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Journal of Adolescent Health 36 (2005) 88–91

JOURNAL OF ADOLESCENT HEALTH

Position paper

Bullying and peer victimization: Position paper of the Society for Adolescent Medicine

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Definition

The scientific literature on aggressive peer relations makes use of several different terms, including bullying, harassment and victimization. Although there may be subtle differences between these terms, they are all used to refer to behavior that is 1) aggressive or intended to harm; 2) carried out repeatedly and over time; and 3) occurs in an interpersonal relationship where a power imbalance exists [1]. A distinction is also made between direct and indirect behaviors. Direct bullying includes physical and verbal attacks or aggression (kicking, pushing, name-calling) while indirect bullying involves behaviors such as ignoring and gossiping which often rely on a third party [2]. Indirect bullying is also referred to as relational bullying, in that it is "aggression directed at damaging a social relationship" [3]. Throughout this paper, we will use the term "bullying" to refer to behaviors meeting the three criteria above, and "victim" or "victimization" to refer to the person or the experience of being bullied.

Scope of the problem

It is estimated that up to three-quarters of young adolescents experience some types of bullying (such as rumors, name calling or public ridicule) and up to one-third report more extreme experiences of coercion or inappropriate touching [4]. In a large study of children in grades 6 through 10, 30% reported moderate or frequent involvement as a victim and/or perpetrator of bullying [5]. Direct bullying is more common among males, and indirect is more common among females [6]. Black youth report being bullied significantly less frequently than white or Hispanic youth [5,6,7]. Bullying behavior tends to peak in early adolescence and to decrease in frequency as adolescence progresses.

Individual characteristics of victims

Youth who are victimized tend to be perceived as physically weaker and have fewer friends than those who are not victimized [8,9,10]. Gay, lesbian or bisexual adolescents are more likely to be victimized than their heterosexual peers [11], and overweight and obese adolescents suffer more harassment than normal weight teens, particularly among girls [12].

Consequences for victims

An Australian study found that victimization in middle adolescence predicted poorer physical health in later adolescence, controlling for baseline health status [13]. The psychosocial consequences of bullying are also significant: victims of bullying have reported increased rates of depression, suicidal ideation and loneliness [2,5]. One study in particular showed that young people who had been bullied repeatedly throughout middle adolescence had lower self-esteem and higher depressive symptoms as young adults, compared to those who had not been bullied, controlling for emotional health at baseline and victim status as young adults [14]. Victimization has implications for academic success as well. Experiencing peer harassment has been associated with lower grades, disliking school and absenteeism [4,15]. In addition, youth who were victimized as children or adolescents also have increased rates of violence-related behaviors compared to those not involved in bullying at all [16].

Individual characteristics of perpetrators

Young people who engage in bullying behaviors tend to have higher levels of overall conduct problems [7], and are more likely to be involved in violence-related behaviors, such as weapon carrying and frequent fighting. These associations appear to persist into adulthood. For

1054-139X/05/$ – see front matter
doi:10.1016/j.jadohealth.2004.09.004

example, Olweus studied former bullies and found a 4-fold increase in criminal behavior at age 24 [17]. Sixty percent of the bullies had one conviction and 35 to 40% had 3 or more convictions.

It is important to note that perpetrators of bullying behavior also have significantly poorer psychosocial outcomes than non-bullies, including depression [7]. The poorest psychosocial functioning may be evidenced by youth who both bully and are bullied by others [18,19].

The associations described above (i.e. poor emotional adjustment, school adjustment, and high-risk health behaviors among those involved with bullying) are remarkably consistent in international comparisons. A large cross-national study by the Health Behaviour in School-aged Children Bullying Analysis Working Group [20] demonstrated that the adverse relationship between bullying involvement – as a victim, bully, or bully-victim – and psychosocial adjustment is similar across youth in 25 countries.

Environmental factors associated with bullying behavior

A variety of socio-environmental factors have been associated with the development of aggressive behavior in adolescence. General family characteristics, such as low involvement with parents, low parental warmth, low family cohesion and single-parent family structure have been found to be related to greater bullying among young people [8,21,22,23,24,25]. Childhood experiences more germane to aggression, such as spanking and other physical discipline, inconsistent punishment, family violence, bullying and/or victimization by siblings, and father's history of bullying have also been positively related to bullying behavior [26,27,28,29].

Studies examining peer influences on bullying behavior have concluded that increased aggressive behavior within peer networks is associated with increased bullying behavior [27,30]. One multi-level longitudinal study determined that after controlling for baseline levels of aggressive behavior, bullying and fighting within friendship groups was significantly predictive of these behaviors for both males and females over time. [31]. At a broader peer level, students in elementary school classrooms where aggression was normative tended to become more aggressive in future years [32].

Additional characteristics of the social context of young people may also contribute to bullying behavior. For example, neighborhood safety concerns were positively associated with increased bullying behavior, while having positive adult role models was associated with less bullying behavior [27].

Interventions to reduce bullying behavior

Comprehensive school-based interventions aimed at reducing bullying behavior attempt to reduce opportunities and rewards for bullying by publicizing school-wide rules; training teachers to recognize and halt bullying; holding classroom discussions; implementing curricular activities; and meeting individually with bullies, victims and their parents. Evaluations of these programs have shown mixed results [33]. The Olweus Bullying Prevention Program, developed in Norway by one of the leading researchers on youth bullying, has shown a 30%–70% reduction in student reports of being bullied and bullying others, significant reductions in student reports of general antisocial behavior, improvements in classroom order and discipline, and more positive attitude towards schoolwork and school [34]. It is considered a "model program" by the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration. Another study assessed the impact of a comprehensive bullying prevention program in an elementary school, developed locally by a team of school personnel and parents; this study demonstrated significant reduction of peer victimization [35]. However, in one of the largest trials in the U.S., conducted in 39 rural South Carolina schools, no significant differences were found between intervention and control schools in victimization rates, bullying rates, general antisocial behavior or attitudes towards bullying at the completion of the two-year intervention [33]. Mixed findings reflect differences in program length, school investment, student age, and concurrence with community–wide campaigns to reduce bullying. Although several states have taken legislative action to address bullying among school children, the effectiveness of such legislation remains unknown [36].

Positions

The Society for Adolescent Medicine (SAM) supports the following positions:

- Bullying among peers, although common, is not acceptable social behavior among youth. Adults and adolescents are encouraged to prevent bullying behavior and to change the perception that such behavior is normative.
- Health care providers should be familiar with the characteristics of youth that may be involved in bullying, either as aggressors or victims. They need to be sensitive to signs and symptoms of bullying, victimization, their influences and their sequelae. Health care providers are encouraged to intervene early when either bullying or victimization behaviors are noted. Discussing possible interventions with the adolescent and parent is appropriate. Additionally, referral for co-occurring mental health disorders (e.g. conduct disorder, depression, anxiety) is recommended. Lastly, health care providers and school personnel can provide leadership and

education to community organizations on these issues.

- Community organizations that serve youth and their families should incorporate anti-bullying messages, address victimization and promote non-violent discipline.
- SAM supports the goals of the National Bullying Prevention Campaign of the Health Resources and Services Administration's Maternal and Child Health Bureau. The campaign goals are to:
  - raise awareness about bullying
  - prevent and reduce bullying behaviors
  - identify appropriate interventions for pre-teens (i.e. 9–12 year olds)
  - foster links between education, public health and other partners
- Future research on bullying and victimization is needed. Large longitudinal studies are needed to determine if the many adverse conditions associated with victimization are long-lasting. Additional research aimed at understanding the biopsychosocial characteristics of bullies and the social circumstances of bullying might lead to better prevention programs. Further rigorous research is also needed to identify specific characteristics or aspects of school-based interventions and prevention programs that are effective in reducing bullying behaviors, and for which types of communities, schools and individuals. Research soundly rooted in theory (e.g. social and peer dynamics of bullying behavior [37], social learning models of peer victimization [38]) will allow those involved in prevention and intervention efforts to focus their programs more effectively.

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