Does Bullying Result in Posttraumatic Stress Disorder?

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Bullying in schools is a widespread problem that has received greater attention in recent years. Half of all students in the US reported experiencing bullying at some time during their school years and 10% reported being bullied on a regular basis (Lyznicki, McCaffree & Robinowitz, 2004). Bullying occurs repeatedly over time and involves an ongoing pattern of harassment, intimidation and abuse. There is a pattern of repeated aggression involving a deliberate attempt to harm or disturb the victim, who experiences an actual or perceived imbalance of power (Smith, 1997; Lyznicki et al, 2004). Bullying can be physical (assault), verbal (name-calling, threats) or relational (spreading rumours, isolating victim). Bullying usually occurs at school (or when the child is travelling to or from school) (Lyznicki et al, 2004) and is generally occurs between peers within the same school year (Smith, 1997). Although bullying is believed to occur more often among boys, boys tend to use physical and verbal bullying, while girls tend to use relational bullying, which is more subtle and difficult to detect (Lyznicki et al, 2004).

As awareness of the problem has increased, there has been increased interest in the potential long-term effects of bullying. Authors have reported on a number of negative psychological and physical effects of school bullying including reduced self-esteem, poor physical health, decreased school attendance and performance and increased depression and anxiety (Leymann & Gustafsson, 1996; Smith, 1997; Lyznicki et al, 2004; Rivers, 2004; Tehrani, 2004). The risk for these negative outcomes is increased if the bullying is severe, prolonged and victim lacks adequate social support (Leymann & Gustafsson, 1996; Rigby, 2003).

Bullying differs from isolated, transitory interpersonal conflicts in that it involves systematic, intentional, prolonged and repeated negative attacks aimed at a person by one or more people, often resulting in the victim feeling unable to cope (Mikkelsen & Einarsen, 2002). Chronically bullied children display symptoms similar to victims of domestic violence (Lyznicki et al, 2004). These features of bullying that have led many researchers to theorize about the potential for bullying to result in the victim experiencing Posttraumatic Stress Disorder (PTSD) and this has led to recent research in both childhood and workplace bullying. It has been theorized that a victim of bullying may develop maladaptive beliefs and assumptions about themselves, the benevolence of other people, the world, justice and controllability and come to anticipate future negative events (Mikkelsen & Einarsen, 2002; Matthiesen & Einarsen, 2004). Instead of rebuilding assumptions about the world that are more viable, victims of bullying may remain in a state of cognitive confusion, helplessness and anxiety characteristic of PTSD (Mikkelsen & Einarsen, 2002; Tehrani, 2004).

Much of the research on the relationship between bullying and PTSD has focussed on workplace bullying in adults. In one of the earlier studies, Leymann and Gustafsson (1996) found that 92% of workplace bully victims self-reported symptoms of PTSD at levels similar to those found in combat, rape and prison camp experiences. They found that PTSD was more severe in situations where the bullying took place over extended periods of time. Additionally, workplace-bullying victims suffer from a “traumatic environment”, whereby they experience rights violations from institutional policies that can exacerbate the trauma experience. Leymann

and Gustafsson conclude that bullying results not only in severe psychological trauma, but also in a prolonged stress condition that threatens the victim's socio-environmental existence. Tehrani (2004) found lower rates of PTSD symptoms in workplace bullying victims, but still reported that 44% experienced high levels of PTSD symptoms, similar to those found in complex PTSD characteristic of battered women and childhood abuse.

Mikkelsen and Einarsen (2002) reported 76% of workplace bullying victims self-reported symptoms of PTSD with 74% endorsing moderate to severe impairment in functioning. They also found a positive relationship between the severity (actual and perceived) of bullying and the level of traumatization the victims experienced. They hypothesized and found that bullying victims who met criteria for PTSD were more likely to report feeling more negatively affected by past events other than bullying. They postulate a diathesis-stress model in which exposure to past trauma may increase vulnerability to the development of PTSD in response to bullying. Additionally, employees distressed by previous negative events may be more vulnerable targets for bullying and resulting PTSD from bullying. A study by Matthiesen and Einarsen (2004) reported similar findings and found a strong link between the personality dimension of negative affectivity and PTSD symptoms in victims of bullying. They conclude that there is a strong personality component in the development of PTSD in workplace bullying.

Fewer studies have empirically examined the incidence of PTSD resulting from childhood bullying. Weaver (2000) presented a case study of a girl who experienced repeated bullying at school and presented with a number of PTSD symptoms including distressing recollections of the bullying, avoidance of places and situations associated with the bullying and increased physiological arousal. A study examining bullying and PTSD in high school students in the United Kingdom (Mynard, Joseph & Alexander, 2000) found that 37% of bullying victims self-reported suffering from PTSD symptoms. In a retrospective study of gays, lesbians and bisexuals, Rivers (2004) reported 17% of participants experienced symptoms of PTSD related to bullying in school due to their sexual orientation. Approximately 25% of these participants reported being troubled by memories of bullying well after leaving school. However, these findings are questionable as Rivers used a non-validated measure of PTSD that he developed.

Storch and Esposito (2003) conducted a study examining bullying and PTSD in elementary school children and found that both overt and relational bullying were positively correlated with symptoms of PTSD. They conclude that bullying can lead to PTSD in a couple of ways. Bullying can result in the victim displaying overt anxiety signals, which can lead to more serious victimization. Alternatively, bullying can indirectly lead to PTSD through the development of personality variables (e.g., low self-esteem) that place the child at increased risk for trauma and maladaptive appraisals that can exacerbate anxiety reactions. They emphasized the need for longitudinal research to clarify the direction of these relationships.

In general, clinical impressions and preliminary research lend support for the likelihood of childhood bullying leading to PTSD. However, the literature reviewed has considerable limitations and the link between childhood bullying and PTSD has not yet been well-established (Storch & Esposito, 2003). While research findings related to workplace bullying are helpful for providing an analogue to understanding childhood bullying, the conclusions may not generalize to child victims of bullying. For adults, bullying is generally not a life-threatening trauma, but in

children, one must consider the developmental level, sociocultural context and the role of the parents as protective factors in the development of PTSD symptoms (Smith, 1997; Weaver, 2002). Additionally, much of the research on bullying and childhood PTSD has been primarily descriptive, retrospective or relied heavily on questionnaire based self-report (Smith, 1997; Rigby, 2003). An additional limitation is that the vast majority of empirical research on childhood PTSD from bullying is correlational, preventing conclusions about causation and open to other possible interpretations (Smith, 1997; Mikkelsen & Einarsen, 2002; Rigby, 2003; Storch & Esposito, 2003). Therefore, longitudinal studies are required to describe the persisting effects of bullying and whether associated emotional difficulties are the consequences or causes of bullying (Lyznicki et al, 2004). Finally, a number of authors have raised questions about the applicability of the PTSD diagnosis for bullying. Specifically, the A1 diagnostic criterion for PTSD (which requires the traumatic event to include actual or threatened death or serious physical injury) does not apply for most instances of bullying and therefore, most victims of bullying do not meet formal diagnostic criteria for PTSD even though they present with all of the symptoms of PTSD (Mikkelsen & Einarsen, 2002). This has led to a number of calls for the widening or altering of the diagnostic criteria for PTSD to include less catastrophic events (Weaver, 2002; Mikkelsen & Einarsen, 2002; Matthiesen & Einarsen, 2004).

In conclusion, although there is some preliminary evidence supporting the association between childhood bullying and PTSD, empirical research in this area is lacking and causal inferences cannot be made. Further longitudinal research studies will be required to better understand the posttraumatic effects of bullying.

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