BULLYING EXPOSURE PREVALENCE AMONG SCHOOL-AGE CHILDREN AND ADOLESCENTS RECEIVING SOCIAL WORK INTERVENTION IN A COMMUNITY MENTAL HEALTH RESEARCH AND TRAINING SETTING

by

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Abstract

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Prior research has examined the prevalence of bullying exposure among school-age children and adolescents. However, data was primarily gathered from a non-clinical population within a school-based setting. The present study examined bullying exposure among a clinical population of school-age children and adolescents who are receiving social work intervention in a community mental health research and training setting. The purpose of the study was to obtain the bullying exposure prevalence rate of a clinical population, in order to compare it to the non-clinical population presented in the literature. It was hypothesized that the prevalence rate obtained from this study would be lower than the national prevalence rate. An epidemiological case record review of 104 cases from the years 2011 to 2012 was conducted at The University of Texas at Arlington's

Center for Clinical Social Work (CCSW), utilizing a data extraction form to determine the prevalence of bullying exposure. The findings concluded that the bullying exposure prevalence rate for the CCSW's clinical school-age population (grades pre-school through 12) was 17.3%. This rate was compared to the national rate, which is between 20% (grades 9 through 12) and 28% (grades 6 through 12). The hypothesis was confirmed.

Keywords: bullying, prevalence, case record review

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Chapter 1

Introduction and Overview

The last Facebook status 18 year old, college freshman Tyler Clementi ever posted was on September 22, 2010. It read, "jumping off the gw bridge sorry" ("Real Life Stories", 2011). Roughly ten minutes later, he did just that. Tyler's roommate bullied him by streaming his private sexual encounters with another male on the Internet for a public audience to view. A year prior to that incident, 12 year old, seventh grader Sarah Butler hung herself because of receiving bullying messages on her MySpace page ("Real Life Stories", 2011). Unfortunately, Tyler and Sarah's incidents are only two out of a growing number of suicides committed by young people. Suicide is the "third leading cause of death among young people" and according to the Center for Disease Control (CDC) is resulting in 4,400 deaths per year ("Bullying and Suicide", 2009, para. 3). Additionally, there are one hundred suicide attempts for every suicide that is committed ("Bullying and Suicide", 2009, para. 3). The CDC also stated that nearly a thousand of the suicides committed by young people is the direct result of being bullied by peers (CDC, 2009). These statistics highlight the severity of this issue and make it evident that bullying is a real problem in our society today.

Bullying has existed for many years, but in recent decades it has had a limelight placed on it (MacDougall, 1993). The frequency of bullying has spread vastly, with national statistics showing that "between 1 in 4 and 1 in 3 US

students say they have been bullied at school" ("Facts About Bullying", 2013, para. 3). The impact of bullying has also spread tremendously and has ended in tragedies because of the extremity of the harshness. Tragedies, such as Tyler and Sarah's cases, appear to have caught the attention of society at large. There appears to be a shift in the way bullying is being perceived. In the past, bullying was viewed as "the usual teenage stuff", but now society appears to be moving away from viewing it as a "rite of passage" (Hertzog, 2011). There appears to be a sense of agreeableness that bullying is a serious problem and our society is in need of a solution to protect the vulnerable. However, there is still a lot of research that needs to be conducted in order to gain a thorough understanding of the reasons and impacts of bullying incidences before an efficient solution can be implemented.

Definition of Bullying

The American Heritage dictionary of the English Language defines bullying as the act of treating in an "overbearing or intimidating manner" and to "force one's way aggressively or by intimidation". This is a broad definition that can be interpreted in many ways. However, there is an extensive amount of evidence in the literature that yields a cohesive definition of bullying. Many of the scholars similarly define the term bullying in their research or further explain what the previous scholar might have left out, with most of the definitions stemming back to a fundamental root.

Dan Olweus is known as a pioneer in bullying research, with his work dating back to the 1970s (Roth, Kanat-Maymon, & Bibi, 2011). He defines bullying as an act in which an individual is "exposed, repeatedly and over time, to negative actions on the part of one or more other students" (Olweus, 1995, p. 197). These negative acts include physical harm, verbal taunts, harmful facial expressions/gestures, and exclusion. He also added an additional criterion that outlined an "imbalance in strength" (Olweus, 1995, p. 197). Essentially, Olweus stated that the individual who is being bullied is unable to defend him or herself and is unable to fight back. Olweus' definition of bullying appears to have provided the fundamental root that many scholars refer to.

Cooper and Nickerson (2013) agree with Olweus' definition, but added that bullying involves "intent to harm" and can be conducted in both direct and indirect ways (p. 526). They also further defined what exclusion means, by stating that it is a form of "social manipulation" (Cooper and Nickerson, 2013, p. 526). Shaw, Dooley, Cross, Zubrick, and Waters (2013) also support Olweus's definition, but further defined the social aspect of bullying. They stated the form of bullying has evolved over the years and now includes "relational and social bullying" (Shaw et al., 2013, p. 1). Relational bullying involves damaging an individual's "peer relationships through exclusion or attempts to break up friendships" and social bullying involves damaging an individual's "social standing" by spreading rumors or lies (Shaw et al., 2013, p. 1). Also, these forms

of bullying often involve a "third party" (Shaw et al., 2013, p. 1). Furthermore, Hinduja and Patchin (2010) appear to be amongst the first scholars who examined the latest form of bullying, which is cyber-bullying. They defined cyber-bullying as "willful and repeated harm inflicted through the use of computers, cell phones, and other electronic devices" (Hinduja and Patchin, 2010, p. 208). They wanted to keep the definition simple but argue that it still addresses the fundamental concepts of bullying (intentional, repetitive, and harmful), while introducing the 21st century avenue of the Internet.

The dictionary provides a broad definition of what bullying is, whereas the literature further defines the problem, while keeping the simplicity of the definition intact. Overall, there appears to be an accepted definition amongst the scholars that entails bullying involving the infliction of some sort of harm (physical, verbal, relational, social, or cyber), conducted in an intentional way, either directly or indirectly, and in a repetitive manner (not just one isolated incident).

Different Forms of Bullying

The basic definition of bullying involves harm being inflicted upon another person. The different forms of bullying further define what "harm" necessitates. There are five different forms of bullying: physical bullying, verbal bullying, bullying through relational aggression, bullying through social aggression, and cyber-bullying (Jordan & Austin, 2010, pp. 444-445).

Physical Bullying

Being physical involves the sense of touch. Therefore, physical bullying involves the bully using their body (arms and legs) to inflict harm. It is an overt behavior. This form of bullying includes: kicks, punches, hits, bites, pinches, restraints, shoves, destroying property, "depantsing (pulling someone's pants down)", wet-willies (sucking on your finger and then sticking it in someone else's ear), wedgies (pulling someone's underpants up), and so on (Jordan & Austin, 2010, p. 444). It is most common amongst younger males and prevalence is decreased with age (Crick, Grotpeter, and Bigbee, 2002).

Verbal Bullying

Verbal bullying involves the bully using their voice and words to inflict harm. This form of bullying is also overt. It includes: "name-calling, abusive language, humiliation, mockery, picking on someone with less power and so on" (Jordan & Austin, 2010, p. 444). This form of bullying is presented equally amongst males and females and does not appear to have a decline with age (Bauman & Del Rio, 2006).

Relational Aggression

This form of bullying involves exclusion. The bully excludes their victim from peer relations. This includes: ignoring that person, eliciting help from other peers to socially isolate that person, and no longer hanging out with them (Jordan & Austin, 2010). This form can occur in both overt and covert ways. Prevalence

rates are typically seen during the middle school age, but can carry into high school age. Also, it typically is presented in females who are friends (Woods & Wolke, 2003).

Social Aggression

Bullying conducted through social aggression is a combination of verbal and relational bullying. However, it occurs in covert ways. This form of bullying involves: gossiping, social exclusion, talking about someone, writing notes about someone, spreading rumors, making up lies about someone and stealing friends or partners (Jordan & Austin, 2010; Shaw et. al, 2013). The goal of this form of bullying is to gain the power and control status of the social hierarchy within the school (Woods & Wolke, 2003).

Cyber-Bullying

Cyber-bullying is the newest form of bullying and it involves the use of electronic devices (Hinduja & Patchin, 2010; Jordan & Austin, 2010). It is a combination of verbal, relational, and social bullying that is conducted over the Internet or phone. With traditional bullying, the victim often knows who the bully is and can try to avoid them. With cyber-bullying, the bully is able to create multiple aliases and remain anonymous. Also, traditional bullying typically occurred on school property, which allowed the victim to find a safe haven within their homes. Cyber-bullying can occur at any time and any place, which makes it harder for the victim to escape for even a few hours.

Definition of a Victim

The individual upon whom the bully is inflicting harm is referred to as the victim. Though the common theme amongst victims is that they are perceived as weaker and unable to defend themselves, there are a few different types of victims. The types presented in the literature are: victim bystanders, passive victims, and bully victims.

Victim Bystanders

A bystander is someone who witnesses some act but does nothing to intervene. Victim bystanders witness the bullying incidence, whether it is happening to a friend or just another peer, and they do nothing to stop it. They are often in fear of the bully themselves and worry about the repercussions that were to happen if they step in. They are even too afraid to tell an adult because they fear the bully might find out. They often worry that they are next (Olweus, 1993).

Passive Victims

These victims are viewed as submissive, insecure, and anxious. They are also seen as physically weak, which makes them unable to defend themselves (Jordan & Austin, 2010). They present with unfavorable behavior, which causes their peers to become irritated and leads to a lack of peer support. This often leaves this type of victim socially isolated, with no social support system (Hoover, Oliver, & Hazler, 1992).

Bully Victims

Bully victims play the role of both the victim and the bully. They are often harassed and belittled by bullies. However, instead of being passive, they are reactive (Whitted & Dupper, 2005). Brockenbrough, Cornell, and Loper (2002) noticed aggressive behavior, carrying weapons, and using alcohol as common traits amongst bully victims. According to Jordan and Austin (2010), some scholars even "hypothesized that school shooters are bully victims who could no longer take the taunting and humiliation and exploded in a burst of violence" (p. 448). Since the bully victim is not docile, but rather exudes bully-like traits, they often do not have many friends and teachers tend to not think favorably of them (Anderson, Kaufman, Simon, Barrios, Paulozzi, Ryan, et al., 2001; McNamara & McNamara, 1997).

Impact of Being Bullied

Victims are repeatedly persecuted and harassed by bullies. The literature indicates that this repetitive nature of abuse leads to psychological harm amongst the victims. Victims are subjugated to the negative forms of bullying, which effect the way they feel. They often feel down, sad, or depressed (Jordan & Austin, 2012). Also, victims tend to lack a support system or are afraid to disclose of the abuse (Jordan & Austin, 2012). They begin to believe the negative claims of harassment, which effects their self-image and self-esteem. As Olweus (1993) stated, victims often fear the next bully attack, which causes them to experience

higher levels of rumination and anxiety. An impact that has received national attention in the recent years is the suicides and suicidal attempts. Bullying victimization has been linked to recurring thoughts of suicide (Jordan & Austin, 2012) and the CDC has reported the link between bullying and suicides.

The literature also states that the majority of bullying incidents occur at school. Researchers have examined the effects bullying has on school performance and found that students who are bullied have reported not feeling safe at school (Fekkes, Pijpers, Fredricks, Vogels, & Verloove-Van Horick, 2004), attempt to skip school as much as they can (i.e.: fake being sick or skipping all together) (Smith, Pepler, & Rigby, 2004), have lower grades (Arsenault, Walsh, Trzesniewski, Newcombs, Capsi, & Moffitt, 2006), and teachers have reported noticing that these students have more of a depressed affect (Jordan & Austin, 2012). Victims have also noticed a lack of action taken on part by school officials (Jordan & Austin, 2012). This lack is causing them to question if anything can be done to stop the harassment. It can also impact their support system because they might view the inaction as a reason to not risk telling someone.

It is important to note that though much of the literature focuses on the psychological impact of being bullied, the physical harm is still apparent. Victims are still being physically hurt as a direct cause of bullying. However, this form of bullying appears to be more manageable (especially by school officials and

onlookers) because they can physically intervene to stop the abuse (Kochenderfer-Ladd & Wardrop, 2001).

Overall, the literature supports that bullying is a serious problem by outlining the impact it has on victims. Being bullied is associated with emotional distress, anxiety, rumination, depression, suicidal ideation and attempts, low self-esteem and even negatively effects academic performance (Kochenderfer-Ladd & Wardrop, 2001, Kuppersmith & Patterson, 1991, Jordan & Austin, 2012).

Focus on Children and Adolescents

Although bullying can occur during any stage of an individual's life, the school age and adolescence stage are especially important developmental periods to study. Erikson's Stages of Psychosocial Development highlight the important events, conflicts, and outcomes that occur during these stages ("Erikson's Stages of Psychosocial Development", 2013). During the school age stage, children are being introduced to new social and academic roles. Through social interactions, they begin to develop a sense of pride. Erikson stated that praise is important for this development. If that praise is lacking, children often begin to self-doubt and develop a sense of low self-esteem. The school environment is significant for this stage of development. During the adolescence stage, adolescents begin to develop their sense of identity and self. Erikson stated that receiving encouragement and reinforcement is significantly important for this development. If it is lacking, adolescents begin to feel insecure and confused about their life trajectory.

The negativity and hindrance that is a product of bullying is a deterrent to the development of crucial stages in one's life, as outlined in Erikson's Stages of Psychosocial Development. Erikson emphasized the importance of encouragement, support, reinforcement, and praise during these essential stages of life and bullying only hinders those positive factors. The harassment victims endure effect the way they develop psychologically and socially. These stages of life are important to examine while studying bullying because this is when victims are most vulnerable and where the impact of bullying can cause the most damage.

National Bullying Prevalence Rate

The US Department of Health and Human Services has analyzed research findings from the literature and has reported national prevalence rates of bullying exposure based on conclusive research. Specifically, they identified "two sources of federally collected data on youth bullying" ("Frequency of Bullying", 2014, para. 1). First, the National Center for Education Statistics and Bureau of Justice Statistics reported in their 2008-2009 School Crime Supplement that the national bullying prevalence rate for students in grades 6 through 12 was 28% ("Facts About Bullying", 2013, para. 4). Second, the Centers for Disease Control and Prevention reported in their 2011 Youth Risk Behavior Surveillance System that the national bullying prevalence rate for students in grades 9 through 12 was 20% ("Facts About Bullying", 2013, para. 4). Additionally, it was also reported that,

"between 1 in 4 and 1 in 3 US students say they have been bullied at school" ("Facts About Bullying", 2013, para. 3).

Population Studied in Literature

There are two types of populations that are typically studied during mental health social work research: clinical and non-clinical (A. Smith-Osborne, personal communication, November 25, 2013). Clinical populations are those who have been diagnosed with a mental illness and are receiving mental health services (such as: community mental health setting). Non-clinical populations are those who have not been diagnosed with a mental illness and are not receiving any formal mental health services (such as: school setting). Much of the bullying literature focuses on the non-clinical population. Most of the researchers have conducted their studies and recruited participants through school settings. For the most part, these participants have not been diagnosed with mental illnesses and typically were not receiving mental health services. Statistics used to determine prevalence of bullying exposure were mainly gathered through surveys or face-to-face communication with participants, who were recruited through school-based settings.

Chapter 2

Present Study

There appears to be a gap in the literature in regards to studying bullying exposure prevalence based on a clinical population. The present study aims to close this gap by examining bullying exposure prevalence among school-age children and adolescents receiving social work intervention in a community mental health research and training facility. Prevalence is defined as "the number of persons with a defined disease relative to the total number of persons in the group or population exposed to risk" (Solberg & Olweus, 2003, p. 239; Cook, Williams, Guerra, & Kim, n.d., p. 350). The clinical population in the present study were receiving counseling services and some had received a formal mental health diagnosis.

Purpose and Hypothesis

The purpose of this study was to determine the prevalence of bullying exposure as reported and documented at a community mental health research and training facility (clinical population) and compare the rates to those reported in the literature, in regards to school-based populations (non-clinical population). It was hypothesized that the prevalence rate of bullying exposure at a community mental health research and training would be lower than the prevalence rate reported in the literature, based on a school setting. The basis for this hypothesis is the differences in reporting methodologies for the different populations.

Researchers have used surveys or questionnaires specifically designed to gather bullying related data when measuring bullying exposure amongst a non-clinical, school-based population (Cook, Williams, Guerra, & Kim, n.d.). This method asked participants about bullying exposure in a direct and specific manner; where as, the clinical population being studied in the present study was not directly or specifically asked about bullying exposure (any incidents narrated were self-disclosed throughout therapy sessions). Also, the scales used by the non-clinical population researchers allowed victims to disclose abuse in an anonymous fashion (Cook, et al., n.d., p. 350). Bullying victims are often afraid to disclose the abuse because they fear the bully might find out (Jordan & Austin, 2012), which could mean that bullying victims were too scared to report incidents of bullying to their counselors and, therefore, incidents were not documented.

Chapter 3

Methodology

Case Record Review

The present study was an epidemiological case record review of clinical records that were obtained from the Center for Clinical Social Work (CCSW) at The University of Texas at Arlington (UTA). The case records were pulled from the years 2011 and 2012. Due to the unpredictability of bullying exposure documented within the case records, a full sample review was conducted from the aforementioned years. This method resulted in the retrieval of 182 case records for inclusion into this study.

Sample Selection

The 182 cases were closely examined to ensure they met the inclusion criteria. Seventy-eight, or 42%, of total records were for adults. The inclusion criterion for this study was to include samples of children and adolescents only (no adults). After excluding records of adult participants, the sample size equaled 104 included cases.

Prevalence Rates

Data related to the bullying exposure of children and adolescents was extracted from each case record. Sensitive information (i.e.: identifying information) was redacted. In order to determine prevalence rates of bullying exposure, synonyms for the term “bullying” were identified in regards to physical

and verbal and emotional bullying. The physical synonyms included: kicked, punched, hit, bit, pinched, restrained, shoved, property destroyed, depantsing, wet-willies, and wedgies (Jordan & Austin, 2010). The verbal and emotional synonyms included: teased, picked-on, harassed, tormented, threatened, made fun on, rumors spread, being ignored, being excluded, humiliated, and mocked (Jordan & Austin, 2010, What is Bullying, 2013).

Data Collection

A data extraction form (Appendix A) was created in order to streamline the process of obtaining pertinent information from the case records. A random selection of three records was taken in order to become familiar with the layout of the case records. From there, the following areas were determined to be important to include in the data extraction form: demographics (age, race/ethnicity, sex, date of birthday, and grade level), mental health diagnosis, referral source (name of school), date of treatment initiation, date of termination, treatment protocol assigned, number of clinic visits (sessions completed, sessions rescheduled, and sessions no-shown), bullying exposure (yes or no), pertinent themes presented in referral form, termination summary, and case notes, incidents of bullying synonyms mentioned, source reporting bullying incidents (self-reported, counselor-reported, or guardian-reported), and type of bullying (physical, verbal, relational aggression, social aggression, cyber, or combination).

Procedures

As the present study was a case record review, no participants were recruited. Therefore, informed consent did not need to be obtained. However, identifying information was redacted. Each case record from the years 2011 to 2012 was analyzed to determine prevalence of bullying exposure. From there, the data extraction form was utilized to gather data. Once collected, the data was analyzed to determine the prevalence of bullying exposure at a community mental health research and training setting. The prevalence rate from the CCSW (clinical population) was then compared to the national prevalence rate (non-clinical population).

Chapter 4

Results

The main purpose of this study was to determine a prevalence rate for bullying exposure of a clinical population. Bullying was defined as an involvement of infliction of some sort of harm (physical, verbal, relational, social, or cyber), conducted in an intentional way, either directly or indirectly, and in a repetitive manner (not just one isolated incident). The clinical population that was selected for this study was school-aged children and adolescents receiving social work intervention at The University of Texas at Arlington's (UTA) Center for Clinical Social Work (CCSW), a community mental health research and training setting.

A full sample case record review was conducted for the years 2011 and 2012, due to the unpredictability of bullying incidents being mentioned. Of the 182 case records that existed for the previously mentioned years, 78 were eliminated due to being adult records. The data extraction form was utilized to gather pertinent information from the remaining 104 child case records to determine whether bullying incidents had occurred.

Clinical Population Bullying Prevalence Rate

Prevalence is defined as "the number of persons with a defined disease relative to the total number of persons in the group or population exposed to risk" (Solberg & Olweus, 2003, p. 239; Cook, Williams, Guerra, & Kim, n.d., p. 350).

There were a total number of 104 cases that represented school-aged children and adolescents who sought out social work services during the years 2011 and 2012. Out of these 104 case records, bullying incidents were reported in 18 records for a percentage of 17.3% and there was no bullying incidents reported in 86 records for a percentage of 82.7% (see Table 1). This result yields that the prevalence rate of bullying exposure among the clinical population of school-age children and adolescents receiving social work intervention in a community mental health research and training setting is 17.3%.

Table 1 Clinical Population Bullying Exposure

	Frequency	Percent	Cumulative Percent
No	86	82.7	82.7
Yes	18	17.3	100
Total	104	100	

Descriptive Statistics

Full Sample

The 104 case records represented a clinical population of school-aged children and adolescents and had the following breakdown in regards to year, gender, race, grade, and age. There were 36 records collected from the year 2011 (34.6%) and 68 records collected from the year 2012 (65.4%). Of the 104 records, 57 belonged to females (54.8%) and 47 belonged to males (45.2%). The sample was composed of four specific racial categories: African American, Caucasian, Hispanic, and Mixed. There were 21 records that represented the African

American race (20.2%), 35 records that represented the Caucasian race (33.7%), 23 records that represented the Hispanic race (22.1%), and 1 record that represented the Mixed race (African American and Caucasian) (1%). The remaining 24 records' race was unknown and that comprised of 23.1% of the total sample size. There were 44 cases from elementary school (42.3%)[a], 21 cases from middle school (20.2%), 38 cases from high school (36.5%), and 1 case was undetermined (1.0%). Please see Table 2 for a display of the descriptive data. The age of the sample size ranged from 4 years old to 18 years old, with 16 years old being the most frequent.

Table 2 Descriptive Statistics of Full Sample

Year	Frequency	Percent	Cumulative Percent
2011	36	34.6	34.6
2012	68	65.4	100
Total	104	100	
Gender			
Female	57	54.8	54.8
Male	47	45.2	100
Total	104	100	
Race			
African American	21	20.2	20.2
Caucasian	35	33.7	53.8
Hispanic	23	22.1	76
Mixed	1	1	76.9
Unknown	24	23.1	100
Total	104	100	
Grade Level			
Elementary[a]	44	42.3	42.3
High School	38	36.5	78.8
Middle School	21	20.2	99

Table 2—*Continued*

Unknown	1	1	100
Total	104	100	

[a]The elementary grade level is composed of grades pre-school through 6.

Bullying Exposure Sample

The 18 cases that reported bullying incidents had the following characteristics: year, gender, race, grade, age, type of bullying, location where the bullying occurred, and source reporting the bullying incident. There were 7 cases of bullying reported in 2011, which comprised of 38.9% of total bullying cases reported in this study, and 11 cases of bullying reported in 2012, which comprised of 61.1% of total bullying cases reported. Thus, the majority of bullying incidents were reported in 2012. There were 13 females (72.2%) and 5 males (27.8%) who reported being bullied. In regards to race, there were 6 cases who were Caucasian (33.3%) and 4 cases each who were African American, Hispanic, and unknown (22.2% respectively). There were 6 cases reporting bullying from elementary school (33.3%)[a], 6 cases from middle school (33.3%), and 6 cases reporting from high school (33.3%). The age range of those who reported being bullied was from 5 years old to 17 years old, with the most frequent age being 13 years old (7^{th}-8^{th} grade). Please see Table 3 for a display of the aforementioned data.

Table 3 Descriptive Statistics of Bullying Exposure Sample

Year	Frequency	Percent	Cumulative Percent
2011	7	38.9	38.9

Table 3—*Continued*

2012	11	61.1	100
Total	18	100	
Gender			
Female	13	72.2	72.2
Male	5	27.8	100
Total	18	100	
Race			
African American	4	22.2	22.2
Caucasian	6	33.3	55.6
Hispanic	4	22.2	77.8
Unknown	4	22.2	100
Total	18	100	
Grade Level			
Elementary[a]	6	33.3	33.3
High School	6	33.3	66.7
Middle School	6	33.3	100
Total	18	100	
Age			
5	1	5.6	5.6
6	1	5.6	11.1
8	1	5.6	16.7
10	1	5.6	22.2
11	2	11.1	33.3
12	2	11.1	44.4
13	4	22.2	66.7
15	3	16.7	83.3
16	2	11.1	94.4
17	1	5.6	100
Total	18	100	

[a]The elementary grade level is composed of grades pre-school through 6.

In regards to the type of bullying that was reported in the case records, there were 5 cases of social aggression bullying (27.8%), 3 cases of verbal bullying (16.7%), 2 cases of physical bullying (11.1%), 2 cases of cyber-bullying

(11.1%), 1 case of relational bullying (5.6%), 1 case of both verbal and social aggression bullying (5.6%), and 4 cases where the type of bullying was not identified (22.2%). The bullying incidents were most commonly reported to have happened on school campuses, with 8 cases reporting this (44.4%). The other locations included: 1 case at a camp (5.6%), 2 cases were cyber (11.1%), 2 cases occurred both at school and amongst friends (11.1%), 1 case occurred at school and church (5.6%), 2 cases occurred at school and home (11.1%), 1 case occurred at school, home, and social event (i.e.: party) (5.6%), and 1 case was undetermined where the bullying occurred (5.6%). Lastly, in regards to who was reporting that bullying incidents were occurring, the most common answer was self-reported, which comprised 12 cases (66.7%). The other reports were school counselor-reported, mother-reported, school counselor and mother-reported, self and mother-reported, and self and school counselor-reported, which comprised 1 case each (5.6% respectively). In one case (5.6%) it was unable to be determined who reported the incident. Please see Table 4 for a display of the descriptive data.

Table 4 Type of Bullying, Site of Bullying, and Source Reporting Incidents

Type of Bullying	Frequency	Percent	Cumulative Percent
Cyber	2	11.1	11.1
Physical	2	11.1	22.2
Relational	1	5.6	27.8
Social Aggression	5	27.8	55.6
Unknown	4	22.2	77.8
Verbal	3	16.7	94.4
Verbal and Social Aggression	1	5.6	100

Table 4—*Continued*

Total	18	100	
Site of Bullying			
Camp	1	5.6	5.6
Cyber	2	11.1	16.7
School	8	44.4	61.1
School and Amongst Friends	2	11.1	72.2
School and Church	1	5.6	77.8
School and Home	2	11.1	88.9
School, Home, and Social Event	1	5.6	94.4
Unknown	1	5.6	100
Total	18	100	
Source Reporting Incidents			
Guardian	1	5.6	5.6
School Counselor	1	5.6	11.1
School Counselor and Guardian	1	5.6	16.7
Self	12	66.7	83.3
Self and Guardian	1	5.6	88.9
Self and School Counselor	1	5.6	94.4
Unable to Determine	1	5.6	100
Total	18	100	

Clinical Characteristics of Full and Bullying Exposure Samples

The clinical characteristics of the bullied population versus those not reporting bullying were as follows. Out of the total 104 sample, 29 of the cases were oppositional defiant disorder (27.9%), 10 cases were depressive disorder NOS (9.6%), 8 cases were adjustment disorder, unspecified (7.7%), 3 cases each were dual diagnosis anxiety disorder NOS and depressive disorder NOS and mood disorder NOS (2.9% each), 2 cases each were anxiety disorder NOS and attention-deficit/hyperactivity NOS (1.9% each), and there was one case each for

encopresis/enuresis, histrionic personality disorder, unspecified, dual diagnosis oppositional defiant disorder and substance abuse, post traumatic stress disorder, and substance abuse (1.0% each). There were also 42 cases that were undiagnosed (40.4%). Please see Table 5 for a display of the data.

Out of the 18 cases that reported bullying exposure, 6 cases were oppositional defiant disorder (33.3%), 2 cases were depressive disorder NOS (11.1%), and there was one case each for anxiety disorder NOS, dual diagnosis anxiety disorder NOS and depressive disorder NOS, encopresis/enuresis, and mood disorder NOS (5.6% each). There were also 6 cases that were undiagnosed (33.3%). Please see Table 6 for a display of the data.

The clinical characteristics were based off of a proxy mental health diagnosis, due to missing data in case records. However, the proxy mental health diagnosis was determined based on symptoms reported throughout the case record's referral forms, case notes, and termination summaries.

Table 5 Clinical Characteristics of Full Sample

	Frequency	Percent	Cumulative Percent
Adjustment Disorder, Unspecified	8	7.7	7.7
Anxiety Disorder NOS	2	1.9	9.6
Anxiety Disorder NOS and Depressive Disorder NOS	3	2.9	12.5
Attention-Deficit/Hyperactivity Disorder NOS	2	1.9	14.4
Depressive Disorder NOS	10	9.6	24
Encopresis/Enuresis	1	1	25
Histrionic Personality Disorder, Unspecified	1	1	26
Mood Disorder NOS	3	2.9	28.8
Oppositional Defiant Disorder	29	27.9	56.7

Table 5—*Continued*

Oppositional Defiant Disorder and Substance Abuse	1	1	57.7
Post Traumatic Stress Disorder	1	1	58.7
Substance Abuse	1	1	59.6
Unknown	42	40.4	100
Total	104	100	

Table 6 Clinical Characteristics of Bullying Exposure Sample

	Frequency	Percent	Cumulative Percent
Anxiety Disorder NOS	1	5.6	5.6
Anxiety Disorder NOS and Depressive Disorder NOS	1	5.6	11.1
Depressive Disorder NOS	2	11.1	22.2
Encopresis/Enuresis	1	5.6	27.8
Mood Disorder NOS	1	5.6	33.3
Oppositional Defiant Disorder	6	33.3	66.7
Unknown	6	33.3	100
Total	18	100	

Hypothesis

It was hypothesized that the prevalence rate of bullying exposure at a community mental health research and training facility would be lower than the prevalence rate reported in the literature, based on a school setting. This hypothesis was supported by the findings of this study, since the prevalence rate from the community mental health research and training facility was 17.3% and the national prevalence rate is between 20% and 28%.

Chapter 5

Discussion

This study was prompted by the gap in the literature in regards to studying school-age bullying exposure prevalence based on a clinical population. The bulk of the studies discussed throughout the literature use samples drawn from school-based populations, with the national rate of bullying exposure being based on this research (US Department of Health and Human Services, 2014). Therefore, it was deemed important to determine the bullying prevalence rate of a clinical population to make comparisons.

Comparing Clinical and Non-Clinical Population Prevalence Rates

The purpose of this study was to determine the prevalence rate of bullying exposure among a clinical population of school-aged children and adolescents receiving social work intervention at a community mental health research and training setting. This study yielded that 17.3% of a clinical population (grades pre-school through 12) is experiencing some form of bullying. According to the US Department of Health and Human Services, the national rate of bullying exposure is between 20% (grades 9 through 12) and 28% (grades 6 through 12) ("Facts About Bullying", 2013, para. 4).

The prevalence rate of the clinical population (17.3%) is slightly lower than the national prevalence rate (20%-28%). A possible reasoning for this is that prior researchers, who have focused on school-based populations, tend to have

used some sort of survey or questionnaire specifically designed to gather bullying related data, which has been the principal way of measuring bullying exposure (Cook, Williams, Guerra, & Kim, n.d.). Examples of the surveys or questionnaires that are often used are the Olweus Bully/Victim Questionnaire (Olweus, 1996) and the Peer Relations Questionnaire (Rigby & Slee, 1993). These scales ask the participants in a direct and specific manner about bullying exposure. Some sample questions include: "have you ever been bullied by someone" or "this is what bullying is […], has this ever happened to you" (Cook, et al., n.d., p. 350). Unlike data gathered from the school-based population, the clinical population was not directly or specifically being surveyed about bullying incidents. Rather, case records were reviewed for bullying incidents and it appeared as though questions about being bullied were never directly asked by the counselor working with the participant. The bullying incidents that were prevalent appeared to be brought up by the participants themselves, school counselors, or guardians. Also, victims of bullying are afraid to disclose the abuse because they fear the bully might find out, which could make the bullying incidents more extreme or frequent (Jordan & Austin, 2012). They also believe there is a lack of action taken against bullying by school officials, so they do not see the benefit in telling a school official about the abuse (Jordan & Austin, 2012). Perhaps, there was a higher rate of children and adolescents who were being bullied but they feared telling their counselor at the CCSW and, therefore, the incidents were never reported. Whereas, with the

school-based population, the researchers utilized the surveys and questionnaires in an anonymous format, which allowed victims to disclose the abuse without anyone being able to link their answers back to them (Cook, et al., n.d., p. 350). Thus, the inference that the prevalence rate for the clinical-based population is lower compared to the school-based populations from the literature because of the lack of direct and specific questions about bullying, asked in an anonymous format can be made.

While, overall, the results of this study (17.3% prevalence rate) are fairly close to the national rates (20-28% prevalence rate), this study's results may suggest that 3-11% of the bullied population is not coming to clinical attention: either because they are resilient to bullying exposure, because bullying as a risk factor contributes to psychopathology primarily as part of a cluster or accumulation of risk factors, because bullying is not being assessed in clinical settings as it is in school settings, or because they are displaying sequelae which are not referred for clinical assessment and treatment.

As stated, the US Department of Health and Human Services broke down the national prevalence rate based on grade level categories. The category that included the middle school grade level (grades 6 through 12) had a higher prevalence rate of 28% and the category specifically looking at only the high school grade level (grades 9 through 12) had a lower prevalence rate of 20%. Data collected from the study resembles the national breakdown with 14 of the 18

cases identified with bullying exposure coming from the middle school through high school grade levels (when middle school is defined as grade 6 through 8 to match the grade level split of the national rate) and 6 of the cases coming from the high school grade level exclusively. The middle school grade level appears to be skewing the prevalence rate higher. Gordon (n.d.) reported "bullying increases around fifth and sixth grade and continues to get worse until around ninth grade" (para. 3). The prevalence rate starts at 39% in sixth grade, drops down to 28% in ninth grade, and down to 20% by twelfth grade (Robers, Zhang, Truman, and Snyder, 2012). This is the stage when the early teens are "transitioning from being a child to an adolescent" (Gordon, n.d., para. 4). Bullying is a form of social power at this stage in an early teen's life and they are willing to take any measures to protect their social status. "The greatest frequency of bullying interactions occur[s] during middle school" (Cooper and Nickerson, 2013, p. 526). Whereas, this desire to have social power tends to decrease during the high school stage and later teen years (Gordon, n.d.) and thus there is a decrease in the prevalence rate when specifically examining the high school grade levels ("Facts About Bullying", 2013, para. 4; Robers, Zhang, Truman, and Snyder, 2012).

Importance of Examining Clinical Population's Prevalence Rate

Bullying is a growing issue in the US ("Facts on Bullying", 2013, para. 1). The prior research based on the non-clinical, school-based population has been the primary basis for evidence supporting practice and policy changes. These

statistics are important; however, for the most part they are leaving out a key aspect: correlation between bullying exposure and mental health. It has already been highlighted that bullying has a negative effect on the mental health of victims. By examining a clinical population, researchers can examine the correlation based on mental health data that are available with a population who has been diagnosed with a mental illness. This will yield to an expanded knowledge on how bullying effects the mental well-being of an individual, which could lead to a growth in the evidence-informed prevention practices. Thus, examining bullying exposure within a clinical population is beneficial to future prevention and the reduction of this growing issue.

The similarity in prevalence rates between the clinical and non-clinical populations shows that bullying issues are being brought up in mental health settings as well, which makes these settings a prime place to conduct further research and analyses. Examining the prevalence rate of bullying exposure of a clinical population was important because it is a baseline to conducting further research to implement practice and policy changes, as well as intervention cost-benefit analyses.

Implications for Practice

The results of this study made it apparent that bullying incidents are being reported in a clinical setting nearly as often as they are at the national rate (non-clinical). A possible implication for practice would be to implement bullying

screening mechanisms into clinical settings. Perhaps, adding a brief questionnaire into the assessment and intake processes or checking for bullying exposure with a school-age population as one would check for suicidal ideation. There have been concerns brought up that victims often do not disclose the bullying incidents (Cook et al., n.d.). The hope is that integrating bullying screening tools into counseling sessions would alleviate this concern due to the nature of rapport-building in the counselor and participant relationship (as long as the rapport between counselor and participant is strong).

Study Limitation

One major limitation of the present study is missing data. The case records are based on information that was reported, either by school counselors, parents, or participants themselves. There is the possibility that bullying incidents did occur, but were not reported by the participant and, therefore, not documented within the case records. Also, there is the possibility that bullying incidents were reported by the participant, but were not documented by the counselor. Another limitation was not having the mental health diagnosis systematically documented in the majority of the case records during this period of the center's operations (prior to late fall 2012). This led to determining a proxy mental health diagnosis based on case reports within the case records, which is simply retrospective. Further, internalizing behavior disorders (behaviors to harm self), which may also be associated with bullying victimization, are known to be underreported by

school referral sources and so may not present in clinical settings (Bowes, Arseneault, Maughan, Taylor, Caspi, & Moffit, 2009).

Future Research

This study adds to the knowledge base on school-age bullying prevalence in a clinical population, but requires the examination of additional clinical populations and larger sample-size in order to be useful for prevention and intervention. Also, future research should focus on determining whether there is a correlation between bullying exposure and mental illnesses. Examining whether being bullied impacted the participants' mental health diagnosis would expand the evidence base of this area of concern. This study's prevalence finding in a clinical population, compared to school prevalence, may suggest that a large proportion of children who are being bullied in schools go on to be referred for and obtain clinical assessment and treatment (and self-report the victimization in this clinical setting), while a minority may be resilient to developmental psychopathology. Future research should examine these indicated relationships. It would also be interesting to examine whether being bullied is associated with increased aggressive behaviors by the victim afterwards. The bully-victim duality has been commonly reported in the school-based literature (Whitted & Dupper, 2005; Brockenbrough, Cornell, & Loper, 2002; Jordan & Austin, 2010; Anderson, Kaufman, Simon, Barrios, Paulozzi, Ryan, et al., 2001; McNamara & McNamara, 1997), but has not been studied amongst a clinical population. In the future,

examining the proportion of self-reported bullying victims who also engaged in bullying behaviors themselves could be important because it could help determine a separate correlation between bully-victims and mental health. Lastly, it would be interesting to examine whether bullies or victims are more likely to be referred to a mental health facility by school counselors.

Conclusion

The purpose of this study was to determine the prevalence rate of school-age bullying exposure for a clinical population and compare the rates to the national prevalence rate of bullying, which is based on a non-clinical population. It was determined that the clinical population prevalence rate (17.3%) was 3-11% lower than the national prevalence rate (20-28%). There was a gap in the literature in regards to examining bullying by studying a clinical population, which is a detriment to social work practices because of the lack of correlation that can be made between bullying and mental illnesses. In order to successfully combat the issue of bullying, this correlation needs to be examined to incorporate evidence-informed prevention protocols. The results of this study can serve as the foundation for future research on bullying exposure within a clinical population. They may be used to initiate and reevaluate bullying prevention programs and protocols, with the goal and hope of reducing the prevalence of bullying.

Appendix A

Data Extraction Form

Data Extraction Form

Year of Record:

Case ID Number:

Demographics

- Age:
- Race/Ethnicity:
- Sex:
- Date of Birth:

Grade Level:

Referral Source (Name of School):

Mental Health Diagnosis

- Axis 1:
- Axis 2:
- Axis 3:
- Axis 4:
- Axis 5:

Date of Treatment Initiation:

Date of Treatment Termination:

Treatment Protocol Assigned:

Number of Clinic Visits

- Sessions Completed:
- Sessions Rescheduled:
- Sessions No-shown:

Bullying Exposure (Yes/No):

Bullying Themes

- Referral Form:

- Termination Summary:

- Case Notes:

Incidents of Bullying Synonyms Mentioned:

Site of Bullying Incident:

Source Reporting Bullying Incidents

- Self-reported:
- Counselor-reported:
- Guardian-reported:

Type of Bullying

- Physical:
- Verbal:
- Relational Aggression:
- Social Aggression:
- Cyber-bullying:
- Combination:

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