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Psychosocial Factors Associated with Bullying Typologies in a Mental Health Population of Adolescents

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PSYCHOSOCIAL FACTORS ASSOCIATED WITH
BULLYING TYPOLOGIES IN A MENTAL HEALTH POPULATION OF
ADOLESCENTS

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Dissertation Approval

This is to certify that the thesis presented to us by Jamie M. Bolton on the 22nd day of March, 2011, in partial fulfillment of the requirements for the degree of Doctor of Psychology, has been examined and is acceptable in both scholarship and literary quality.

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Abstract

Despite the well documented mental health consequences of bullying behavior, bullying has not been studied in a mental health population. This study has examined psychosocial factors (symptoms of internalizing disorders and cognitive style) in a population of adolescents admitted into a partial hospitalization program. Sixty-four participants completed five self-report measures. This study was not able to differentiate among bully typologies based on internalizing symptoms (PTSD and depression) or self-debasing cognitive style. Instead, a more relevant finding was that more than half of the sample had clinical levels of PTSD and depressive symptoms. Because this sample was more similar than it was different, bully typologies were not relevant. It was proposed that trauma focused treatment strategies would better address the core issue of trauma.
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Statement of the Problem

Bullying in children and adolescents is a significant problem that can affect both the victim’s and the perpetrator’s short-term and long-term psychological well-being. Bullying behavior has been studied primarily in the school setting, but it is not often examined in a population of children or adolescents with a mental health diagnosis. Mental health problems can expose children to become more vulnerable to bullying behavior in terms of being either the victim or the bully. Additionally, bullying that co-occurs with individuals who already have mental health problems can further complicate mental health treatment.

Purpose of the Study

The purpose of the study was to determine those psychosocial factors in a mental health population that are related to bullying behavior. Three different typologies or characteristics of youth involved in bullying behavior have been identified: bully, bully-victim, and victim. The study examined if a profile can be developed to guide treatment that includes mental health diagnoses and cognitive styles associated with bullying behavior.

Relevance

This study added to the knowledge base about bullying behavior and psychosocial factors that might be associated with this behavior in a mental health population.
Chapter 2

*Bullies, Victims, and Bully-Victims and Prevalence in School Settings*

Bullying behavior was not formally studied until 1970 by Dan Olweus (1993). Definitions of bully behavior have had slight changes over time. For instance, Olweus originally defined the idea that bullying behavior occurs “when one person picks on, harasses, or pesters another” (p. 8). However, he currently uses the following definition of bullying or victimization: “A student is being bullied or victimized when he or she is exposed, repeatedly over time, to negative actions on the part of one or more other students” (p. 9). Bullying research categorizes participants into four categories based on their involvement or lack of involvement in bullying behavior. These include: (a) bully, (b) victim, (c) bully-victim, and (d) non-bully/non-victim. The primary methods in which the subjects are classified in a bully typology vary in research studies and are based on self-reports and observer reports from parents, teachers, and peers. Each typology will be described and prevalence rates will be given, based on various studies of participants in the school setting.

*Bully.* In order to be classified as a bully, one must repeatedly and intentionally use aggression towards someone with less power (Orpinas & Horne, 2006). Most definitions of bullying overlap in the identification of repeated overt acts of aggression against an individual over a period of time (Sveinsson & Morris, 2007, as cited in Zins, Elias, & Maher, 2007). Types of aggression towards a victim may include physical and verbal forms, as well as direct and indirect acts of aggression. A direct act is one which is overt, such as name-calling or pushing. Indirect aggression is covert, because the act is less obvious, e.g., through excluding an individual or spreading lies or rumors about
another individual. Orpinas and Horne (2006) categorized three types of bullies: aggressive bullies, bullying followers, and relational bullies. An aggressive bully refers to an individual who utilizes overt aggression towards others. A follower, or passive bully, is someone who follows or continues the bullying behavior against someone else when he or she is reinforced for continuing that behavior. Olweus (1993) pointed out that followers join the bullying behavior for social reasons, but are not likely to initiate the act. A relational bully uses indirect or covert means of bullying others through impacting one’s social relationship, such as excluding someone from a group or through spreading rumors (Orpinas & Horne, 2006). In order to compare prevalence rates, various studies will be presented in order to compare the frequency of different typologies. Fekkes, Pijpers, and Verloove-Vanhorick (2003) conducted research with 2,766 participants and found that 3.5% were classified as bullies. However, these results were low in comparison with other prevalence data. The prevalence of bullies in studies conducted in the school setting range from 3.5% to 18% (Fekkes, et al., 2003; Klomke, Marrocco, Kleinman, Schonfeld, & Gould, 2007; Ivarsson, Brogren, Arvidsson, & Gillberg, 2005; Nansel, Overpeck, Pilla, Ruan, Simons-Morton, & Scheidt, 2001). In a population of adolescent criminal offenders, Viljoen, O’Neill, and Sidhu (2005) found that 32% of the participants in the study met criteria for the bully classification.

**Victim.** A victim of bullying is someone who sustains repeated and intentional acts of aggression from someone holding more power in the situation. Olweus (2003) further delineated various types of victims into two categories: passive/submissive victims and provocative victims. Passive or submissive victims exhibit less assertive behavior when bullied and often display an anxious and yielding reaction, whereas
provocative victims have both a yielding response as well as an aggressive temperament that provokes others into responding negatively. Orpinas and Horne (2006) label a third category as relational victims; these are victims of relational bullying. The prevalence of victims in the school setting range from 9% to 14.2% (Fekkes, et al., 2003; Klomek, et al., 2007; Ivarsson, et al., 2005; Nansel, et al., 2001). In comparison, Viljoen and colleagues (2005) found that 8% of their adolescent participants in a juvenile offender population identified themselves as victims.

**Bully-victim.** Those who bully others and are also victimized by bullies are labeled bully-victims. Therefore, a bully-victim sustains repeated acts of intentional harm from someone more powerful, as well as repeatedly and intentionally harming someone else with less power. In schools, bully-victims range in prevalence from 2% to 9% (Fekkes, et al., 2003; Klomek, et al., 2007; Ivarsson, et al., 2005; Nansel, et al., 2001). In a study with juvenile offenders, 37% were classified as bully-victims (Viljoen, et al., 2005).

**Non-bully/non-victim.** A non-bully/non-victim describes someone not classified as a bully, victim, or bully-victim. A non-bully/non-victim is someone who is not involved in bullying behavior. A majority of the participants, 80.2% of 2,766 children were not classified as bullies, victims, or bully-victims (Fekkes et al., 2003). However, in the study with adolescent offenders, only 23% of the participants were classified as non-bully/non-victims (Viljoen, et al., 2005).

**Mental Health Issues Associated with Bullying Behavior**

In terms of mental health concerns, internalizing and externalizing behaviors have been associated with bullying behavior. Internalizing behavior is directed inward,
whereas externalizing behavior is directed outward. The most frequent internalizing disorders in the literature are anxiety, posttraumatic stress disorder, and depression. Suicidal and homicidal ideation and behaviors have also been related to these disorders of internal and external manifestations. Last, conduct disorder and oppositional defiant disorder have been reviewed as being externalizing disorders associated with bullying.

Anxiety and PTSD. The impact of bullying has recently been explored in terms of the development of anxiety and posttraumatic stress symptoms. Mynard, Joseph, and Alexander (2000) were the first researchers to explore the connection between peer victimization and posttraumatic stress symptoms. Other researchers, such as Carney (2008), have assessed posttraumatic stress symptoms using the Impact of Events Scale.

Mynard, Joseph, and Alexander (2000) were interested in determining if children with a substantial amount of victimization from peers would also have greater frequency of symptoms of posttraumatic stress. In this study, conducted in the United Kingdom, the investigators hypothesized that the type of aggression as well as the victim’s self-worth would influence the level of symptoms. Additionally, Mynard and colleagues speculated that the child’s internal locus of control would be associated with the level of self-worth and posttraumatic stress symptoms. Three hundred and thirty-one children and adolescents in grades 8 through 11 completed the Victim Scale, the Peer Victimization Scale, the Multidimensional Measure of Children’s Perceptions of Control, and the Impact of Event Scale. The researchers found that those victimized by peers had a higher level of posttraumatic symptoms. More specifically, social manipulation by more powerful peers was highly correlated with posttraumatic stress symptoms. Furthermore, those experiencing verbal acts of victimization had a lower self-worth, as well as an
external locus of control. These findings suggest that children experience greater posttraumatic stress symptoms when they have been verbally victimized, have a lower self-worth, and an external locus of control.

Weaver (2000) published a case report of a 14-year-old adolescent female and highlighted how post-traumatic stress disorder can develop without a specific and identifiable life threatening stressor. This case portrayed how repeated bullying by name-calling and teasing can be manifested as school refusal because of flashbacks, nightmares, and generalization of fear. Weaver questioned whether or not criteria in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) should be revised to take into consideration the impact of repeated peer victimization.

Storch and Esposito (2003) investigated if overt and relational peer victimization were related to posttraumatic stress symptoms in a population of children in the United States. The participants consisted of 201 students between 10 and 13 years of age, who were primarily African American and Hispanic. The Social Experience Questionnaire (SEQ) and the Posttraumatic Stress Subscale of the Trauma Symptom Checklist for Children were given to participants to complete. The SEQ consists of 15-items on a 5-point scale that assesses overt and relational peer victimization as well as prosocial support. The Posttraumatic Stress Subscale is a 10-item measure on a 4-point scale that indicates the level of symptoms consistent with Posttraumatic Stress Disorder. The results indicated that overt and relational victimization appeared to be related to posttraumatic stress, whereas only relational victimization was significantly related to posttraumatic stress for girls. Limitations of study include the inability to generalize results to other
populations, because the sociodemographics were limited to urban children living in an area with high crime rates.

A more recent study that correlated traumatic symptoms with bullying was conducted by Carney (2008). Participants were 91 adolescents between the ages of 11 and 14, in a sixth grade rural school setting. The School Bullying Survey, a hypothetical bullying scenario, and the Impact of Event Scale were administered to participants. The School Bullying Survey assisted the researcher with classifying students into a typology of bullying behavior, such as a victim or witness. Next, a hypothetical bullying scenario was presented and the adolescents were asked to complete the Impact of Event Scale as if they were the victim in the scenario. Carney wanted to examine the levels of trauma that the study participants perceived after reading the hypothetical bullying scenario, as well as to determine the variables that predict these trauma levels. The Impact of Events Scale is further divided into two subscales, Intrusion and Avoidance, which are related to Criteria B and C, respectively in the DSM-IV diagnosis category for Posttraumatic Stress Disorder. In terms of the results of the study, Carney discovered that females rated higher on overall trauma levels, as well as on the level on the Avoidance subscale, compared with males. No statistically significant sex differences were found between participants when analyzing the Intrusive subscale. Seventeen percent of the total variance in perceived trauma was accounted for by sex, bully type, and exposure of bullying. However, the most significant predictor of trauma level was exposure to bullying.

Mueser and Taub (2008) were interested in determining the prevalence rates of Posttraumatic Stress Disorder in adolescents with severe emotional and behavioral disorders. The researchers recruited 69 adolescents between the ages of 11 and 17.
Caregivers completed the Child Behavior Checklist (CBCL) and the Caregiver Strain Questionnaire (CGSQ). The Child and Adolescent Functional Assessment Scale (CAFAS) and the Children’s Interview for Psychiatric Symptoms (ChIPS) were administered via an interview format. Mueser and Taub found that there was a higher rate of Posttraumatic Stress symptoms (28%) among this population compared with general population estimates among adolescents (0.5%-22%). Female adolescents were more likely to have been diagnosed with Posttraumatic Stress Disorder compared with male adolescents. Additionally, adolescents in the study who had Posttraumatic Stress symptoms also had higher levels of anxiety, depression, self-injurious behavior, somatic complaints, and aggressive behavior.

*Depression.* Another internalizing symptom that can result from repeated bullying is depression. Fekkes and colleagues (2003) were interested in studying the relationship between bullying behavior and psychosomatic and psychological complaints such as depression, in order to educate the medical community in identifying and treating these symptoms. Two thousand, seven hundred and sixty-six children from Dutch elementary schools were assessed cross-sectionally before an ongoing longitudinal study was begun to implement and assess the effectiveness of an antibullying program. The participants were given a questionnaire with items that assessed bullying behavior, psychosomatic symptoms, and health symptoms. The Short Form Depression Questionnaire for Children (KDVK) was also incorporated into the combined questionnaire to assess depression. The KDVK included nine items, resulting in a total score of 0 to 9. A score of 4 or greater indicated moderate depression, whereas 7 or greater was a strong indication of depression. Based on the results from questions asked in regard to bullying behavior, four
groups were derived, including: (a) bully, (b) bully-victim, (c) victim, and (d) neither a bully nor a victim. Out of a total of 2,766 participants, 80.2% were not involved in bullying behavior; 14.2% were victims; 3.5% were bullies, and 2% were bully-victims. Victims were at a higher risk of psychosomatic complaints, including headaches, sleeping problems, and abdominal pain, because these were reported more frequently, in comparison with other groups. Also, victims reported a moderate degree of depression, which indicated that victims were more likely to experience depression, compared with those not involved in bullying behavior. Those participants categorized as bullies did not evidence strong symptoms of depression and psychosomatic complaints compared with those not involved in bullying behavior. However, bullies were associated slightly more frequently with bed-wetting and headaches compared with non-involved participants. Bully-victims evidenced a higher level of health symptoms compared with those not involved in bullying behavior; these included abdominal pain, bad appetite, bed wetting, and feeling tired. Additionally, bully-victims indicated a higher level of depression compared with those not involved in bullying behavior.

*Suicidal ideation and attempts.* Tishler, Reiss, and Rhodes (2007) point out that suicide is the fourth highest leading cause of death for 12 year old adolescents. Additionally, adolescents with a psychiatric disorder are at a higher risk of committing suicide. Those victimized by peers are also at risk for suicidality.

Klomek and colleagues (2007) designed a longitudinal study to assess suicidal ideation, suicidal attempts, and depression among those involved in bullying behavior. Participants included 2,432 adolescents between 13 to 19 years of age in six New York State high schools; this occurred between 2002 through 2004. A self-report questionnaire
was designed with the Beck Depression Inventory, the Suicidal Ideation Questionnaire, questions about lifetime suicide attempts, and questions about bullying behavior. The results revealed that those involved in bullying behavior, being either a bully or victim, had a higher risk of suicide attempts, suicidal ideation, and depression. Those participants that bullied others more frequently and those more frequently victimized had a higher risk of developing depression, suicidal ideation and suicidal attempts.

Ivarsson and colleagues (2005) studied the level of suicidality and suicide attempts in various typologies of bullying involvement in Sweden. These researchers hypothesized a connection between suicidality and bullying, as well as varying social skills across the different bullying categories. Two-hundred and thirty-seven adolescents between the ages of 13 and 16 years participated by completing the Youth Self-Report (YSR), the Depression Self-Rating Scale (DSRS), Swedish version of the Beck Depression Inventory; a few questions were also incorporated about their involvement in bullying behavior. In addition, health records were reviewed, and the school health official provided a score on the Social and Occupational Functioning Scale. The results indicated that suicide attempts were associated with bullying involvement, either as bully, victim, or bully-victim. There was no relationship between social skills and bully typology. Those identified as bully-victims have both internalizing and externalizing symptoms. Victims had higher internalizing symptoms, whereas bullies had more externalizing problems.

Suicidal behavior and violence have been explored separately, but Lubell and Vetter (2006) suggest that the relationship between suicidal attempts and violence towards others is more similar than once thought. These researchers reviewed literature
and found that when there is a lack of coping skills or problem solving ability, adolescents resort to other means of dealing with distressing emotions. More specifically, suicide or violence is more likely to occur as a means to escape or to avoid their emotional distress.

*Conduct disorder and oppositional defiant disorder.* Viljoen and colleagues (2005) studied bullying behaviors in a population of adolescent offenders between the ages of 13 and 19. Nine different juvenile offender facilities had 193 male and 50 female participants. The Adolescent Health Survey was administered, which included scales of victimization, school connectedness, and family connectedness. There were additional questions that assessed psychological adjustment; these were derived from the Minnesota Adolescent Health Survey, the World Health Organization’s Health Behavior in School-Aged Children, McCreary Centre Society, and Centers for Disease Control and Prevention’s Youth Risk Behavior Survey. These questions asked about drug use, emotional and physical health, and safety. Of the 243 participants, 37% were bully-victims; 32% were bullies; 22% were not involved in bullying behavior, and 8% were victims only. Bully-victims and victims were more likely to report previous sexual abuse and had higher levels of suicidality. Bully-victims were significantly more likely to report physical abuse. Victims evidenced greater psychological distress and emotional health concerns than bullies.

*Risk Factors of Bullying Behavior*

Bullying behavior is more prominent when certain factors are present. The presence of risk factors is correlated with an increase in bullying behavior. Risk factors
range from family discord (Ahmed & Braithwaite, 2004) to lack of peer support (Rigby, 2003; Orpinas & Horne, 2006).

In order to understand family and school variables that contribute to bullying behavior, Ahmed and Braithwaite (2004) designed a study that differentiated children into the different typologies of bullying involvement based on corroborating self-reports from parents and children. Bully, bully-victim, victim, and non-bully/non-victim were dependent variables, whereas parenting style and school related aspects served as independent variables. One-thousand, four-hundred and one Australian students participated; these had a mean age of 11; also involved were 1401 caregivers of those students. The measure given was Life at School Survey, which is an online self-report questionnaire. In addition, these students gave their parents another version of the questionnaire to complete and return to the school. Ahmed and Braithwaite proposed that bullies would be more likely to have higher levels of school problems, conflicted family environment, and parents with an authoritarian parenting style compared with the other groups of children in the study. Additionally, the authors predicted that non-bully/non-victims would like school and feel a sense of control regarding the occurrence of bullying behavior, compared with bullies and victims. Results showed that bullies and bully-victims were more likely to have parents with an authoritarian parenting style. Also, non-bully/non-victims favored school more highly and perceived that the school had more control of bullying behavior. As hypothesized, bully-victims and victims had more problems at school. However, the other hypotheses were not supported. For instance, non-bully/non-victims and victims were not more likely to have parents with an authoritative parenting style. Bullies did not have significantly higher levels of family


disharmony, as compared with other classification groups. Interestingly, victims were more likely to have family disharmony, which was expected to be more in line with bullies. On a secondary analysis, the researchers fared better with school variables compared with family variables in terms of predicting bullies and victims. When only family variables were analyzed, these variables accurately predicted all typologies 41% of the time and bully category 54% of the time. School variables combined were 54% accurate, especially with non-bully/non-victims being predicted 73% of the time but were accurate only 35% of the time in predicting the bullies. When family and school variables were combined, an overall 61% of the groups were being accurately identified, with non-bully/non-victims being the strongest predictor at 76%, bullies at 61%, and victims at 57%. Ahmed and Braithwaite attributed problems with classification accuracy to incorrect placement in the beginning of the study. For instance, victims may not have been strictly victims and may have been unaware of their bullying behaviors. Similarly, bullies may not have been classified as bullies, but instead parents may have viewed their children more frequently as victims. Parents may not be the best corroborators, because neither victims nor bullies may be likely to disclose school related problems and if they do discuss situations, they may not report the situation in its entirety.

Kochenderfer-Ladd and Pelletier (2008) analyzed how a teacher’s response to bullying impacts the frequency of bullying behavior and how victimized children cope with being bullied. These researchers explored whether or not grade levels and student gender alter teachers’ beliefs and responses to bullying. Thirty-four teachers from the 2nd and 4th grade levels completed the various questionnaires that explored their classroom management strategies and views on the victimization of their students. Teacher
strategies included the following: (a) punishment, (b) advocate assertion, (c) advocate independent, (d) involve parents, (e) advocate avoidance, and (f) separate students. Assertive, normative, and avoidance were the three teacher views that were assessed. A teacher with an assertive view believes that children can be more assertive to reduce the likelihood of victimization. Normative views hold that bullying is normal behavior. Last, avoidance refers to the belief that victims and bullies should avoid each other in order to reduce bullying incidents. Three-hundred and sixty-three of their students completed questionnaires in relation to peer victimization and coping. Kochenderfer-Ladd and Pelletier discovered that teachers were more likely to view peer victimization as normal for boys and expect boys to cope independently, whereas girls were seen as more passive in their coping style. Younger peers were more likely to get adults involved when they were victimized, whereas higher grade levels experienced higher levels of peer victimization. In terms of teacher strategies, punishment was more frequently used, but having students handle situations independently was a strategy that was the least likely used. As hypothesized, avoidance beliefs were correlated with advocating avoidance and assertive beliefs with advocating assertion. The strategy of advocated avoidance revealed higher levels of victimization, whereas separating students evidenced a lower level of victimization.

**Protective Factors of Bullying Behavior**

It is imperative to determine protective factors against bullying behavior in order to improve resiliency to acts of bullying. Baldry and Farrington (2005) were interested in determining protective factors that increase an adolescent’s resilience to bullying behavior. They hypothesized that protective factors of parenting style and coping strategy
would moderate the effects of bullying. More specifically, authoritative parenting style and problem-focused coping would be the protective factors against bullying involvement. Two Italian vocational high schools with a combined total of 702 male students between the ages of 14 and 19 years of age participated in the study by completing a self-report questionnaire. The questionnaire combined various questions using a continuous scale to assess bullying behavior, parenting style, and coping strategies. With questions involving bullying, students who responded that bullying occurred never or once or twice within a matter of three months were considered to be not involved. Those participants indicating sometimes, once a week, or several times a week were categorized as bullies or victims, depending on the question. Parenting styles were assessed using a 5-point Likert scale in which participants rated the frequency with which parents respond in a certain manner. In terms of coping strategies, students were divided into the following orientations: (a) problem-oriented, (b) emotion-oriented, or (c) avoidance-oriented. The researchers found that 37.4% of students had bullied others at least sometimes in the past three months and of these students, 13.9% bullied others at least once a week. Victims that reported being sometimes bullied composed 17.1% of the participants, whereas 5.6% indicated that they were bullied at least once a week. Bully-victims were identified in 7.4% of the sample. As expected, bullies and victims were more likely to utilize emotional coping and to have conflicted parents. Protective factors of increased parental support and of coping, using a problem-solving approach were found in corroboration with the researcher’s hypotheses in that these factors had a buffering effect on the likelihood of being involved in bullying behavior. Another avenue
of findings that is of interest deals with how children with more supportive parents who have low conflict are more likely to report the incidents of bullying.

In order to determine protective factors of those not involved in bullying, Kochenderfer-Ladd and Skinner (2002) conducted research with 356 children in 4th grade between the ages of 9 and 10 years. The researchers utilized participants who were also enrolled in a longitudinal study since their inception into kindergarten. Children were administered a revised version of Kochenderfer and Ladd’s 1996 Peer Victimization Scale to which four more items were added to the original version. In addition, the responses were changed from a 3 to a 5-point scale. The Self-Report Coping Scale and the Loneliness and Social Dissatisfaction Questionnaire were also administered. Sociometric measures were utilized, in which students indicated those classmates that they least liked to play with as well as those with whom they most liked to play. Teachers completed the Child Behavior Profile in relation to anxious and depressed symptoms of each student, as well as each one’s social difficulties. The researchers found that peer victimization was positively correlated with loneliness, anxiety/depression symptoms as well as with social difficulties for male participants. Also, the coping strategy of problem-solving was beneficial only to non-victimized children. The use of social support differed for female and male participants because the girls were less prone to victimization; however, victimized boys in the study who were seeking social support were less preferred by peers compared with non-victimized boys seeking social support.

Hodges, Boivin, Vitaro, and Bukowski (1999) conducted research on the power of friendship and how this variable impacts bullying behavior. Participants were 533 French-Canadian children in 4th and 5th grades as the first part of data collection. The
second data collection retained 393 participants for their 5th and 6th grade years. Children completed a self-report on loneliness and peer-nominated those victimized. Additionally, children had to choose three children they considered to be their best friends. If children had reciprocally chosen each other as their first pick, these children were considered to be best friends. With their best friend in mind, children completed the Bukowski and colleagues (1994) Friendship Qualities Scale. Teachers completed the Rutter’s (1967) Children’s Behavior Questionnaire on their students. This 26-item questionnaire assesses internalizing and externalizing behaviors. The researchers found that “internalizing and externalizing behaviors predicted increases in victimization over the 1-year interval of the study” (p. 98). Additionally, having a “best friend predicted decreases in victimization” (p. 98).

*Cognitive Distortions of Bullies and Victims*

Another psychosocial factor that can be utilized to differentiate between bullies and victims is cognitive distortions. Cognitive distortions are an individual’s thoughts that inaccurately appraise a given situation without sufficient evidence to warrant the basis of the thought. Based on the following literature review, there are two categories of cognitive distortions: (a) self-serving and (b) self-debasing. Self-serving cognitive distortions are thoughts that improve one’s self-worth and purpose; however, self-debasing cognitive distortions are thoughts that blame oneself for one’s shortcomings.

*Self-serving.* Cognitive distortions that function to improve one’s perception, self-worth and purpose are called self-serving cognitive distortions. Various researchers delineate distortions in thinking that are labeled as self-serving cognitive distortions as being correlated with antisocial behavior (Liau, Barriga, & Gibbs, 1998; Barriga, Laudau,
Bullying

Liau, Barriga, and Gibbs (1998) investigated self-serving cognitive distortions in a sample of 52 male delinquent adolescents, compared with 51 male non-delinquent adolescents between the ages of 14 to 18 years. The researchers hypothesized that delinquent adolescents would have higher levels of self-serving cognitive distortions and antisocial behavior. Additionally, overt and covert thoughts about behavior would align with overt and covert antisocial acts. Overt behaviors consist of direct behaviors such as fighting, whereas covert behaviors encompass indirect means of hurting others such as stealing and lying. The How I Think (HIT) Questionnaire was utilized to examine the frequency and type of self-serving cognitive distortions. In conjunction with HIT, the Self-Reported Delinquency (SRD) scale was administered as an adapted version that excluded covert items. The results indicated that adolescents with antisocial behavior were highly correlated with cognitive distortions endorsed on the HIT. Additionally, delinquent youths scored higher on overt behaviors on the HIT compared with non-delinquent youths as the control group. These results support the hypothesis that delinquent youth that commit overt antisocial behaviors have more self-serving cognitive distortions.

In order to determine if self-serving and self-debasing cognitive distortions were correlated with internalizing and externalizing behaviors, Barriga, Landau, Stinson, Liau, and Gibbs (2000) administered self-report measures to adolescent delinquents between 13-19 years of age, and high school students between 15 and 19 years of age. Barriga and colleagues had 96 male and female incarcerated youth and 66 male and female high
school students complete the HIT questionnaire, Children’s Negative Cognitive Error Questionnaire (CNCEQ), and Youth Self-Report (YSR). As stated previously, the HIT questionnaire measures self-serving cognitive distortions. The CNCEQ is a tool designed to measure self-debasing cognitive distortions, whereas the YSR assesses problems and competencies of adolescents. The results showed that delinquent adolescents scored higher on the HIT, CNCEQ, and YSR compared with the control group of high school students. As hypothesized, the HIT predicted those participants who had externalizing behaviors, whereas the CNCEQ predicted those with internalizing problems.

Toblin, Schwartz, Hopmeyer Gorman, and Abou-ezzeddine (2005) targeted the impact of psychosocial functioning of aggressive victims of bullying. Two-hundred and forty urban school students with a mean age of 9.5 participated by completing a self-report inventory, a peer rating inventory, and an interview. The self-report inventory consisted of the Social Behavior Rating Scale, Emotion Regulation Checklist, Children’s Depression Inventory, and Loneliness and Social Dissatisfaction questionnaire. Grade point average was also recorded. The researchers classified participants into four groups, based on the peer nomination inventory, including: (a) aggressive victims, (b) passive victims, (c) bullies, and (d) normative contrasts. Each participant was classified according to high or low levels of aggression and victimization. For instance, aggressive victims were high on aggression and victimization, whereas normative contrasts were low on both. The results suggested that aggressive victims had higher levels of emotional dysregulation and hyperactivity compared with the other groups. Passive victims had higher levels of depression, emotional dysregulation, hyperactivity, and submissiveness-withdrawal compared with normative contrasts. This research substantiates the fact that
classifying multiple subgroups of bullying behavior in relation to levels of aggression and victimization would assist clinicians in formulating treatment goals that directly address the distinct symptoms for each particular subgroup.

*Self-debasing.* A second cluster of cognitive distortions, called self-debasing cognitive distortions, involve thoughts that blame oneself for one’s shortcomings. These distortions include: (a) catastrophizing, (b) personalizing, (c) overgeneralization, and (d) selective abstraction (Leung & Wong, 1998; Messer, Tempton, Van Hasselt, Null, & Bukstein, 1994).

A two-year longitudinal study of 644 high school students between the ages of 13 and 16 was conducted by Marcotte, Levesque, and Fortin (2006) in order to investigate, through self-report instruments, how cognitive distortions vary in terms of depressive symptoms. The Beck Depression Inventory, Dysfunctional Attitudes Scale, Cognitive Styles Test, and Cognition Checklist were administered three times during the length of the study. Marcotte and colleagues found that 19% of the participants experienced depression symptoms at the beginning of the study, with a cutoff score of 16 on the Beck Depression Inventory. Depressed participants reported a higher amount of cognitive distortions over time on the Cognitive Styles Test (CST) and the Cognition Checklist (CCL). For female participants, cognitive distortions changed readily with remission of depressed symptoms, in comparison with the relatively stable scores on the Dysfunctional Attitudes Scale (DAS). These findings suggest that depression for girls is more state-dependent rather than being a personality trait.

Prinstein, Cheah, and Guyer (2005) refer to self-debasing cognitive distortions as critical self-referent attributions with their two samples of 116 kindergarteners and 159
adolescents. For the first study, the researchers hypothesized that those kindergarteners with self-referent attributions based on a hypothetical scenario would exhibit more internalizing symptoms, such as depression, anxiety, and withdrawal from others. The results substantiated their hypothesis that children with self-referent attributions would evidence greater internalizing symptoms as well as poor peer experiences. With the second study, adolescents between the ages of 15 and 17 were given a hypothetical scenario; they then had to choose from a list of attributions, complete self-report measures (Children’s Depression Inventory, Social Anxiety Scale for Adolescents, Loneliness Scale, and Self-Perception Profile for Adolescents) and also a sociometric assessment of peers. Prinstein and colleagues hypothesized that those with more self-referent attributions would exhibit more internalizing symptoms, as well as being related to victimization by peers or another actual social stressor. As hypothesized, higher self-referent attributions were related to depressive symptoms and high self-referent attributions were associated with high levels of peer rejection.

In order to determine if discrepancies exist between self-reports and peer-reports of aggression and victimization, Reyes and Prinstein (2004) studied with 203 adolescents between the ages of 15 and 17 years. Participants completed a sociometric assessment of their peers and also self-reports, which included the Children’s Depression Inventory and the Revised Peer Experiences Questionnaire (RPEQ). Results indicated that boys with higher depressive symptoms overrated their levels of overt victimization compared with peer-reports. In terms of relational and reputational victimization, boys and girls with higher levels of depressive symptoms overestimated their victimization compared with peer reports.
Chapter 3

This study assessed differences in each typology of bullying involvement in order to guide mental health treatment. These differences consist of a particular cognitive style of self-serving or self-debasing cognitive distortions and the likelihood of internalizing disorders of PTSD and Depression. Hypotheses and support for each hypothesis are delineated in the following section.

**Hypothesis 1.** In comparison with typical prevalence rates measured in the school setting, as indicated in the literature review, it was hypothesized there would be more frequent incidents of bully, bully-victim, and victim in a sample of adolescents in a mental health setting, as measured by the brief questionnaire adapted from a survey conducted by the World Health Organization. This hypothesis is supported by research indicating that victims and bullies are more likely to experience short-term and long-term mental health problems (Mynard, Joseph, & Alexander, 2000; Carney, 2008; Weaver, 2000; Fekkes, et al., 2003; Storch & Esposito, 2003; Ivarsson, et al., 2005; Rigby, 2003). Because of this, it was predicted that those youth in a mental health population would be more likely to be involved in peer victimization compared with adolescents in a school setting.

**Hypothesis 2.** It was hypothesized that victims of bullying, as defined by a brief questionnaire, were more likely to have internalizing disorders such as PTSD and Depression when compared with bullies and non-bully/non-victims, as evidenced by high scores on My Worst Experiences Scale and The Reynolds Adolescent Depression Scale (RADS-2). Similar to the first hypothesis, victims of bullying behavior in a school setting are more likely to have internalizing disorders (Mynard, Joseph, & Alexander, 2000;
Carney, 2008; Weaver, 2000; Fekkes, et al., 2003; Storch & Esposito, 2003; Ivarsson, et al., 2005; Rigby, 2003). Therefore, adolescents participating in a mental health program that have been victimized by peers are hypothesized to be more likely than other bully typologies to experience a greater number of internalizing symptoms.

**Hypothesis 3.** Bullies, identified by a brief questionnaire, are just as likely to have internalizing disorders of PTSD and Depression compared with victims. Additionally, it was predicted that bullies would have more frequent symptoms of internalizing disorders compared with non-bully/non-victims, as evidenced by high scores on My Worst Experiences Scale and the Reynolds Adolescent Depression Scale (RADS-2). This hypothesis is supported by Lubell and Vetter’s (2006) review of literature suggesting that adolescents with distressing feelings, such as depression, are likely to act out violently against others in order to cope with these feelings.

**Hypothesis 4.** It was hypothesized that victims of bullying are more likely to have self-debasing cognitive distortions, as measured by the CNCEQ, compared with bullies and non-bully/non-victims. This hypothesis is supported by literature suggesting that victims have self-referent attributions (Prinstein, et al., 2005).

**Hypothesis 5.** It was predicted that bullies are more likely to have self-serving cognitive distortions, as measured by the HIT questionnaire, compared with victims and non-bully/non-victims (Liau, Barriga, & Gibbs, 1998; Barriga, Laudau, Stinson, Liau, & Gibbs, 2000; Toblin, Schwartz, Hopmeyer Gorman, & Abou-ezzeddine, 2005); however, bullies and bully-victims with internalizing symptoms are predicted also to have self-debasing cognitive distortions, as measured by the CNCEQ (Lubell & Vetter, 2006; Barriga, et al., 2000; Prinstein, et al., 2005).
Hypothesis 6. Bully-victims are predicted to be likely to have a mixed
presentation of self-debasing and self-serving distortions and internalizing disorders of
PTSD and Depression, as evidenced by the CNCEQ and HIT questionnaire, My Worst
Experiences Scale, and the Reynolds Adolescent Depression Scale (RADS-2; Liau, et al.,
Weaver, 2000; Fekkes, et al., 2003; Storch & Esposito, 2003; Ivarsson, et al., 2005;
Rigby, 2003).
Chapter 4

Research Design

This research study is a cross-sectional case control design. Participants completed five self-report measures at one point in time, within five days of being admitted into a Partial Program.

Participants

Of the 64 participants who completed the questionnaires, 39.1% were male and 60.9% were female. Most participants were of Caucasian descent (85.5%), followed by 3.2% Black, 9.7% Hispanic, and 1.6% Bi/Multiracial. The participants ranged in age from 12-18 years and were enrolled in 5th through 12th grades. Twenty-five percent of the participants were 16 years of age, followed by 17.5% being 15 years of age (Table 1). Most of the participants were in 7th grade (21%) and 9th grade (21%); see Table 2 for the grade frequencies and percentages.

In regard to bullying involvement, there were more victims (n=24; 37.5%), compared with bullies (n=11; 17.3%), bully-victims (n=10; 15.6%), and non-bully/non-victims (n=19; 29.7%). In terms of discharge diagnoses, close to half of the participants displayed a combination of greater number of internalizing and externalizing disorders (n=31; 48.4%) and a comparable level of participants displayed an internalizing disorder only (n=26; 40.6%), compared with participants diagnosed with only an externalizing disorder (n=7; 10.9%).

Inclusion and exclusion criteria. Inclusion criteria included the following: (a) male and female adolescents between the ages of 12 and 18 who were admitted into a partial hospitalization program for displaying unstable behaviors that warranted more
intensive treatment and were at risk for inpatient hospitalization if left untreated and (b) demonstrated fluency in English comprehension, as evidenced by the ability to read and understand statements at a third grade reading level. Exclusion criteria included: (a) adolescents who had already participated in the current study during a previous admittance into the program and (b) adolescents who were unable to understand the self-report questions asked because there was an inability to comprehend items even when read to them by staff. The hospital staff member or intake person made a decision based on whether or not the patient would be able to understand the questions prior to asking the patient and his or her parent/guardian to participate. Additionally, if the patient agreed to participate and the hospital staff member realized that the participant was not able to understand the questions, the participant could stop completing the questionnaires.

Any data set that was incomplete was not included.

Informed consent and assent procedures. Informed consent was obtained from parents/guardians of patients within the first week of admittance into the program by the intake staff. The signed consent was placed in the patient’s chart, and the administrative assistant assigned the participant a number that was placed on the consent form and on each of the self-report forms given to the participant to complete. Additionally, assent was obtained from participants. Parents and adolescents received a one-page letter explaining the purpose of the study, the ability to withdraw from the study at any time, the procedures utilized to keep information confidential, and information necessary to contact an on-call staff person at the hospital if any distressing thoughts arose requiring additional support and intervention.
Measures

Questions about bullying behavior. In order to distinguish the level of bullying behavior (i.e. typologies of bullying involvement), participants were asked to answer a few questions utilized by various researchers (Fekkes, et al., 2004; Klomek, Marrocco, Kleinman, Schonfeld, & Gould, 2007; Nansel, Overpeck, Pilla, Ruan, Simons-Morton, & Scheidt, 2001) from a survey by the World Health Organization geared toward students from 6th through 10th grades. For instance, participants were asked to respond with one of six answers to the question, “How often did other children bully you during this year?” The forced choice response categories included: zero times, one to two times, a few times a month, once a week, two to three times a week, or almost every day. Similarly, another question asked participants the frequency of situations in which they participated in bullying other children.

CNCEQ. Leitenberg, Yost, and Carroll-Wilson (1986) devised the Children’s Negative Cognitive Error Questionnaire, which was modeled after Lefebre’s (1980, 1981) Adult Cognitive Error Questionnaire. The CNCEQ is a 24-item self-report measure that assesses four cognitive errors in three areas through vignettes on a third grade reading level. These cognitive distortions include selective abstraction, overgeneralization, catastrophizing, and personalization. Cognitive distortions are explored in the athletic, social, and academic domains. Messer and colleagues (1994) measured the construct validity of the CNCEQ in an inpatient sample. Unfortunately, the four distortions did not reflect four factors, but instead reflected a more general factor of negative cognition. Additionally, the researchers wanted to determine if the CNCEQ could differentiate between adolescents 11-18 years of age who had been diagnosed with
affective (depression, anxiety) and conduct disorders. The results indicated that the CNCEQ is not able to differentiate between different levels of negative distortions, but that it can differentiate between affective and conduct disordered youth, using the overgeneralization distortion scale.

_HIT_. The original How I Think (HIT) questionnaire was developed by Gibbs, Barriga, and Potter (1996). This questionnaire assesses self-serving cognitive distortions, which include the following: (a) self-centered, (b) blaming others, (c) minimizing/mislabeling, and (d) assuming the worst. The HIT (2001) consists of 54 items, at a fourth grade reading level, on a 6-point Likert scale, which ranges from strongly agree to strongly disagree. The questionnaire takes 5 to 15 minutes to complete.

Internal consistency using Cronbach’s coefficient alpha for the overall score ranged from 0.92 to 0.96. In regard to convergent and divergent validity, the HIT questionnaire scores were compared with various measures of antisocial behavior and non-related measures, such as age, socioeconomic status, intelligence, achievement, and grade point average. As for convergent validity, the HIT correlated highly (between 0.47 and 0.55) with externalizing behavior. In sum, the HIT Questionnaire is a reliable and valid measure.

_MWES_. My Worst Experiences Scale (MWES; Hyman & Snook, 2002) was designed as a self-assessment scale to identify Posttraumatic Stress Disorder in youth. It consists of two parts, totaling 132 items and was normed on children and adolescents between the ages of 9 and 18 years. The first part has 21 events that the participant chooses as his or her worst experience. The categories include death of a parent, war, school problem, family fighting, fire, loss of a pet, robbery, sexual assault, and physical
assault. After choosing one, the participant then writes a descriptive narrative about his or her worst experience. If the participant indicates that none of the events listed can describe his or her worst experience, then the description will be used to categorize the experience. Additional questions include the duration of the event, the frequency, and the impact. The second part consists of 105 items of thoughts, feelings, and behaviors related to the worst experience and the participant rates the frequency on a scale from 0 (did not happen) to 5 (all the time). The MWES is written at a third grade level and takes approximately 20 to 30 minutes to complete. The results are categorized into the following: (a) Inconsistent Responding (INC) Index, (b) MWES Total (TOT), (c) four DSM-IV Criterion Subscales, and (d) seven Symptom Subscales. The validity of the measure continues to be an ongoing process because the sample was under-representative of African American and Hispanic minority groups.

In regard to reliability, the Cronbach’s alpha for internal consistency for the total score is 0.97, with a range from 0.69 to 0.94 for the subscales and impact scale. Test-retest reliability was demonstrated for the total score at 0.95, although the administration period was less than 6 weeks.

*RADS*-2. The Reynolds Adolescent Depression Scale-2 (RADS-2; Reynolds, 2002) consists of 30-items rated on a 4-point scale and is divided into four subscales. The subscales consist of the following: (a) Dysphoric Mood, (b) Anhedonia/Negative Affect, (c) Negative Self-Evaluation, and (d) Somatic Complaints. The measure also combines into a total depression score with cutoff points to indicate severity of depression: normal, mild, moderate, and severe. This measure was normed on adolescents and young adults between the ages of 11 and 20. The RADS-2 was written for comprehension between a
second and third grade reading level (i.e. “I feel lonely,” “I feel tired,” and “I feel like nothing I do helps any more”) and takes 5 to 10 minutes to complete.

In terms of validity and reliability, the RADS-2 has strong evidence that it is a reliable and valid measure. More specifically, Chonbach’s alpha coefficients range from 0.78 to 0.94. There is also high internal consistency reliability for the total depression score ranging from 0.80 to 0.87 with the total school sample, 0.79 to 0.89 for the school-based restandardization sample, and 0.81 to 0.87 for the clinical subsample. Additionally, test-retest reliability is good and estimates of the Depression Total scale over a two week period are high (0.85). For validity, the manual reviewed various studies of content, criterion-related construct, convergent, and discriminant validity, all of which indicated strong validity.

Procedure

The Partial Program Director selected two staff members who were trained in methods of informing participants and their parents about the research study and of asking participants and parents if they would like to participate. The hospital staff member provided the one page summary of the study and obtained written consent for treatment from the participants’ parents/guardians. The hospital staff member was instructed to be available when the participants were completing the questionnaire, should any questions arise. The researcher had trained staff members in how to answer questions that the participants or parents might ask. Additionally, the staff members provided the completed questionnaires to the administrative assistant to be placed in a separate, secure location that was separate from each participant’s chart.
After consent and assent, each participant was assigned a number that was able to be linked to the patient’s name only by the administrative assistant. After giving assent to participate in the research, participants completed the following five self-report measures: (a) brief questionnaire to assess bullying typology, (b) CNCEQ, (c) HIT questionnaire, (d) MWES, and (e) RADS-2. The participants were given the option of reading and completing the measures independently or having a hospital staff member read the measures aloud. After completing the measures, a hospital staff member asked the participant if he or she wanted to discuss any feelings that came about as a result of completing the measure. Additionally, the staff member scanned various items on the Reynolds Adolescent Depression Scale (RADS-2) to determine any risk of harm to self or others before the adolescent returned to the milieu. If item number 14 and 30 (Item 14: “I feel like hurting myself;” Item 30: “I feel like nothing I do helps any more”) on the RADS-2 was identified by 3 to signify “sometimes” or 4 to signify “most of the time,” a staff member was instructed to inquire further and assess for suicidal risk according to hospital policy.

Confidentiality Procedures

In order to protect participants’ confidentiality, specific procedures were followed. As indicated above, when participants and parents were informed of the study through a consent form and the consent was signed, the administrative assistant assigned the participant a number and placed the consent form in the patient’s chart according to hospital policy (Policy Number: 1200.30, Effective Date: 7/12/93). The number was recorded on each measure that the participant completed so that this researcher was not able to identify the participant’s name. The completed measures were placed safely in a
secure file that was separate from the patient’s chart. This researcher, only, had access to the completed measures and did not have access to the patient’s chart.
Chapter 5

Over half of this sample (53.13%) had a sufficient number of PTSD symptoms to warrant a clinical diagnosis of PTSD. Moreover, bully-victims had the highest incidence of PTSD symptoms, followed by bullies, victims, and non-bully/non-victims, respectively (see Table 3). However, a one-way ANOVA comparing PTSD symptoms and bullying groups revealed no significant differences between groups (F=1.691, p=0.198).

Additionally, 66.7% of this sample had severe levels of depressive symptoms. Further analysis revealed that victims exhibited a greater frequency of severe depressive symptoms compared with bully-victims, bullies, and non-bully/non-victims (see Table 3). However, severity of depressive symptoms between groups, as analyzed using a one-way ANOVA (F= 0.765; p = .0518), did not reach statistical significance.

With regard to self-debasing thoughts, bullies displayed an equal number of self-debasing thoughts compared with victims. Interestingly, non-bully/non-victims had a higher percentage of self-debasing thoughts compared with bully-victims (see Table 4). However, a one-way ANOVA demonstrated no statistically significant differences in self-debasing thoughts between groups (F= 0.478; p =0.625).

Self-serving thoughts were found to differentiate groups significantly (F= 6.112; p< .01). Further analysis using a Tukey post hoc test revealed significant differences between the following groups: bullies and non-bully/non-victims (p=0.036), victims and bully-victims (p=0.019), and bully-victim and non-bully/non-victim (p=0.002). A majority of bully-victims displayed clinical levels of self-serving thoughts, whereas a little over one-half of the bullies had this same clinical level of self-serving thoughts.
Only a few of the victims had self-serving thoughts. Last, non-bully/non-victims had the least frequent number of self-serving thoughts.
Chapter 6

Bullying involvement is often studied in the school setting. However, it has not been studied in a clinical population. This study sought to develop a profile of psychosocial factors in order to guide treatment in a partial hospitalization setting for adolescents. Depression, PTSD, self-serving thoughts and self-debasing thoughts were all considered as possible factors differentiating between bully types. However, as indicated by the results, only self-serving thoughts significantly differentiated the groups. Because of these findings, a profile cannot be developed; nonetheless, the hypotheses will be reviewed and discussed, and limitations to the current study will be reviewed. Finally, future direction in terms of bullying research in a clinical setting for adolescents will be discussed.

The current study revealed a greater number of victims (37.5%) and bully-victims (15.6%) in the hospital setting compared with prior research which considered those in a school setting (victims 9-14.2%; bully-victim 2-9%). However, the number of bullies (17.3%) was comparable with the rate discussed in the literature among a normal school population (bullies 3.5-18%; Feekes, et al., 2003; Klomek, et al., 2007; Ivarsson, et al., 2005; Nansel, et al., 2001). In comparison with a study involving juvenile criminal offenders (victims 8%; non-bully/non-victims 23%), this current sample of participants in a mental health setting had greater numbers of victims (37.5%) and non-bully/non-victims (29.7%), but fewer bullies and bully-victims (Viljoen, et al., 2005); see Table 5.

Based on prior research, it was believed that victims would have more internalizing symptoms compared with bullies and non-bully/non-victims (Mynard, Joseph, & Alexander, 2000; Carney, 2008; Weaver, 2000; Fekkes, et al., 2003; Storch &
Esposito, 2003; Ivarsson, et al., 2005; Rigby, 2003), and that bullies would exhibit more internalizing symptoms when compared with non-bully/non-victims (Lubell & Vetter, 2006). In contrast to what was hypothesized, victims were not found to have a greater frequency of internalizing symptoms compared with other bully types. Instead, a majority of the participants exhibited internalizing symptoms, regardless of bully type. The lack of differentiation between groups was a factor of acuity level in a hospital setting because a majority of the participants did exhibit internalizing symptoms and internalizing diagnoses, as well as a combination of internalizing and externalizing diagnoses upon discharge, regardless of their bullying involvement. In other words, those admitted to the program were suffering from internalizing symptoms such as depression, and that these adolescents in this particular setting displayed, to a significant degree, more internalizing symptoms compared with those exhibiting only externalizing symptoms, such as acting out, aggression, and conduct related issues. This is also the reason for their being placed in a mental health program, as opposed to a juvenile justice placement.

With regard to cognitive errors, it was proposed that victims would display clinically elevated levels of self-debasing thoughts (Prinstein, et al., 2005), whereas bullies would have more self-serving thoughts when compared with other bully types (Liau, Barriga, & Gibbs, 1998; Barriga, Laudau, Stinson, Liau, & Gibbs, 2000; Toblin, Schwartz, Hopmeyer Gorman, & Abou-ezzeddine, 2005). There were no differences between groups with regard to self-debasing thoughts, although this may be attributed to the sample selected. In general, adolescent patients are typically admitted to a mental health hospital program because of internalizing symptoms and related self-debasing thoughts; in fact, these symptoms are deemed to be medically necessary criteria for
admission into a hospital setting. For example, an adolescent experiencing depression would typically report self-debasing thoughts such as “not being good enough,” “never having friends” or belonging, and perhaps even believing that his or her behavior has ruined his or her social status. This hospital sample was more similar relative to experiencing self-debasing thoughts, coinciding with a large number of the participants being diagnosed with an internalizing disorder.

In contrast, there was a significant difference between groups relative to self-serving thoughts. More specifically, there was a difference between bullies and non-bully/non-victims, victims and bully-victims, and bully-victim and non-bully/non-victim. Bullies and bully-victims displayed a greater frequency of self-serving thoughts compared with victims and non-bully/non-victims. In other words, bullies and bully-victims identified a cognitive style of blaming others, had an inflated self-worth (such as feeling entitled to getting what they wanted, when they wanted) and had a general sense that the worst would happen. Instead of feeling vulnerable, bullies and bully-victims presented themselves in a manner that distinguished them from others in order to make others believe they deserved respect. This is believed to be a protective feature to defend against being seen as weak or being an easy target. Bullies and bully-victims exhibited more externalizing behaviors such as acting out and aggression, perhaps as a way to protect themselves from being hurt.

Bully-victims are labeled as such because of being bullied and also of being victimized; therefore, it was believed that this group would exhibit a mixture of symptoms (Liau, et al., 1998; Barriga, et al., 2000; Toblin, et al., 2005; Mynard, et al., 2000; Carney, 2008; Weaver, 2000; Fekkes, et al., 2003; Storch & Esposito, 2003;
Ivarsson, et al., 2005; Rigby, 2003). However, this was not the case. It appeared that differences were not found between other symptoms because the groups were too similar. The bully-victim category may have decreased the chances of observing differences in groups because this type was hypothesized to have mixed characteristics, making it difficult to be distinguished from the bully or victim group. Because bully-victims have both internalizing and externalizing symptoms, as well as self-serving and self-debasing cognitive styles, it would make sense that this group was too similar to both the victim group and the bully group. Statistically, this group was not different from the victim group or the bully group.

Although taking into consideration prior research with regard to bullying involvement in the school setting and the results of this study in a clinical setting, it was surprising to see that bully types in the school setting were much more clearly differentiated compared with those in a mental health setting. Those placed in a mental health setting were far more similar than they were different. It was interesting to find that there was an equal playing field when it came to symptoms reflected in a specialized mental health treatment program as opposed to a more diverse spectrum of behaviors in the school setting. Bullies and victims in the school setting appear much different when combined with non-bully-non-victim types. The current results point to the idea that admission to a mental health treatment facility such as a partial hospitalization program equalizes the bullying type; instead, it forms a common theme of internalizing symptoms that may include a history of trauma and other risk factors.

One possible explanation for these findings is that youth in treatment may have more similarities than differences when it comes to symptomatology. The similarities in
symptoms for adolescents in partial hospitalization point to the idea that treatment could then be more highly focused and be more specifically attuned to similar manifestations of symptoms and behaviors. Although a one-size fits all treatment approach may seem to be counterintuitive and controversial, it may be that adolescents placed in a mental health setting have similar treatment needs and could thus benefit not only from group therapy but also from a realization of common group goals surrounding the impact of trauma and, in addition, learn healthy coping skills. The group dynamics in the mental health setting may provide a framework with which to increase resiliency and protective factors, despite the shortened length of stay that is often dictated by insurance agencies. It is suggested that aftercare planning assist patients in connecting with ongoing services in the community to address specific and individualized trauma treatment.

Limitations

First and foremost, there were unequal groups which may have contributed to statistical limitations in finding differences between groups. Confounding factors may have contributed to the lack of differences between groups, such as a history of trauma, instability in their lives, and lack of adequate social support and resources to cope with trauma and instability. Those in a mental health setting appear to be similar rather than different when compared with research findings on bully typology in the school setting. Perhaps equal groups would have reduced confounding variables that appear to make the groups more similar than they are different. However, internalizing symptoms and diagnoses were common in this mental health sample. Despite the sample size appearing to be adequate when combining groups, the sample was further divided according to bully types and this lowered the chance of observing statistical differences.
Another factor that may have contributed to a lack of differences between groups was the sample itself, which was composed of hospitalized patients. Specifically, it may have been difficult to differentiate between groups on the proposed factors because the criteria for patient eligibility for hospitalization often included an internalizing disorder and self-debasing thoughts, making these factors common characteristics of this sample. The adolescents in this sample were similar to each other more than they were than different from each other. A majority of the sample was suffering from symptoms of depression and trauma, which is typical for a population of adolescents in mental health treatment.

*Future Directions*

With regard to future directions in bullying research, a replication of this study is needed in other adolescent hospital-based treatment programs in order to confirm or disconfirm these findings. If a lack of differences between groups is once again confirmed with further research, then this would call into question the importance of differentiating between bully types in a partial hospitalization setting, and thereby decrease the need to specialize treatment based on bully type alone. In this particular sample, the reason for similarities in bully groups is the presence of internalizing disorders, such as PTSD and depression, because over half the sample had internalizing symptoms. More specifically, 53.13% had clinical symptoms of PTSD and 66.7% reported severe depression symptoms. Therefore, it may be that differentiating bully types is not necessary and it would be more beneficial to determine the reason for the similarities. The more relevant finding in this study points to trauma. Fehon and colleagues (2005) found that adolescents on an inpatient unit displayed high levels of
PTSD symptoms as a result of witnessing violence and of enduring maltreatment. Combined with this trauma history, adolescents with impulsivity as a result of the trauma were more likely than their non-trauma counterparts to engage in violence. This is one of many studies that points to trauma as the factor that links to re-enacting behavior, such as violence and peer victimization (Dyregrov & Yule, 2006; Perrin, Smith, and Yule, 2000).

In conjunction with situations of re-enactment and re-victimization behaviors related to trauma, these adolescents cycled in and out of treatment; they are known as revolving door patients. As the study went on, it was more difficult to obtain new participants, because a handful of the adolescents who had already participated were being re-admitted. It is necessary to put supports in place for these patients after they leave the intense treatment, such as family education and continuity of treatment for trauma. Treatment setbacks are to be expected and should not be seen as failures. The recovery model is aimed at addressing these gaps and bridging treatment. Recovery-oriented services would take into consideration how trauma impacts the person across every aspect of his or her life, how to assist the person with building on his or her strengths, and how to empower the person to take charge of his or her recovery (Jacobson & Greenley, 2001; Jacobson & Curtis, 2000; Department of Health and Human Services, 2003). This model has been transformed into practice at various levels of treatment and it would be imperative for those in mental health treatment to receive a high standard of care that addresses the underlying issues rather than placing blame on the patient for continuing to cycle through various levels of care in treatment.

Specifically with this sample, the participants were being treated for their current symptoms and for the reasons that they entered a high level of care, rather than the core
underlying issue of trauma. With such a high percentage of the subjects reporting symptoms of PTSD and depression, it would be important for staff at the partial program to improve early identification of these symptoms to better direct treatment (Mueser & Taub, 2008). A symptom checklist is proposed at the outset of admittance in the program in order to screen for PTSD and depression. With this information, the partial program would be able to tailor individual and group treatment towards trauma focused strategies, as well as to begin to teach patients how to understand their symptoms and how to cope with feelings of depression, hopelessness, and fear. The most highly researched and efficacious treatment for children and adolescents with PTSD and depression has been Trauma Focused Cognitive-Behavioral Therapy (TF-CBT; Silverman, et al., 2008; Cohen, Mannarino, Berliner, & Deblinger, 2000). The components of TF-CBT consist of the following: (a) psychoeducation and parenting skills, (b) relaxation techniques, (c) affective expression and regulation, (d) cognitive coping and processing, (e) trauma narrative, (f) in vivo exposure, (g) conjoint parent/child sessions, and (h) enhancing personal safety and future growth (Cohen, Mannarino, & Deblinger, 2006).

Using TF-CBT in a partial hospitalization setting has advantages and limitations. For instance, initiating this treatment in the hospital setting would assist the patient with beginning to heal from the trauma. However, there may be limitations on the amount of time the patient is in the program because of insurance limits or even in the event that the patient begins to decompensate and needs admitted into an inpatient hospitalization program. If the TF-CBT treatment is interrupted the patient would be more vulnerable and more highly exposed. In addition to staff training in the TF-CBT model, the hospital program would need to modify the treatment protocol in consideration of the disruption
in treatment and the transition to another therapist in the community to continue the trauma focused treatment. However, there is a limitation in regard to continuity of treatment, because the outpatient or community based therapist, may not have training in TF-CBT.

As indicated above, TF-CBT would be instrumental in assisting adolescents with dealing with trauma and related sequelae. Therefore, because bullying behavior seems to occur as a result of having trauma in one’s psychosocial history (Fehon et al., 2005), it seems more beneficial to address the treatment of trauma, rather than in examining bullying types to distinguish behavior.
References


Appendix: Tables

Table 1

*Age Frequency and Percentage of Participants*

<table>
<thead>
<tr>
<th>Age (in years)</th>
<th>Frequency</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>12</td>
<td>10</td>
<td>15.9%</td>
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<tr>
<td>13</td>
<td>10</td>
<td>15.9%</td>
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<tr>
<td>14</td>
<td>6</td>
<td>9.5%</td>
</tr>
<tr>
<td>15</td>
<td>11</td>
<td>17.5%</td>
</tr>
<tr>
<td>16</td>
<td>16</td>
<td>25.4%</td>
</tr>
<tr>
<td>17</td>
<td>7</td>
<td>11.1%</td>
</tr>
<tr>
<td>18</td>
<td>3</td>
<td>4.8%</td>
</tr>
</tbody>
</table>

Table 2

*Grade Level Frequency and Percentage of Participants*

<table>
<thead>
<tr>
<th>Grade Level</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>5th grade</td>
<td>2</td>
<td>3.2%</td>
</tr>
<tr>
<td>6th grade</td>
<td>3</td>
<td>4.8%</td>
</tr>
<tr>
<td>7th grade</td>
<td>13</td>
<td>21%</td>
</tr>
<tr>
<td>8th grade</td>
<td>7</td>
<td>11.3%</td>
</tr>
<tr>
<td>9th grade</td>
<td>13</td>
<td>21%</td>
</tr>
<tr>
<td>10th grade</td>
<td>10</td>
<td>16.1%</td>
</tr>
<tr>
<td>11th grade</td>
<td>7</td>
<td>11.3%</td>
</tr>
<tr>
<td>12th grade</td>
<td>7</td>
<td>11.3%</td>
</tr>
</tbody>
</table>
Table 3

*Percentage of Internalizing Disorders for Bully Typologies*

<table>
<thead>
<tr>
<th>Bully Typology</th>
<th>PTSD</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bullies</td>
<td>63.6%</td>
<td>18.2%</td>
</tr>
<tr>
<td>Victims</td>
<td>54.2%</td>
<td>37.5%</td>
</tr>
<tr>
<td>Bully-Victims</td>
<td>70%</td>
<td>20%</td>
</tr>
<tr>
<td>Non-Bully/Non-Victims</td>
<td>36.8%</td>
<td>15.8%</td>
</tr>
</tbody>
</table>

Table 4

*Percentage of Self-Debasing and Self-Serving Cognitive Thoughts for Bully Typologies*

<table>
<thead>
<tr>
<th>Bully Typology</th>
<th>Self-Debasing Cognitive Thoughts</th>
<th>Self-Serving Cognitive Thoughts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bullies</td>
<td>54.4%</td>
<td>63.3%</td>
</tr>
<tr>
<td>Victims</td>
<td>54.17%</td>
<td>33.33%</td>
</tr>
<tr>
<td>Bully-Victims</td>
<td>42.12%</td>
<td>80%</td>
</tr>
<tr>
<td>Non-Bully/Non-Victims</td>
<td>30%</td>
<td>21.1%</td>
</tr>
</tbody>
</table>

Table 5

*Percentage of Bully Typologies in Current Study Compared to School Studies and Criminal Offenders*

<table>
<thead>
<tr>
<th>Bully Typology</th>
<th>School Setting</th>
<th>Current Study</th>
<th>Criminal Offenders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bully</td>
<td>3.5-18%</td>
<td>17.3%</td>
<td>32%</td>
</tr>
<tr>
<td>Victim</td>
<td>9-14.2%</td>
<td>37.5%</td>
<td>8%</td>
</tr>
<tr>
<td>Bully-Victim</td>
<td>2-9%</td>
<td>15.6%</td>
<td>37%</td>
</tr>
<tr>
<td>Non-Bully/Non-Victim</td>
<td>80.2%</td>
<td>29.7%</td>
<td>23%</td>
</tr>
</tbody>
</table>