and the types of bullying examined.

A wide range of involvement in cyber bullying has been reported. Almost half of children have witnessed cyber bullying, 4–20% identify themselves as cyber bullies, 9–35% as victims of cyber bullying, and 7% as cyber bully-victims.[6,7,10] Eight percent of children report being cyber bullied monthly or more often. Of those children who were bullied, half were victimized more than once, and almost one in three were victimized more than three times in the previous year.[6] Children report cyber bullying via various methods: 60% have been ignored by others online, 50% were disrespected by others, 30% have been called names, 21.4% have been threatened by others, 19.8% were annoyed by others, 19.3% were made fun of by others, and 18.8% had rumors spread about them by others.[6]

CLINICAL CORRELATION

Consequences of Bullying and Victimization

There are significant short and long-term psychosocial consequences of bullying. Bullies may experience poor school adjustment and academic performance, higher rates of alcohol and substance use, and increased externalizing behavior, such as fighting and weapon-carrying.[3,8,18,25,31,50,51] Long-term consequences include antisocial development, intimate partner violence perpetration, unemployment, delinquency, and criminality in adulthood.[8,15,19] One study found that 60% of boys who bullied in 6th–9th grades had at least one criminal conviction by age 24 and 35; 40% of these boys had three or more convictions by this time.[8] Perpetrators of bullying also are more likely to have children who bully.[8]

Victimization is associated with negative consequences. Bullying victims experience anxiety, depression, poor academic performance, and psychosomatic complaints, such as headaches and abdominal pain, especially in the morning.[8,52–55] This may lead to chronic absenteeism from school, with one study showing that 7% of US students in 8th grade stayed home from school at least one day a month due to bullying.[8] Victims also may experience difficulty sleeping and have nightmares.[8] Long-term consequences include lower self-esteem, poor academic achievement, and poor psychosocial adjustment as adults.[52–55] Victims are more likely than non-victims to carry weapons to school for safety or retaliation,

and have a greater likelihood of perpetrating school shootings.[52–55] A study of school-associated homicides in the 1990's found that almost 20% of perpetrators had been bullied, and perpetrators of school shootings were more than twice as likely their victims to have been bullied.[52]

Bully-victims may be at highest risk for serious consequences, including perpetrating school shootings.[8] Bully-victims are at higher risk of weapon-carrying, fighting, alcohol and substance use, depression, anxiety, psychosomatic complaints, and psychiatric illnesses as adults, compared with bullies, victims, and children uninvolved in bullying.[8] Compared with bullies and victims, bully-victims have more conduct problems and school disengagement, and are socially ostracized by peers.[16]

Bullying and Suicide

Bullying is significantly associated with suicidal ideation and suicide attempts. Studies in Europe, Asia, and the US have found higher risk of suicidal ideation in victims and perpetrators of bullying.[7,56] More frequent involvement in bullying is associated with higher risk, and these risks appear to be higher for girls than for boys.[7,56] Boys who are bullied are 2.5 times more likely to have suicidal ideation than non-bullied boys and bullied girls are more than four times as likely as non-bullied girls to have suicidal ideation. Similar relationships exist for bullies, with bullying boys and girls at higher risk for suicidal ideation than non-bullying children, and girls at higher risk than boys.[7] Lesbian/gay/bisexual (LGB) youth and children with learning disabilities are at particularly high risk of suicidal ideation and suicide attempts.[56] Bully-victims are at highest risk.[56] Although bullying and victimization are associated with higher risk of suicidal ideation, bullying involvement explains only a small proportion of the variability in suicidal ideation.[7] The relationships between bullying involvement and suicidal ideation for boys are mediated by childhood depression and externalizing problems, such as conduct disorder.[57] This suggests that bullying involvement is more likely to be a contributor than the sole cause of suicidal ideation.[7] Among girls who are frequently victimized, however, the association with suicide attempts and completed suicides persists even after accounting for depression and conduct problems.[57] The difference between boys and girls may be because girls are more likely to be victimized by relational bullying, whereas boys are more likely to be victimized by physical bullying.[57]

Anti-Bullying Interventions

There currently are no rigorously-evaluated, effective primary-care-based bullying interventions. School-based interventions to reduce bullying have been studied in Asia, Europe, and North America (Table 3).[58]

School-Based Interventions—Bullying interventions are primarily school-based and consist of whole-school multidisciplinary interventions, curriculum interventions, social and behavioral skills group training interventions, and other single-component interventions.[59] Evaluations of these interventions show variable results in the US and internationally.

The whole-school approach directs interventions to the entire school context, rather than only bullies or victims.[60] It is based on the theory that bullying is a systemic problem which involves multiple contexts such as individual students, peers, teachers, and parents;[60] bullying interventions, therefore, need to be directed at changing all of these contexts. The Olweus Bullying Prevention Program was the first evaluated, whole-school, multidisciplinary school-based intervention.[59,60] It consists of a videotaped classroom curriculum, school-personnel training, and materials for parents.[59] It includes intervention components at the individual student, classroom, school, and community levels.[1] Initial

evaluations of this program in Bergen, Norway demonstrated significant reductions in school bullying.[59] Victimization from bullying decreased from 10% to 3.6% and bullying perpetration decreased from 7.6% to 3.6%.[1] A five-year follow-up study of this intervention in Norway, from 2001 to 2006, showed continued effectiveness in bullying and victimization.[1] Evaluations of the program in other locations in Norway and the US have, however, shown variable results.[59] In the US, for example, the program showed decreased self-reported bullying and victimization in suburban California elementary schools, reductions in relational and physical victimization in white students only in Washington, and no effects on victimization in rural South Carolina elementary and middle schools.[1,61] This variability in effectiveness may be due to modifications to the original curriculum, decreased staff involvement, or lack of fidelity in replication of the Bergen model.[59]

Other whole-school interventions include the Sheffield Anti-Bullying Project, which includes a school anti-bullying policy, anti-bullying curriculum, individual and peer-level intervention, and playground intervention.[61] This intervention has shown decreases in bullying in victimization compared to some schools. The Sevilla Anti-Violencia Escolar (SAVE) program showed reductions in bullying and victimization in intervention schools using a pre-post design for the evaluation.[61] Whole-school programs in Germany, Belgium, and Switzerland show variable outcomes depending on age, type of bullying, and reporter of bullying.[61] A few interventions in Canada and Switzerland have been shown to be ineffective or to increase bullying.[61]

A 2008 meta-analysis of school bullying intervention programs concluded that these types of interventions were effective in improving social competence, self-esteem, and peer acceptance among students, and in enhancing teacher knowledge and efficacy about intervention.[5] This study also stated, however, that the small effects produced by these programs on bullying were unlikely to be practically meaningful.[5] Another review concurred with this finding that school-based anti-bullying programs do not appear to have a practically significant reduction in bullying,[4] but found that they may be effective in reducing bullying for at-risk youth.

A 2009 meta-analysis of 44 school-based bullying intervention programs identified elements that are associated with reductions in bullying and victimization.[58] Programs with the characteristics listed in Box 6 are most likely to be effective. Box 7 lists specific program components that are important. Parent trainings/meetings, firm disciplinary methods, and the use of videos were found to be the most effective components.

The authors concluded that results of the effectiveness of school-based anti-bullying programs were encouraging.[58] It appears that increased time and effort invested in program implementation may result in better outcomes.[61] Parent training and education also seem to be essential components for effective interventions.[58] School-based interventions, however, have minimal parental involvement, and primarily target children or school personnel.[62] Interventions with a substantial component focused on parenting and parent-child interactions may be useful to consider in future program implementation.

Interventions of classroom-based curricula in isolation and social and behavioral-skills training group interventions demonstrate variable results.[59] The Second Step Violence Prevention program, a classroom-based intervention, had some success in reducing anti-social behaviors and aggression, and improving social competence.[4] Social skills training interventions may be effective for some children.[8] One study of elementary school students who had difficulties with peers found that a social skills group training intervention reduced aggression and bullying; such interventions with older children were ineffective.[59] A

mentoring program for “at-risk” children was effective in decreasing bullying, fighting, and depression.[59]

Zero-tolerance Policies in Schools—Zero-tolerance policies in isolation are ineffective in reducing bullying.[63] These policies result in higher suspension and expulsion rates, but do not increase consistency of school discipline, and worsen school climate. Student suspension is associated with higher likelihood of future suspension and drop-out and an increase, rather than a decrease, in misbehavior. Students view suspension and expulsion as ineffective, and studies of parents and communities regarding zero-tolerance are inconclusive. There is no evidence that zero tolerance policies, as currently practiced, improve school safety or student behavior.[63] Interventions which include zero-tolerance policies as well as other components have not been evaluated.[8]

Cyber Bullying Interventions—There are currently no evidence-based cyber bullying interventions, therefore, children are left to handle cyber bullying in various ways. Victims respond to cyber bullying by blocking the sender, ignoring the message, telling the bully to stop, and staying offline; almost 25% of victims do nothing.[6,20] More than half of victims tell a friend, and some tell a parent, sibling, or other adult. Almost 25% of victims tell no one and a small number respond to cyber bullying by bullying others.[6] Students report that they do not know how to respond when they are bystanders to cyber bullying and are unsure of how to request the removal of negative material from websites.[20]

Anti-Bullying Policies

In response to recent incidents of school bullying and bullying-related suicides, there has been a push for anti-bullying initiatives at the federal, state, and local levels. The US Department of Health and Human Services, Health Resources and Services Administration, launched its anti-bullying campaign in 2001.[64] The campaign has partnered with several agencies and community organizations to raise awareness about bullying and its prevention. The first White House Conference on Bullying Prevention was held in March 2011.

No federal anti-bullying laws currently exist. Federal civil rights laws do, however, address discriminatory harassment based on race, color, national origin, sex, and disability.[64] Fifty states have anti-bullying laws in their state education or criminal codes, and forty-two also have model policies that provide guidance to school districts in these states.[64] Many of these state laws include a definition of bullying, although all do not include cyber bullying. These laws also may state the scope of environments in which the law is applicable, and direct local school districts to enact anti-bullying policies.[64] Local anti-bullying policies may vary by region and school district.

Clinical Management of Bullying

Organizations for clinical professionals have recognized the need for clinicians to have a role in bullying prevention and intervention.[65,66] The American Academy of Pediatrics and the American Medical Association have issued policy statements about bullying and provide educational resources for providers and patients.[65,67] Providers are encouraged to identify children at risk for bullying, provide counseling for children and families, screen for co-morbidities, and advocate for bullying prevention at the local, state, and national level.[65,66]

Identification—Providers can identify bullies and victims using several methods. All school-age children can be screened for bullying involvement during health maintenance visits using tools such as the American Academy of Pediatrics Bright Futures materials. Providers also can use questions such as those listed in Box 8 to probe about bullying.

Some children are at especially high risk of bullying and victimization (Box 9). These children should be screened for bullying at all provider visits and should be asked directly about any involvement in bullying.

Screening and Counseling—Children involved in bullying should be screened for anxiety, depression, and other mental health problems. Providers can screen bullies for ADHD or other emotional, developmental, or behavioral problems using validated measures such as the Pediatric Symptom Checklist or Children's Behavior Checklist[69] and refer them to mental health professionals for further evaluation and counseling. Bullies, victims, bully-victims, and their parents should be provided with resources and strategies for dealing with bullying and victimization. These include referring children and families to mental health providers for screening and counseling, promoting parent-child involvement and communication, directing parents to informational resources such as the US Department of Health and Human Services website (www.stopbullying.gov), and encouraging parents to work with teachers, counselors, and school district leadership to address the bullying. Additional recommendations for victims could include enrollment in activities to build confidence and self-esteem, practicing scenarios on how to respond in assertive, non-violent ways to bullying, and promoting friendships with protective peers. Increased supervision and monitoring of children's cell phone and Internet use by parents may be beneficial for preventing cyber bullying.[6] Parents should be aware of their child's school's policy on technology use and schools can provide information to parents about cyber bullying.[20]

Advocacy—Clinicians can educate themselves about state and local anti-bullying policies and inform parents about them. Parents and providers could advocate with schools to consider limiting or prohibiting cell phone use at school, and enforcing consequences for policy violations.[20] Providers also can work with schools to advocate for the use of effective anti-bullying programs.

SUMMARY

Bullying affects many children in the US and internationally. Bullies, victims, and bully-victims are at high risk for negative short and long-term consequences. Slight decreases in trends in bullying and victimization may be due to increased awareness and response to bullying and bullying-related incidents. Despite this, there are still a substantial number of children affected by bullying. School-based bullying interventions appear to be promising however, it is important to choose an evidence-based program, to administer the program with fidelity, and to enlist adequate parental involvement and school personnel effort to make the program effective. Additional research on effective intervention strategies is needed. Clinicians can play a role in identifying bullies and victims, evaluating them for co-morbid conditions, and providing resources and referrals as necessary. Parents, providers, and schools can work together to prevent and intervene in childhood bullying.

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Box 1

Key elements of bullying

1. a physical, verbal, or psychological attack or intimidation
2. an actual or perceived power imbalance between the perpetrator(s) or victim(s)
3. intent to cause fear, and/or harm to the victim
4. it is repeated and produces the desired effect

Box 2

Electronic media used for cyber bullying

- Text messaging/cell phones
- Internet websites or chat rooms
- Email
- Computer instant messaging

Box 3

Risk factors for bullying perpetration

- Younger age of the child[10,21,22]
- Male gender[23,24]
- Presence of depression,[22,25,26] mental health problems,[25] or emotional/developmental/behavioral problems[27,28]
- Low academic achievement[29]
- Substance use[22]
- Exposure to child abuse and domestic violence[26,30]
- African-American or Latino race/ethnicity[10,25,30–32]
- High levels of anger in the child[33,34]
- Parental use of corporal punishment[24]
- Poor parent-child communication[29]
- Suboptimal maternal mental health[27,28]
- Parental anger with their child[27,28]
- Parents' reporting that their child bothers them a lot[27,28]
- Lack of parental monitoring[24]
- High family conflict[35]
- Poor relationships with classmates[29]
- Negative influences from peers[24]
- Living in an unsafe neighborhood[24]

Box 4

Risk factors for victimization from bullying[2,45]

- Being physically weaker
- Low self-worth
- Negative self-perceptions
- Low social competence
- Poor social skills and problem-solving abilities
- Internalizing behaviors (depression, anxiety)
- Insecure mother-child attachment
- Maternal over-protectiveness
- Intrusive or coercive parenting
- Child abuse

Box 5

Risk factors for being a bully-victim[2,45]

- Emotional dysregulation
- Hyperactivity
- Low social competence
- Poor problem-solving skills
- Poor self-esteem
- Negative perceptions about others
- Poor academic performance
- Peer rejection and isolation
- Negative influences from those peers with whom the child interacts
- Disconnectedness from school

Box 6

Bullying intervention program characteristics most likely to be effective

- Programs inspired by the Olweus Bullying Prevention Program
- Include parental involvement
- Longer duration of the program
- Inclusion of multiple important components

Box 7

Important program components for reducing bullying and victimization

- Parent trainings and meetings (Most effective for victimization and bullying)
- Firm disciplinary methods (Most effective for victimization and bullying)
- Use of videos (Most effective for victimization)
- Information for parents
- Teacher training
- Classroom management
- Classroom rules
- School conferences
- Whole-school anti-bullying policy
- Spending more time working with peers increased victimization

Box 8

Questions to identify children involved in bullying

- How are things going at school?
- Do you enjoy school?
- Do you have friends at school? Outside of school? Tell me the name of one of your friends.
- Has anyone picked on you or been mean to you at school? Outside of school? On the Internet/your computer or your cell phone?
- Have you picked on anyone or been mean to anyone at school? Outside of school? Using the Internet/your computer or your cell phone?
- Have you ever been in any pushing or shoving fights?

Box 9

Identifying children at high risk of bullying involvement[8]

- Present with signs of victimization
  - Physical bruises
  - Torn clothes
  - Constantly requesting or stealing money from family members to pay bullies
- Present with non-specific and psychosomatic complaints
  - Headaches
  - Abdominal pain
  - Enuresis
  - Difficulty sleeping or nightmares
  - Feeling sad
- Refusal to go to school or worsening academic performance
- Children with chronic medical problems
- Children with emotional, developmental, or behavioral problems (e.g. ADHD, learning disabilities)

Key Points

- Bullying affects a large proportion of children in the US and internationally.
- Bullies, victims, and bully-victims are at high risk for negative short and long-term consequences.
- Slight decreases in US trends in bullying and victimization may be due to increased awareness and response to bullying and bullying-related incidents.
- School-based bullying interventions appear to be promising; implementing programs with fidelity and enlisting adequate parental involvement and school personnel effort increase the likelihood of success.
- Parents, providers, and schools can work together to prevent and intervene in childhood bullying.

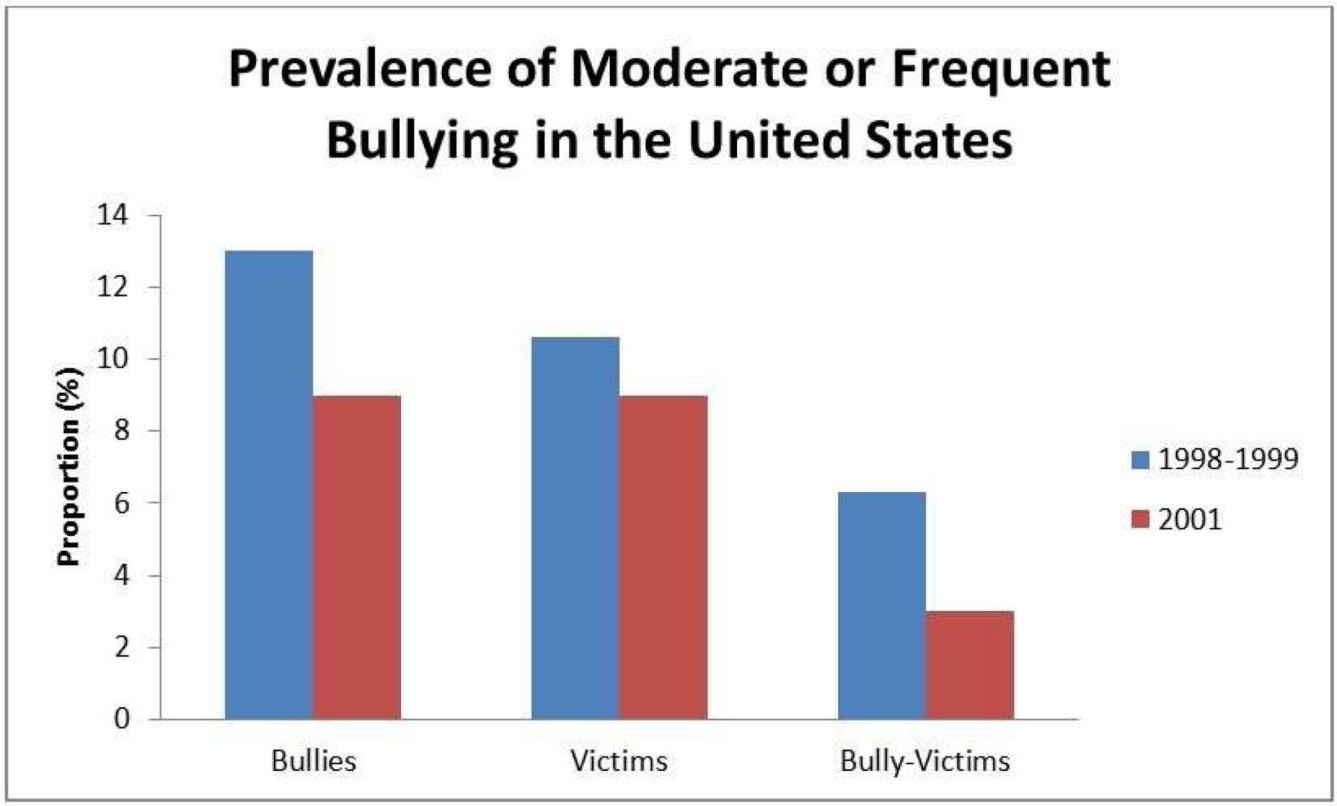

Figure 1.
Prevalence of Moderate or Frequent Bullying in the United States from 1998 to 2001

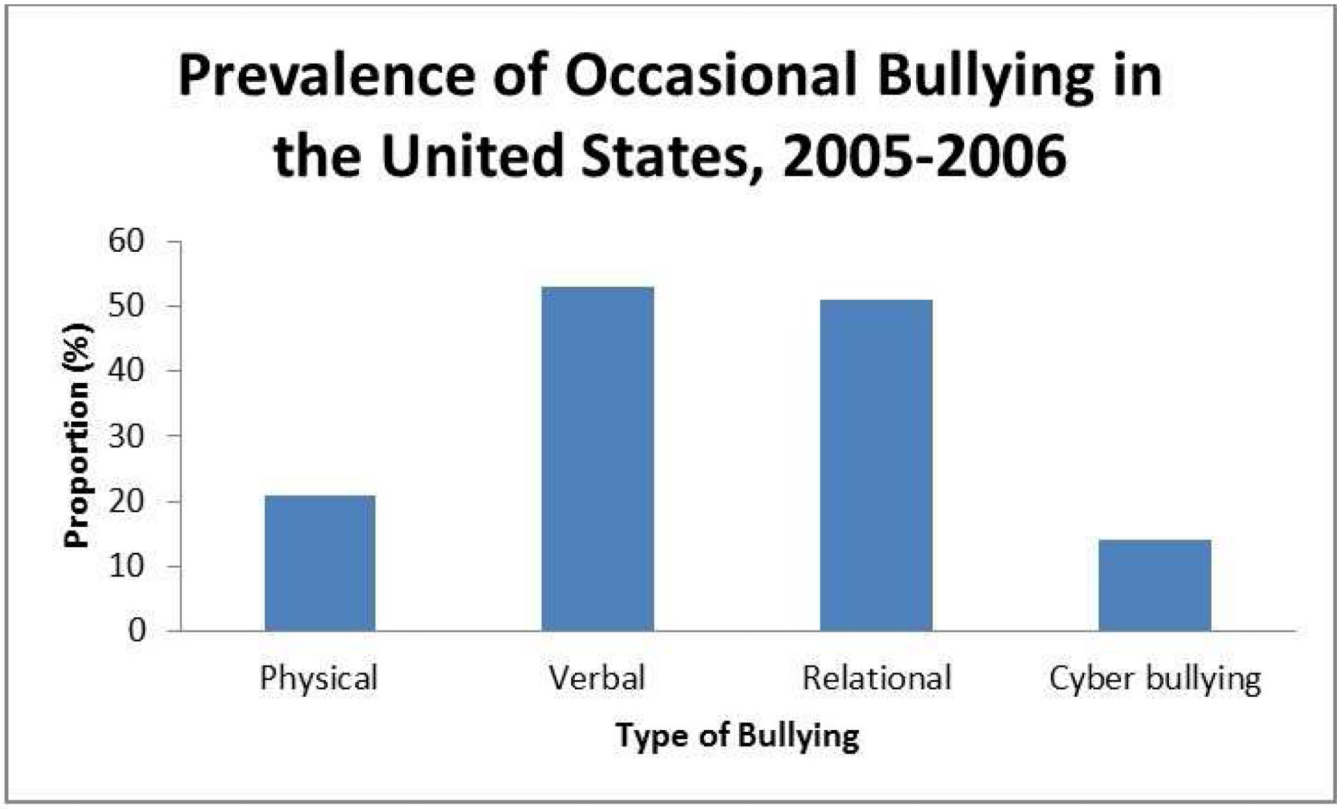

Figure 2.
Prevalence of Occasional Bullying in the United States in 2005–2006

Table 1

Types of Bullying

Type of Bullying	Method/Behavior
Traditional forms of bullying	
Physical bullying (direct)	Hitting, pushing, kicking, choking, forcefully taking something from victim
Verbal bullying (direct)	Name-calling, threatening, taunting, malicious teasing, psychological intimidation using words
Relational bullying (indirect)	Gossiping, slandering, sabotage, convincing peers to exclude victims
Cyber bullying	Threatening, harassing, taunting, intimidating using electronic medium

Table 2

Characteristics of Bullies, Bully-Victims, and Victims

Bullies	Bully-Victims	Victims
Dominant	Impulsive	Physically smaller than peers
Boys more than girls	Low self-esteem	Low self-esteem
Defiant behaviors	Poor social skills	Difficulty making friends
Drug use	Poor problem-solving skills	Less assertive than peers
Co-morbid conditions (ADHD, depression, oppositional/conduct disorder)	Co-morbid conditions (anxiety, ADHD, depression, oppositional/conduct disorder)	Co-morbid conditions (anxiety, loneliness, depression)

Table 3

Anti-Bullying Interventions

Type of Intervention	Results
Whole-school, multidisciplinary, school based (Olweus Bullying Prevention Program, Bergen)	Reduced school bullying, effective at 5-year follow-up
Whole-school, multidisciplinary, school based (Olweus program adaptations in US)	Effective in suburban elementary-school students and white students, ineffective in rural elementary and middle-school students
Whole-school (Sheffield Anti-Bullying Project)	Reduced bullying and victimization in intervention schools compared with some, but not all, control schools
Whole-school (Sevilla Anti-Violencia Escolar)	Reduced bullying and victimization in intervention schools using pre/post evaluation
Classroom-based (Second Step Violence Prevention Program)	Some reduction of anti-social behavior and aggression, improvement in social competence
Social skills group training	Reduced aggression and bullying in elementary-school students, ineffective for older students
Zero-tolerance policies in schools	Increase drop-out, suspension, and future incidents of misbehavior