SACS HIGH SCHOOL
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In This Issue

What is Bullying?

Bullying is generally understood as a form of aggression. Most authors describe bullying as repeated and lasting negative actions of one or more children (the offender[s]) directed to a specific child (the victim). The victims are typically not able to defend themselves. Bullying appears to have certain ingredients, for example, an imbalance of power and the intent to do harm. Our inclination is to think of bullying in physical terms, but "relational aggression" – placing conditions on friendship and using these conditions as a tool for bullying is commonplace.

Minne Fekkas and her colleagues conducted a study on bullying in the Netherlands. In her survey, she described bullying in the following manner:

"Bullying is, for example: when another student or students say nasty and unpleasant things, or call somebody names; ignore or exclude somebody, like not allowing him or her to participate in play; take away, destroy or hide another student's stuff; hit, push or shove another student around; tell lies, spread rumours, or send mean notes. We don't call it bullying when two students of about equal strength or power argue or fight."

This provides a useful definition of bullying and is consistent with internationally used definitions (Olweus, 1999).

Forms of Bullying

1. **Relational Aggression:** Behaviour that is intended to harm someone by damaging or manipulating his or her relationships with others.
2. **Covert Aggression:** Indirect, hidden acts of aggression, social isolation, and/or excluding.
3. **Physical/Overt Aggression:** Direct, blatant acts of aggression, can be physical or verbal. Harm through damage or threat of damage to another's physical well- being.
4. **Verbal Aggression:** Obvious and hidden acts of aggression towards a child such as threats, putdowns and name calling.

5. **Reactive Relational Aggression:** Defensive response to provocation with intent to retaliate.

6. **Proactive Relational Aggression:** Proactive behaviours are a means for achieving a goal, for example, a child may exclude someone to maintain his or her own social status.

7. **Cyber – bullying**: Using internet- based social platforms to bully others.

Social Roles

Bearing in mind cautions to ourselves in respect of unfair labelling (and appropriate apologies to the drama department), complex social adolescent pecking orders may present a form of "teen royalty" which operates with fairly identifiable roles. There are many ways to conceptualise the roles that victims and perpetrators play as well as the bystanders in the bullying drama. This is one view:

1. **The King**, an aggressor, who may at will choose to damage a relationship. His friends will generally do his bidding. He is not intimidated and can out-argue even adults, but is often charming to adults. He can be manipulatively affectionate and trades on loyalties and disloyalties which he defines. He controls his social environment and operates with an aura of arrogance and superiority.

2. **The Sidekick**, second to the King, can also be a target (victim), but supports the King because this is where his power lies. Often similar to the King, these two together present the impression of impenetrable force. The sidekick has his own personal agenda in which he uses bullying tactics. The sidekick may view the King as an authority figure in his life telling him how to think and what to do. He will allow himself to be ordered around by the King.

3. **The Gossip,** a secretive fellow, self-aggrandizing and a good communicator, gives the perception of being a good listener and trustworthy. He appears to be friends with everyone and has a need to be admired and to feel important. He is rarely excluded from the group. He is a good actor and seems nice but may use confidential information to elevate his position. This boy presents as the confidant but cannot be trusted. He may even start a conversation with: "Don't tell anyone I told you this but…"

4. **The Floater** moves freely among subgroups. He is nice, not very sophisticated and avoids conflict. He may exhibit more self esteem because his sense of self is not based on one group. He has respect from other boys perhaps because he is not trying to rule. He does not want to exclude others, is not trying to win all conversations and is less competitive.

5. **The Bully is** devious, outspoken and tough. He is cruel to weaker people. His bullying is the most overt in the group. He will use physical violence as well as relational aggression.

6. **The Witnesses,** those boys who are not aggressors or targets but are caught somewhere in-between. The witness is part of the social situation as a bystander and finds himself having to choose between friends. He often tries to be the peacemaker ("can't we all just get along?"), but finds it difficult to say "no" and cannot stand up to anyone. It is as if he has access to the group but goes undetected.

7. **The Wannabees** will do anything to be part of the inner circle of the King. He gossips, is a pleaser and will go to great lengths to increase the King's position. He will not express a personal opinion outside of what the King thinks and will not go against the group. He needs the feeling of belonging and not being a target and will often get swept up in the mood of the crowd. He is the one who will encourage a fight hoping it will please the King.

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8. **The Target** feels helpless to stop the other children's behaviour. He feels excluded and feels like a loser. He is more isolated. He takes a defensive stance designed to shut people out to mask his hurt. He feels humiliated by the rejection he feels from other boys. He feels exposed and vulnerable tempting him to change himself in order to fit in.

Minne Fekkas wanted to discover whether within a school year bullying precedes psychosomatic and psychosocial problems or whether these problems precede bullying. In short, are children vulnerable to bullies or are children bullied into vulnerability? Specifically she asked whether:

1. a child who was the victim of bullying at the beginning of a year had an increased risk of health related problems by the end of the same year

2. a child's health related problems at the beginning of a school year increased the risk that that child would become a victim of bullying by the end of the year.

In a 6 month cohort study including 18 elementary schools in the Netherlands comprising 1118 children completed over a 6 month period she tested for a variety of symptoms including depression, anxiety, headaches, sleeping problems, abdominal pain, poor appetite, feelings of tension and tiredness.

The Impact of Bullying

Fekkas' summary results indicated that: v*ictims of bullying had significantly higher chances of developing <u>new</u> psychosomatic and psychosocial problems compared with children who were not bullied. In contrast, some psychosocial, but not physical, health symptoms preceded bullying victimization. Children with depressive symptoms had a significantly higher chance of being newly victimized, as did children with anxiety.*

In her discussions, she stated:

Many psychosomatic and psychosocial health problems follow an episode of bullying victimization. These findings stress the importance for doctors and health practitioners to establish whether bullying plays a contributing role in victimization in order to ascertain the aetiology of such symptoms. Furthermore, our results indicate that children with depressive symptoms and anxiety are at increased risk of being victimized. Because victimization could have an adverse effect on children's attempts to cope with depression or anxiety, it is important to consider teaching these children skills that could make them less vulnerable to bullying behaviour.

Fekkes found that:

Children who are regularly bullied at the beginning of a school year have a higher risk of developing *<u>new</u>* health related problems during the year. This supports the idea that victimization causes the development of somatic and psychological problems. Children who are depressed and anxious at the beginning of a school year are at enhanced risk of becoming *<u>new</u>* victims of bullying during the year.She suggested that anxious or depressed behavior may make vulnerable children both an easier and more attractive target for aggressive children.

Bullying children may have less fear of retaliation from sub-assertive children. In addition, children with vulnerabilities may interpret benign experiences as hostile as a result of their vulnerability.

It appears to be significant that episodes of anxiety and depression could follow episodes of bullying. Of importance is that a large number of *other* health related problems may follow a period of being bullied.

It is interesting that these studies have found that related psychosocial problems both preceded and followed a period of victimization, but that related physical symptoms only followed a period of victimization and did not precede it.

It has been suggested that children may themselves consider it socially unacceptable to bully and to be mean to those children who display physical illness and it may be possible that children consider it more permissible to bully those who are psychologically fragile and non-assertive. Results indicate that children with psychosocial health symptoms, like depression and anxiety, are at increased risk of being victimized.

This has implications for interventions. Smith indicates that several studies have shown that school-based interventions can reduce bullying. Olweus and colleagues found that many years later victims of bullying still suffered feelings of depression and that bullies were more likely to commit offences later in life. Effective bullying programs might decrease the number of children who manifest with psychological and physical problems. Effective programs are needed to help children learn the social skills that would decrease their likelihood of being bullied.

Direct and Indirect Bullying

Van der Wal took things a step further in an attempt to understand the implications of direct (overt) and indirect (covert) bullying.

Direct bullying includes all sorts of physical and verbal aggression, such as kicking, hitting, threatening, name-calling, and insulting.

Direct bullying occurs more frequently in boy's behaviour. Indirect bullying occurs more frequently in girl's behaviour.

Indirect bullying includes aspects of social isolation such as ignoring, excluding, and backbiting.

In respect of both indirect and direct bullying and despite the negative effect of bullying on mental health, many victimized children do not mention it at home or report it to teachers. Victims of bullying fear retaliation from the bully and /or social group, are afraid they will not be believed, or perceive their situation in the long run as normal. As a result, bullying can take place for many years without being noticed by adults.

What van der Wal's study did reveal is that depression was a stronger symptom for indirect bullying. It may be that there is a view that physical bullying is more socially unacceptable and has a greater negative impact on victims than indirect bullying. Indirect bullying appears to have a more significant relationship to later maladjustment (loneliness, depression).

Paquette and Underwood found in a sample of adolescents, who recalled acts of social and physical aggression of which they were victims, that social aggression left them with greater feelings of sadness and badness about themselves than physical aggression.

Indirect bullying may therefore have greater negative effect and be less likely to be noticed by teachers. It is often less visible and harder to prove, perhaps additional reasons why children leave it unreported.

Crick and Grotpeter consider indirect bullying to be "relational victimisation".

Incidentally, while we understand that being a victim of bullying may have a negative impact on psychosocial and physical health, being a bully is also associated with poorer health outcomes. Both delinquency later in life and depression are associated with being a bully. Van der Wal found that adolescent tendency to aggression is part of a broader syndrome of potentially more serious conduct disorder. The association between bullies and depression may indicate that bullies may well have been victims of bullying themselves.

Early onset of bullying behaviour may predict a longer term pattern of social interaction showing considerable stability over time.

The causes of bullying are too numerous to mention in this summary, but some aetiologies are: value systems based on domination (business, politics, sport, entertainment), culture, adaptation and acceptance of aggressive behaviour and attitudes, socio-economic status, family circumstances, family history, personality and character traits, denial of the impact of bullying, complicit adult support, talionic responses (an eye for an eye), collapse of family structures, group think, absence of positive role models and confusion between assertiveness and aggression.

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A proper accounting of the characteristics of a bully belong in another summary, but some features are: a bully is a child who values the rewards that aggression yields, who lacks active compassion and empathy, who tends to lack guilt, who needs to dominate and win in all situations, who thinks unrealistically, who may struggle with self esteem, envy, impulse control, who may blame the victim of his bullying and who may fear social rejection.

Victims of bullies fall into two categories: passive victims and provocative victims.

Passive victims show a lot of emotion, rarely tell about being bullied, because they think it will make matters worse, don't think adults can help, may carry weapons for protection, do not encourage attack, are sensitive, cry easily, and are easy to pick on, may be shy and lacking in social skills, may get on better with adults and younger children than their age group, are usually insecure and lacking in self-esteem, are usually chosen last or left out, may appear to lack humour, have few or no friends, are often anxious and easily upset, are bullied repeatedly, may use money or toys (as bribes) for protection.

P*rovocative* victims often present as pesky and repeatedly irritate others, are quick-tempered and prone to try to fight back, get others charged up, may be clumsy, immature, and restless. Provocative victims may encourage kids who bully and look as if they are bullies themselves.

While we may need to refine and define the causes of bullying and the characteristics of the children involved, understand the prevalent places that bullying takes place (hallways, at break time, during P.E lessons, during period changes) and understand the dynamic interaction between all of these factors, including our own roles and responses, it seems that the association between bullying (direct and indirect) and psychosocial health is a clear indication that interventions are necessary and should pay attention to both children who are bullied and to children who bully.

What to look out for

Certain on-going behaviours are indicators of bullying. Obviously, direct bullying, open physical violence when seen cannot be ignored. Subtle physical bullying (pushing, pulling, “mild slapping etc.) need to be seen in context. There is a point when bullying behaviour does not concur with “boys will be boys”.

When observing, look out for children whose bullying methods may include:

- Exclusion
- Ignoring
- Spreading Rumours
- Verbal Insults
- Teasing
- Intimidation
- Eye Rolling
- Taunting
- Manipulative Affection

Look also for the impact of bullying in the responses of the recipient. These may include:

- Shame
- Embarrassment
- Shyness
- Anger
- Self Exclusion

- Sadness
- Anxiety

In short, research shows reliably that bullying can cause loneliness, depression, anxiety, lead to low self-esteem and increased susceptibility to illness. Any of these signs reflecting in the children may be an indication that the child is being bullied. Remember, the child may not just being bullied at school, there may be bullying in other areas of his life.

Our next task may well be to formulate a bullying policy and to put in place and “anti-bullying” program.

As an addendum and for your information:

Physical Stress Symptoms:

- Reduced immunity to infection leading to frequent colds, coughs, flu, glandular fever, etc (especially on days off, e.g. weekends and holidays)
- Chest pains and angina
- High blood pressure
- Headaches and migraines
- Loss of appetite (although a few people react by overeating)
- Irritable bowel syndrome
- Reactive vomiting before, during or after meetings (or at the site of a "triggering" incident, person, place or thing or from just the thought of going to certain locations ie workplace)
- Skin irritations and skin disorders (eg eczema, psoriasis, shingles, internal and external ulcers, urticaria)
- Hormonal problems (loss of libido, impotence)
- Unusual clumsiness (such as an inability to grasp small objects, separate sheets of paper or tendency to drop cups, etc.)
- Sleep problems including nightmares, problems falling asleep and waking early
- Disturbance of balance
- Panic attacks, feelings of nervousness and anxiety, excessive sweating, trembling, palpitations
- Joint and muscle pains with no obvious cause
- Back pain
- Excessive need to bite or teeth grinding
- Tics
- Scratching
- Physical numbness, especially in fingers, toes and lips
- Eye problems, such as new prescriptions needed "virtually overnight"

- Dislike of loud noises and bright lights
- Development of new allergies

Emotional Stress Symptoms:

- Bewilderment and confusion, an inability to understand what is happening or why it happened
- A strong sense of denial, an inability to convince yourself that the experience was real; your denial is reinforced by the denial of those around you and especially of people in authority
- Tearfulness
- Irritability, short-temperedness, sudden intense anger and occasional violent outbursts
- Hyperawareness, an acute sense of time passing, the seasons changing, distances when travelling
- An enhanced environmental awareness, a greater respect for the natural world, a feeling of "wanting to save the planet"
- Hyper-vigilance, which feels like but is not paranoia, and which may be (sometimes deliberately) mislabelled as paranoia by those around you
- Flashbacks and replays which you are unable to switch off
- Impaired memory, forgetfulness, memory which is intermittent, especially of day-to-day trivial things
- Difficulty in learning new information
- Inability to concentrate
- Exaggerated startle response
- Hypersensitivity – small actions or remarks are perceived as critical or threatening, even when you know it isn't
- A deep sense of betrayal
- Obsessions - experience that seems to takes over your life, repeated thought that you can't get out of your mind
- Depression (reactive, not endogenous)
- Excessive shame, embarrassment and guilt
- Undue fear
- Low self-esteem and low self-confidence
- A deep sense of unworthiness and non-entitlement
- Emotional numbness, anhedonia (an inability to feel love or joy)
- Sullenness (a sign the inner psyche has been damaged)
- Detachment, avoidance of anything that reminds you of the experience
- Physical and mental paralysis at any reminder of the experience
- Increased reliance on drugs (caffeine, nicotine, alcohol, sleeping tablets, tranquillisers, antidepressants, other substances) resulting in further compromised health

- Comfort spending (and consequent financial problems)
- Thoughts of suicide and in some cases homicide

In addition to these stress symptoms, research is suggesting that diabetes, asthma, allergies, fibromyalgia, multiple sclerosis (MS), chronic fatigue syndrome (ME), hydradentitis supurativa (painful skin disorder) and even some forms of cancer are caused or aggravated by stress.

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Bernard Altman

Clinical Psychologist

1 Bramble Way, Oakridge, Cape Town, South Africa

Tel / Fax: +27 21 7153600

altmanb@iafrica.com

If you have any suggestions for future topics, let me know at altmanb@sacollege.org.za

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