Bullying and mental health – the risk factors and legacy

Mark Greener

Bullying damages lives and can leave a legacy of increased risk of mental illness for its victims. Mark Greener reviews some of the recent research into bullying and considers what more need to be done to help understand and deal with this pervasive problem.

Once regarded as just part of growing up, teachers, parents and mental health professionals increasingly appreciate that bullying damages lives, often irremediably. The torment of victimisation can become too much to bear, leading some bullied children to commit suicide.1,2 Sometimes there’s no escape from the victimisation: bullying continues at home by siblings or online.1,3 Recent studies underscore the marked psychological toll exerted by childhood bullying and suggest that a ‘continuity of victimisation’ means the problem persists across settings and into adulthood. The best way to tackle this pervasive problem remains, however, less clear and research into some fundamental questions is needed desperately.

Bullying’s many faces
Bullying includes, of course, overt physical violence and verbal aggression. More subtle forms of bullying include relational aggression, such as social isolation and rumour spreading, and cyberbullying.2 Tragically, such abuse is widespread: about 30% of children are bullied during their school years. Five per cent to 10% endure regular bullying, such as weekly or more often.2,4 Yet, as a recent Lancet editorial notes, ‘bullying is not a normal behaviour: it is a dangerous one that has profoundly negative implications for all’.5

After all, even bullies can become victims. Children who are bullies may be prone to externalising disorders and criminality, such as violence and illicit drug use. Children who are victims of bullies, but also bully others, seem to be vulnerable to internalising and externalising disorders, and criminal behaviours.6 This feature focuses on bullied children, who are at high risk of internalising and externalising disorders, and criminal behaviours.6 This feature focuses on bullied children, who are at high risk of internalising and externalising disorders, and criminal behaviours.6 This feature focuses on bullied children, who are at high risk of internalising and externalising disorders, and criminal behaviours.6 This feature focuses on bullied children, who are at high risk of internalising and externalising disorders, and criminal behaviours.6 This feature focuses on bullied children, who are at high risk of internalising and externalising disorders, and criminal behaviours.6 This feature focuses on bullied children, who are at high risk of internalising and externalising disorders, and criminal behaviours.6 This feature focuses on bullied children, who are at high risk of internalising and externalising disorders, and criminal behaviours.6 This feature focuses on bullied children, who are at high risk of internalising and externalising disorders, and criminal behaviours.6 This feature focuses on bullied children, who are at high risk of internalising and externalising disorders, and criminal behaviours.6 This feature focuses on bullied children, who are at high risk of internalising and externalising disorders, and criminal behaviours.6

A serious form of victimisation
A growing number of longitudinal studies underscore the psychological scars left by bullying. For instance, researchers analysed data from 4026 children in the Avon Longitudinal Study of Parents and Children (ALSPAC) in the UK and 1420 children from the Great Smoky Mountains Study (GSMS) in the USA. ALSPAC assessed physical, emotional, or sexual abuse, or severe maladaptive parenting between ages eight weeks and 8-6 years reported by mothers and being bullied based on the child’s reports at eight, 10, and 13 years. GSMS assessed maltreatment and bullying at annual interviews with parents and children between nine and 16 years of age.7

Compared with controls who were neither maltreated nor bullied, GSMS children who were maltreated by adults but not bullied by peers were four times (odds ratio [OR] 4.1) more likely to develop depression in young adulthood, after adjusting for family hardships and gender. Overall, ALSPAC children who were maltreated, but not bullied, were no more likely to develop mental health problems than controls. Nevertheless, sexual and emotional abuse significantly increased the risk of a mental health problem (OR 6.4 and 2.1 respectively). The other two components of maltreatment (physical abuse and harsh parenting) were not significantly associated with mental health problems in young adults.7

Children who were bullied by peers were 1.6 (ALSPAC) and 3.8 (GSMS) times more likely than those who were maltreated but not bullied to develop mental health problems. Differences emerged for anxiety (GSMS OR 4.9), depression (ALSPAC 1.7) and self-harm (ALSPAC 1.7). In other words, poly-victimisation does not fully explain bullying’s effects on mental health. Nevertheless, maltreated children were also more likely to be bullied.7 So, the study supported a ‘continuity of victimisation’ in which bullied people are more likely to be maltreated in other situations.

Perhaps not surprisingly, being a victim of bullying undermines academic performance4 which could undermine long-term educational attainment and employment prospects. A study from secondary
schools in East London, for example, reported that adolescents who had been bullied in the last term were 54% less likely to achieve their academic benchmark and 42% more likely to show depression. Bullied boys were especially likely to report depressive symptoms.4

A safe haven
Home is supposed to be a safe haven. For many children, however, bullying continues behind closed doors. One recent study, for instance, examined the relationship between sibling bullying and psychiatric outcomes. Among 1810 controls who had not been bullied by a sibling at 12 years of age, 6.4% had depression, 9.3% experienced anxiety and 7.6% had self-harmed in the previous year when they were 18 years old. Among 786 children who reported bullying by a sibling several times a week, 12.3% had depression, 16.0% anxiety and 14.1% had self-harmed.3

Children frequently bullied by siblings when they were 12 years old were more likely to have depression (odds ratio [OR] 2.16), self-harm (OR 2.56) and experience anxiety (OR 1.83) when they were 18 years old than controls. Assuming the relationship is causal, sibling bullying could account for 13.0% of cases of depression and 19.3% of cases of self-harm.3

Sibling relationships, unlike peer groups, tend to endure through a child’s development and there are few opportunities to escape. Again, victims of sibling bullying are more likely to be bullied by their peers.Sibling bullying typically occurs in families characterised by conflict between parents and poor parent-child relationships. The authors suggest integrating siblings into child and family programmes. Nevertheless, the impact on mental health is ‘over and above the effects of multiple family risk factors’, underscoring the importance of specifically targeting sibling bullying. Yet, the authors note, ‘sibling bullying is neglected by researchers, clinicians and policy makers’.3

Cyberbullying also limits opportunities for escape from the bullies and may offer additional opportunities for bullies who are not physically dominant. A recent study used the EU Kids Online survey (2010) to model links between online exposure to content about self-harm, internet addiction and cyberbullying to ‘unnatural’ death in children from 24 European countries. The model suggested that each 1% increase in the prevalence of exclusively online bullying increased unnatural deaths by 28%. For example, an increase in prevalence of exclusively online bullying from 5% to 6% could increase the annual incidence of unnatural child deaths from 6.48 to 8.28 per 100 000 children at risk. No significant link emerged with either internet addiction, or information regarding self-harm or suicide. The correlation appeared to be independent of the prevalence of depression and ‘traditional’ bullying.1 Future studies need to examine the association between cyberbullying and outcomes in adults.6

Maltreatment of children often occurs across several settings and the continuity of victimisation means that bullying can persist into adult life. For instance, Andersen and colleagues questioned 2181 people in Denmark in 2004, when they were 14–15 years old, and again three years later. Being bullied when 14–15 years old emerged as the strongest risk factor for being bullied when they were 17–18 years. The risk of being bullied at 17–18 years of age was approximately two to three times higher in those who were bullied at school at age 14–15 years. Approximately 45% of those who experienced bullying at school when 14–15 years old also experienced bullying in higher education or at work three years later.2 The Lancet notes that recognising that maltreatment often occurs across several settings and persists ‘is vitally important for families and clinicians who must look for bullying behaviours in every setting in which bullying can and does take place’.5

A complex relationship
Numerous factors increase the risk of bullying. Andersen et al. for example, reported that several factors increased the risk of being bullied at school: being obese; low self-assessed position in class; overprotective parents; low self-esteem; low sense of coherence, and low socioeconomic status. Risk factors for being bullied at work were: being overweight; smoking; low self-assessed position; low sense of coherence, and low socioeconomic status.2

Disentangling the relationships can, however, prove difficult. For example, overweight adolescents have poorer psychological wellbeing and more depressive feelings than their leaner counterparts. This, in turn, increases their risk of being bullied which compromises the victim’s ability to make it harder to
manage teasing and bullying from peers. On the other hand, a strong sense of coherence bolsters resistance to stress and stressors, such as bullying.\(^2\)

The risk factors seem to be mutually reinforcing and further studies need to characterise the interactions.\(^3\) Moreover, there is a need to better understand the continuity of victimisation. For example, dysfunctions in self-perception and the view of other people, temperament, self-esteem, coping skills could perpetuate victimisation. Nevertheless, supportive, friendly environments and social climates can attenuate the risk that bullying will persist into adulthood.\(^2\)

### The future

Understanding the relationships between these factors, bullying and the long-term outcomes is essential to develop innovative methods of tackling this pervasive problem. To date, programmes to prevent or mitigate the problem in childhood and adolescence have had a limited impact on self-reported bullying.\(^2\)

Against this background, there is a need for future research to examine the risk of adverse long-term outcomes associated with bullying and the influence of gender and ethnic origin on the risk of psychopathology, suicide or criminal behaviour. Prospective, large-scale longitudinal studies should examine mechanisms (eg behavioural, interpersonal, social, genetic, or biological) that translate childhood bullying into problems as adults and identify those amenable to interventions.\(^6\)

There is also a need to examine protective factors, including parental and social support and a child’s cognitive, emotional, and behavioural skills.\(^5\) The study from East London showed that support from family and friends protected bullied adolescents from poor academic outcomes and approximately halved the likelihood of bullying. However, the study also ‘demonstrated that support from friends and family alone cannot mitigate against the strong negative effect that bullying has on mental health’.\(^4\)

Tackling bullying depends on politicians’ and policy makers’ willingness to address the issue. Lereya et al. noted that governments ‘have focused almost exclusively on public policy to address family maltreatment’. They argue that because ‘bullied children have similar or worse long-term mental health outcomes’ than those maltreated by adults ‘this imbalance requires attention’. Schools, health services and other agencies need to coordinate responses, and research needs to assess interagency policies and processes.\(^7\) For the victims of bullying, such initiatives will not come a moment too soon.

- The Global Health Initiative for the Prevention of Bullying (GHIPB) aims ‘to raise international awareness about the serious health and safety risks associated with bullying, across social settings and along the lifespan’. GHIPB promotes prevention, detection and treatment of bullying related morbidity by health professionals (www.ghipb.org).

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### References