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Internalizing Problems in Students Involved in Bullying and Victimization [Chapter 5]

Susan M. Swearer, Adam Collins, Kisha Haye Radliff, and Cixin Wang

Misery is...

Misery is when you go to school and bullies pick on you.

Misery is when you share with someone, but they don't share with you.

Misery is when friends become bullies.

Misery is when you go to school and kids threaten you by telling you that they will get you after school.

Misery is when you are at breakfast recess and kids push you around for no reason.

Misery is when people invite everyone but you to play tag and football.

(Written by a 10-year-old depressed and anxious male bully-victim)

In this chapter, we will review the literature on internalizing problems in youth who are involved in bullying. Involvement in bullying occurs along a continuum (i.e., the bully-victim continuum), meaning that students can participate in multiple roles, including bullying others, being bullied, both bullying others and being bullied, witnessing bullying, and no involvement in bullying (Espelage & Swearer, 2003; Swearer, Siebecker, Johnsen-Frerichs, & Wang, 2010). It is clear that involvement in bullying is not defined by static and fixed roles in individuals. It is also evident that students involved in the bully-victim continuum experience greater levels of internalizing problems compared to students who are not involved in bullying (Craig, 1998; Swearer et al., 2010; Swearer, Song, Cary, Eagle, & Mickelson, 2001). The goal of this chapter is to examine the relation between internalizing problems and the bully-victim continuum, to present longitudinal data on this dynamic, and to provide suggestions for effective mental health interventions for youth involved in bullying. It is our contention that parents, students, teachers, and mental health professionals must work in tandem in order to derail the destructive cycle of bullying and mental health problems (Swearer, Espelage, & Napolitano, 2009).

Internalizing Issues and Involvement in Bullying and Victimization

Depression and the Bully-Victim Continuum

Youth who experience depressive symptoms typically report feelings of sadness, anger, worthlessness, and hopelessness. How might these feelings be connected to bullying and victimization? As the opening poem, "Misery is..." illustrated, students who are bullied often feel hopeless about themselves and their situation.

The prevalence of depressive disorders among children and adolescents vary depending upon age, sex, and appear to be increasing. Prevalence rates range from 1% to 2% in children and from 1% to 7% in adolescents (see Avenevoli, Knight, Kessler, & Merikangas, 2008). The affect of depressed youth can be characterized as sad, depressed, irritable, and/or angry (Friedberg & McClure, 2002). Youth with depression display a negative cognitive style, marked by negative perceptions of themselves, the world, and their future (Beck, Rush, Shaw, & Emery, 1979). Additionally, youth with depression typically experience problems in their interpersonal relationships and may experience decreased interest in activities. They may also experience distorted thinking and poor problem-solving skills (Friedberg & McClure, 2002), as well as loss of appetite, insomnia, psychomotor agitation, fatigue, and suicidal ideation (APA). Thus, symptoms of depression are related to both inter- and intrapersonal functioning.

Researchers and clinicians have identified a significant association between depression and being bullied (Callaghan & Joseph, 1995; Swearer et al., 2001) and with bullying others (Craig, 1998; Kaltiala-Heino, Rimpela, Rantanen, & Rimpela, 2000; Kumpulainen, Räsänen, & Puura, 2001). Research suggests that all participants in the bully-victim continuum, regardless of role (i.e., victim, bully-victim, or bully) are likely to experience symptoms of depression (Austin & Joseph, 1996), with bully-victims endorsing the highest levels of depression (Haynie et al., 2001; Swearer et al., 2001). Kumpulainen and colleagues (2001) found higher rates of depressive disorders among bully-victims compared to victims, bullies, and controls. Specifically, they found that 18% of bully-victims, 13% of bullies, and 10% of victims were diagnosed with a depressive disorder.

There are dire consequences associated with depression and bullying. Findings from an analysis of school shootings over the past three decades indicated that 79% of the attackers had a history of suicide attempts or suicidal thoughts and 61% had a history of serious depression (Vossekuil, Fein, Reddy, Borum, & Modzeleski, 2002). Over two-thirds of the attackers were victimized prior to the school shootings. Kaltiala-Heino, Rimpela, Marttunen, Rimpela, and Rantanen (1999) assessed the relation between involvement in bullying, depression, and suicidal ideation among adolescents aged 14 to 16. After controlling for age and gender, results indicated that bully-victims endorsed the highest risk for depression, followed by victims and then bullies. Bully-victims were the most at-risk group for suicidal ideation, followed by bullies and then victims. The high frequency of suicidal ideation among youth involved in bullying is not surprising, given that, by definition, bullying is a repeated behavior over time. Those individuals experiencing bullying are likely to feel hopeless as a result of the bullying (Haye, 2005). Depressed children often view their future as hopeless (Kazdin, Rodgers, & Colbus, 1986; Weisz, Sweeney, Profitt, & Carr, 1993). Kazdin and colleagues (1986) have defined hopelessness as negative expectations toward oneself and the future. Over the past two decades, researchers have evaluated the role of hopelessness as it relates to depression. Known as the Hopelessness Theory of Depression, Abramson, Metalsky, and Alloy (1989) have championed hopelessness depression as a subtype of depression. According to their research, individuals are more likely to experience feelings of hopelessness if they have an attribution style that (1) attributes negative events to stable and global causes, (2) catastrophizes the consequences of negative events,

or (3) attributes negative events to self-characteristics. This study as well as others (Brozina & Abela, 2006; Kazdin, French, Unis, Esveldt-Dawson, & Sherick, 1983) suggests that hopelessness likely precedes depression.

Individuals may also experience hopelessness and depression because of the level of control they believe they have in their environment. When individuals do not believe they can influence their environment, they may "give up" trying to change their environment, resulting in feelings of helplessness, hopelessness, and depression (Abramson et al., 1989). The attributions individuals make toward either positive or negative events has also been shown to correlate with depressive symptoms. More specifically, individuals who attribute negative events to internal, stable, and global factors and attribute positive events to external, specific, and unstable factors are at-risk for future depressive symptoms (Dodge, 1993).

Although there is a limited body of research on the topic of the bully-victim continuum and hopelessness, Gibb and Alloy (2006) recently examined the mediating role of attribution style between verbal victimization and depression. In the study, 415 4th and 5th-grade students were administered a modified version of the Childhood Trauma Questionnaire-Emotional Abuse subscale, the Revised Children's Attributional Style Questionnaire, and the Children's Depression Inventory. The researchers concluded that attributional style partially mediated the connection between verbal victimization and depressive symptoms. Specifically, verbal victimization (negative events) correlated with developing a negative attributional style, which created a vulnerability to depression. In addition, they found that depressive symptoms may increase the occurrence of negative attribution styles and verbal victimization, suggesting a cyclical pattern. These depressive symptoms can then lead to other adaptive problems for a student. Errors in information processing, for example, may lead the student to focus on negative events while effectively ignoring the positive (Stark, Napolitano, Swearer, Schmidt, Jaramillo, & Hoyle, 1996).

Anxiety and the Bully-Victim Continuum

Anxiety disorders are the most common psychiatric disorder diagnosed in children and adolescents (Anderson, 1994; Beidel, 1991; Costello & Angold, 1995). Estimated prevalence rates of anxiety disorder have been reported to range between 5.8% and 17.7% (Silverman & Kurtines, 2001) and between 2% and 4% (Costello, Mustillo, Erkan, Keeler, & Angold, 2003; Ford, Goodman, & Meltzer, 2003) for children and adolescents. Anxiety can be debilitating for youth and can negatively impact friendship-making skills, school attendance, and school performance. Research has repeatedly shown that individuals who are victimized typically experience social anxiety (Gladstone, Parker, & Malhi, 2006; Huphrey, Storch, & Geffken, 2007; La Greca & Harrison, 2005; Storch, Zelman, Sweeney, Danner, & Dove, 2002). There are three responses to anxiety that can be present individually or in combination: (1) motoric responses (e.g., isolation), (2) physiological responses (e.g., sweating), and (3) subjective responses (e.g., fearful thoughts) (Wicks-Nelson & Israel, 1991). Among school-aged youth, this can be expressed in several ways. For example, the victim of bullying may manifest his or her anxiety by skipping classes shared with the perpetrator to avoid potential conflict and harassment.

There are also common comorbid behavioral or psychological problems associated with individuals who suffer from anxiety. The most common co-occurring problems with anxiety are depression (Lewinsohn, Zinbarg, Seeley, Lewinsohn, & Sack, 1997), an inability to establish or maintain satisfying relationships (Chipuer, 2001; Cacioppo et al. 2000), loneliness (Galanaki & Vassilopoulou, 2007; Crick & Ladd, 1993), low self-worth (Grills & Ollendick, 2002), and school refusal behaviors (Heyne & Rollings, 2002; Kearney, Eisen, & Silverman, 1995). In a recent study, Starr and Davila (2008) examined the correlates of depression and anxiety and found that while many cor-

relates were common to both depression and anxiety, social anxiety was shown to have a greater correlation with peer variables (e.g., social competence, communication in friendships).

Bullying has been characterized as a peer relationship problem (Pepler, Graig, & O'Connell, 2010) and given the peer difficulties that students with anxiety experience, it is particularly important to understand the experience of anxiety among students who are involved in the bully-victim continuum. Gazelle (2008) examined the differences in children who are both anxious and social isolates. These children typically want to play with their peers, but are unable to do so due to either shyness or social anxiety. In a diverse sample of 688 3rd graders, children's degree of anxious solitude (e.g., watching other kids play, but not joining in), agreeableness (e.g., being good at sharing with other kids), attention-seeking-immaturity (e.g., trying to get attention of other kids in ways that are considered annoying), and externalizing behaviors (e.g., starting fights) were assessed. Results showed several different subgroups of anxious solitary children. The first group of children, coined, "agreeable anxious solitary," were less excluded and victimized and perceived by peers as more likable than the other subgroups. In contrast, a second group, coined "attention-seeking-immature anxious solitary," had much different outcomes. Specifically, children in this group experienced higher levels of rejection, exclusion, and victimization. The variability of peer responses in children with anxiety with isolating behaviors demonstrates the complexity of peer relationships problems among anxious youth.

While the correlation between anxiety and victimization has been well documented, less is known regarding the directionality of these phenomena. Recent research on anxiety and victimization has focused on the cause and effect between these two variables. Research has shown that students who exhibit anxious behaviors as well as other internalizing behaviors (e.g., withdrawal, shyness) are often victimized (Gladstone et al., 2006; Hodges & Perry, 1999). It has been hypothesized that anxiety is maintained or results from victimization. Because bullying typically takes place in a student's social milieu, anxiety involving social situations may be even more likely to occur among victimized youth (Craig & Pepler, 1995). Thus, students who are victimized might avoid school and social situations.

The effects of victimization and anxiety can often last beyond the school year in which it occurs. Sourander and colleagues (2007) examined the outcomes of males who bullied or were bullied in childhood and long-term effects were found for both groups. The longitudinal study followed an original population of 2,540 boys born in 1981 and used parent, teacher, and self-reports to determine bully-victim status and psychiatric disorders. Being classified as a bully was predictive of future substance abuse, depression, and anxiety. Those boys classified as bully-victims were prone to antisocial personality disorder and anxiety disorders. Finally, those boys classified as victims were more likely to be diagnosed with an anxiety disorder. Regardless of a boy's status on the bully-victim continuum, involvement in bullying was associated with anxiety.

In a similar study with younger children, Snyder and colleagues (2003) examined the relations between victimization and teacher and parent reported variables (e.g., antisocial behavior, depressive behavior) during kindergarten and 1st grade. The results for the boys in the study revealed an association between aggressive behavior and chronic victimization. Boys who responded to chronic victimization with antisocial behavior saw a reduction in victimization in the short term. However, in the long term, these boys were more likely to continue being victimized and to receive higher teacher-reported antisocial behavior. This suggests that there may be a link between aggressive behavior and persistent victimization.

Some researchers have found that childhood victimization can have effects that last for years, in some cases into adulthood. In a retrospective study by Roth and colleagues (Roth, Coles, & Heimberg, 2002), adults who reported victimization during childhood had higher levels of trait anxiety, social anxiety, worry, and anxiety sensitivity. Other forms of anxiety have been correlated with childhood victimization as well. Gladstone and colleagues (2006) found that adults

were more likely to suffer from social phobia and agoraphobia and have greater levels of state anxiety if they had experienced childhood bullying. Thus, even though victimization decreases with age (Byrne, 1994; Salmivalli, Lappalainen, & Lagerspetz, 1998), the effects of victimization on symptoms of anxiety still persist into adulthood (Gladstone et al., 2006; Olweus, 1993; Roth et al., 2002).

Aggression, Anxiety, and the Bully-Victim Continuum

The relationship between aggression and anxiety has both empirical and theoretical foundations. One assertion is that students who are anxious are more aggressive. The findings from Snyder and colleagues (2003) support this claim. In addition, Kashani, Dueser, and Reid (1991) found similar results between anxiety and physical and verbal aggression. In both studies, children compensated for apparent weaknesses by behaving aggressively. An explanation for this behavior can be explained by the correlation between anxiety and false interpretations. Research has shown that children who have a high level of social anxiety misinterpret ambiguous situations in a negative fashion (Barrett, Rapee, Dadds, & Ryan, 1996; Miers, Blöte, Bögels, & Westenberg, 2008). In addition, children with anxiety have been shown to discount positive social events (Vassilopoulos & Banerjee, 2008). In combination, these two cognitive distortions may perpetuate and maintain an anxious child's aggressive, maladaptive behaviors.

Another explanation linking aggression and anxiety is that anxiety mediates aggressive responses. According to this argument, anxious youth are less likely to be aggressive and more likely to display increased caution or inhibition. Support for the mediating effects of anxiety on aggression has been shown across various studies, many examining the variable of behavioral inhibition (Mick & Telch, 1998; Schwartz, Snidman, & Kagan, 1999; van Ameringen Mancini, & Oakman, 1998). To better understand the role of behavioral inhibition in anxiety, Gladstone, Parker, Mitchell, Wilhelm, and Malhi (2005) examined the relation between early childhood inhibited temperament and lifetime anxiety disorders. They found that individuals reporting higher levels of childhood behavioral inhibition were more likely to meet criteria for an anxiety disorder. Many questions remain about the associations among anger, aggression, anxiety and the bully-victim continuum. The correlation between anxiety and bully-victims and victims has been well documented. However, the relation between anxiety and youth who perpetrate bullying is still debated. Ivarsson, Broberg, Arvidsson, and Gillberg (2005) found that bullies were more likely to experience externalizing behaviors (e.g., delinquency, aggression) than internalizing behaviors. However, other studies have found that bully perpetrators do experience elevated levels of anxiety (Duncan, 1999; Kaltiala-Heino et al., 2000). Given that there are several anxiety disorders that can be diagnosed in youth, an interesting question for further study is whether there are different anxiety disorders associated with different types of involvement in the bully-victim continuum?

As previously discussed, research has found an association between negative psychological outcomes for students involved in bullying, such as depression (Austin & Joseph, 1996; Bosworth, Espelage, & Simon, 1999; Craig, 1998; Haynie et al., 2001), and anxiety (Craig, 1998; Rigby, 2003; Sourander et al., 2007; Swearer et al., 2001). However, few longitudinal studies have explored the developmental relations among aggression, depression, and anxiety in the bullying dynamic. Given the dearth of empirical literature in this area, we were interested in examining the following research questions:

1. Does previous bully-victim status (bully, victim, bully-victim, and not involved) predict depression, anxiety, physical and relational aggression?

2. What are the developmental trajectories of depression, anxiety, physical and relational aggression?
3. Does initial status in aggression, depression, and anxiety predict changes in those variables?

Method

Participants

Participants for this study were recruited as part of a larger longitudinal investigation examining school experiences in the United States, Japan, Korea, Australia, and Canada. Data were gathered in the fall of 2005 (Time 1), spring of 2005 (Time 2), and the fall of 2006 (Time 3). The sample included 1,173 students (53% female and 47% male) in the 5th through 9th grades at Time 1, 1,112 students at Time 2, and 995 students in the 6th through 10th grades at Time 3 from nine Midwestern schools (i.e., four elementary schools, three middle schools, and two high schools). The attrition rate was 5.0% from Time 1 to Time 2 and 10.4% from Time 2 to Time 3. Students' attrition from the study was mostly due to students moving to a different school and absence from class at the time of assessment. The age range of the participants across all time points was 10 to 16 at Time 1 ($M = 12.20$, $SD = 1.29$), 10 to 16 at Time 2 ($M = 12.57$, $SD = 1.27$), and 10 to 17 at Time 3 ($M = 13.11$, $SD = 1.29$). Most students self-identified as European-American (82.8%), with the remaining identifying as African American (7.4%), Hispanic (5.6%), Asian American (2.5%), Asian (0.9%), Native American (0.4%), and Other (0.5%) in the fall of 2005.

Measures

The Children's Depression Inventory-Short (CDI-S; Kovacs, 1992). The CDI-S is a tenitem measure comprising a subset of the original CDI items, designed as a screening measure for children 7 to 17 years of age. Participants are asked to rate the severity of each item on a three-point scale from 0 through 2 during the two weeks prior to testing, with higher scores indicating more severe symptoms. Items on the CDI-S are summed to reach a total depressive symptoms score. The CDI-S yields scores with high reliability with alpha reliability coefficients of 0.83 (Houghton, Cowley, Houghton, & Kelleher, 2003), and 0.84 (Frerichs, 2009). At least one study indicated a significant positive correlation between the CDI and CDI-S ($r = 0.91$; Houghton et al., 2003). In the current study, the internal consistency reliability for the CDI-S using coefficient alpha was 0.84 at Time 1, 0.87 at Time 2, and 0.85 at Time 3, suggesting that this measure yields scores with high internal consistency.

The Multidimensional Scale for Children-10 (MASC-10; March, 1997). The Multidimensional Scale for Children is a self-report measure designed to assess symptoms of anxiety in children ages 8 to 19 years. Individuals are asked to rate the severity of each item based upon a four-point Likert-type scale from "Never true about me" to "Often true about me." the MASC has demonstrated satisfactory to excellent test-retest reliability with a coefficient alpha of 0.83. The MASC-10 scores have demonstrated satisfactory internal reliability with a coefficient alpha of 0.67 for females and 0.68 for males and test-retest reliability with a coefficient alpha of 0.82 (March, 1997). In the current study, the internal consistency reliability for the MASC-10 using coefficient alpha was 0.76 at Time 1, 0.80 at Time 2, and 0.81 at Time 3, suggesting good internal consistency of the measure's scores.

The Children's Social Behavior Scale (CSBS; Crick & Grotpeter, 1995). The Children's Social Behavior Scale is a 15-item self-report measure used to assess how often children engage in various aggressive and prosocial behaviors on a five-point Likert-type scale from "Never" to "All

the time." Responses to items are summed to reach total scores. The CSBS consists of 15 items and six subscales (Relational Aggression, Physical Aggression, Prosocial Behavior, Verbal Aggression, Inclusion, and Loneliness). The subscales have shown acceptable internal consistency, ranging from 0.66 to 0.82 (Crick & Grotpeter, 1995). In the current study, the internal consistency reliability for Physical Aggression subscale using coefficient alpha was 0.80 at Time 1, 0.80 at Time 2, and 0.81 at Time 3. The internal consistency reliability for Relational Aggression subscale was 0.83 at Time 1, 0.83 at Time 2, and 0.85 at Time 3, suggesting good internal consistency of scores.

Results

Prediction of Physical and Relational Aggression

ANOVA results showed that Time 1, Time 2, and Time 3 bully-victim status predicted Time 3 physical aggression, $F(4, 925) = 2.88, p < 0.05$, $F(4, 925) = 6.43, p < 0.001$, $F(4, 925) = 18.995, p < 0.001$, respectively. Time 1 and Time 2 bully-victim status predicted Time 2 physical aggression, $F(4, 1060) = 4.40, p < 0.01$, $F(4, 1060) = 18.90, p < 0.001$, respectively. Time 2 and Time 3 (not Time 1) bully-victim status predicted Time 3 relational aggression, $F(4, 911) = 3.44, p < 0.01$, $F(4, 910) = 20.47, p < 0.001$, respectively. Time 1 and Time 2 bully-victim status predicted Time 2 relational aggression, $F(4, 1055) = 4.32, p < 0.01$, $F(4, 910) = 8.97, p < 0.001$, respectively. Post hoc analysis indicated that students who previously or currently bullied others engaged in significantly more physical and relational aggression than students who were victims or not involved in bullying ($ps < 0.05$).

Prediction of Depression and Anxiety

Time 1 and Time 3 (not Time 2) bully-victim status predicted Time 3 depression, $F(4, 910) = 3.72, p < 0.01$, $F(4, 910) = 12.41, p < 0.001$, respectively. Time 2 (not Time 1) bully-victim status predicted Time 2 depression, $F(4, 1054) = 4.45, p < 0.001$. Time 1, Time 2 and Time 3 bully-victim status predicted Time 3 anxiety, $F(4, 900) = 2.59, p < 0.05$, $F(4, 900) = 4.88, p < 0.001$, $F(4, 900) = 6.62, p < 0.001$, respectively. Time 1 and Time 2 bully-victim status predicted Time 2 anxiety, $F(4, 1051) = 3.84, p < 0.01$, $F(4, 1051) = 12.08, p < 0.001$, respectively. Post hoc analysis showed that bully-victims and victims (previous and/or current) were significantly more depressed and more anxious than both the bullies and the students who were not involved in bullying ($ps < 0.05$).

Relationship between Initial Status and Change in Aggression, Depression, and Anxiety

An associative latent growth curve model (Little, Bovaird & Slegers, 2006) was developed to model the initial status at the first time point and behavior change over time using Mplus software. Residual variances were allowed to correlate between variables at the same time points. The model depicted in Figure 5.1 represents the data well, $0.2(12) = 16.99, p = 0.15$; CFI = 0.99; RMSEA = 0.02, $p = 0.998$. The covariance and variance estimates for initial status and change constructs are listed in Table 5.1. The model shows that the initial status of physical aggression correlates negatively with change in physical aggression and relational aggression, and correlates positively with depression, anxiety, and relational aggression at the initial time point. Relational aggression at the initial time point correlates negatively with change in physical aggression and relational aggression, and correlates positively with depression at the initial time point. Depression at the initial time point correlates negatively with change of depression. Anxiety at the initial

time point correlates negatively with change of anxiety and depression (Table 5.1). The results were consistent with previous studies, which have found a relation between depression, anxiety, aggression and bully-victim continuum, not only concurrently (Craig, 1998; Snyder et al., 2003; Swearer et al., 2001, 2010) but also longitudinally (Gladstone et al., 2006; Olweus, 1993; Roth et al., 2002). Students who scored higher on aggression, depression, and anxiety at Time 1 were at increased risk for continuously experiencing internalizing and externalizing problems compared with peers who had lower scores at Time 1.

Translating Research into Practice: Implications for Bullying Prevention and Intervention Programs

The experiences of bully perpetration and victimization have a long-term negative impact on externalizing and internalizing symptoms for students across the bully-victim continuum. Given the empirical connection between bullying and mental health difficulties, bullying prevention and intervention should include treatment for concomitant mental health issues. The complexity among bully perpetrators and the students who are victimized suggests that a “one size fits all” approach is likely to fail. Thus, one mechanism for effective intervention is individual treatment for those affected by bullying behaviors.

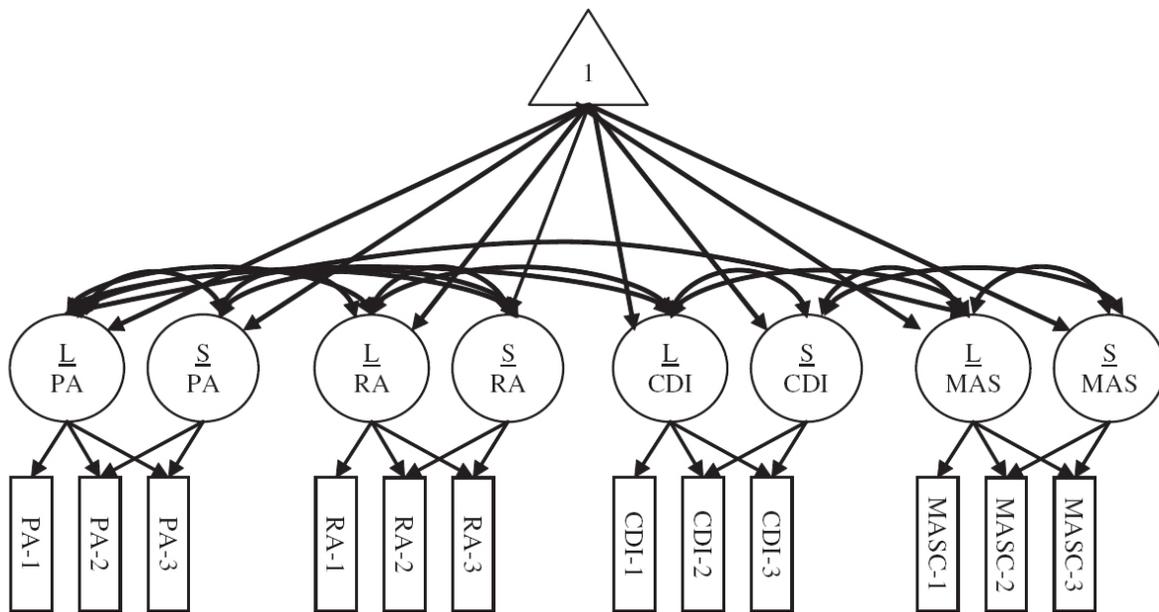


Figure 5.1 The final associative level and shape model.

Working Individually with Students Who Bully Others

Given our findings linking bully-victim status to depression and anxiety over time, it is clearly important to consider working individually with the students who are involved in bullying (Doll & Swearer, 2006). Interventions to help students change their behavior can powerfully reduce bullying in schools. The Bullying Intervention Program (BIP; Swearer & Givens, 2006) is an individual cognitive-behavioral intervention for use with students who bully others. The guiding premise behind BIP is twofold. First, we are guided by the reality that the social-cognitive perceptions of students involved in bullying interactions are as critical as are the aggressive behaviors, because the perceptions and cognitions of the participants serve to underlie, perpetuate, and escalate bullying interactions (Doll & Swearer, 2006; Swearer & Cary, 2003). Second, research suggests that homogenous group interventions are not helpful for aggressive youth and, in fact, may be damaging (Dishion, McCord, & Poulin, 1999). Based on these two principles, the BIP was developed as a mechanism for school counselors and school psychologists to work directly with students who bully others.

The BIP is an alternative to in-school suspension for bullying behaviors. When a student is referred for bullying behaviors, the typical protocol is that the student is sent to in-school suspension. In BIP, parents are given a choice: in-school suspension or the BIP. In order to participate in BIP, active parental consent and student assent are obtained. Then, the BIP is scheduled according to the same policies and procedures that the school uses to schedule in-school suspension.

Table 5.1 Correlations (Off-diagonal Elements) and Variance Estimates (Diagonal Elements) for Initial Status and Change Constructs

	Initial Status/Level				Change/Shape			
	PA	RA	CDI	MASC	PA	RA	CDI	MASC
L_PA	1.76 *							
L_RA	2.47 *	6.11 *						
L_CDI	0.52 *	1.56 *	7.55 *					
L_MASC	-0.94 *	-0.82	5.11 *	23.68 *				
S_PA	-0.44 *	-0.55 *	-0.15	0.07	0.37 *			
S_RA	-0.64 *	-1.36 *	-0.38	-0.02	0.45 *	0.78 *		
S_CDI	-0.14	-0.31	-1.83 *	-1.00 *	0.14	0.21	1.36 *	
S_MASC	0.00	0.38	-0.83	-4.70 *	0.19	0.07	0.75 *	5.12 *

Note: PA = Physical aggression score measured by the Children's Social Behavior Scale (Crick & Grotpeter, 1995). RA = Relational aggression score measured by The Children's Social Behavior Scale (Crick & Grotpeter, 1995). CDI = Depression score measured by Children's Depression Inventory- Short (Kovacs, 1992). MASC = Anxiety score measured by Multidimensional Scale for Children- Short (March, 1997). L= Initial Status/Level. S= Change/Shape.

All non-included paths were not statistically significant at the $p < 0.05$ level. Residual errors and residual correlations between errors at the same time point are not shown.

The BIP is a three-hour one-on-one cognitive-behavioral intervention session with a masters-level student-therapist under the supervision of a licensed psychologist. There are three components to the BIP: (1) assessment, (2) psychoeducation, and (3) feedback. The assessment component consists of widely used measures to assess experiences with bullying, depression, anxiety, cognitive distortions, school climate, and self-concept. The psychoeducation component lasts about two hours and consists of the student-therapist presenting an engaging and youth-friendly PowerPoint presentation about bullying behaviors. The presentation is followed by a short quiz to assess for understanding. This is followed by several worksheet activities about bullying behavior that are used from *Bully Busters* (Newman, Horne, & Bartolomucci, 2001). Finally, the student-therapist and the referred student watch a video about bullying. The session ends with a debriefing component where the referred student talks about his or her experiences with bullying and impressions of BIP. Based on the assessment data and the interactions with the referred student, a bullying intervention treatment report is written. Recommendations are based on the data collected. The treatment report is reviewed with the parents, student, and school personnel during a face-to-face solution-oriented meeting.

Suggested Interventions for Depression

Individuals along the bully-victim continuum experiencing depression would likely benefit from a therapeutic component that includes increasing positive views of the future. Abramson et al. (1989) suggested two therapeutic approaches to treating hopelessness depression: (1) a direct approach to treating hopelessness including reattribution training, and (2) an indirect treatment approach including a modification of the environment that induces hopefulness through pleasant-events scheduling. Both problem-solving training and cognitive restructuring have been suggested as intervention strategies for hopelessness (Stark, Sander, Yancy, Bronik, & Hoke, 2000); thus, targeting the individual's attributions or behaviors that contribute to the hopelessness are therapeutic approaches that can be utilized as a component of bullying-intervention programs.

Group treatments for depression have also been found to be effective. Clarke, Rohde, Lewinsohn, Hops, and Seely (1999) conducted a study that examined the effectiveness of a cognitive-behavioral group intervention for adolescents with depression in comparison to a wait-list group. The study consisted of two treatment groups that utilized the same adolescent group format, while one also included a parent component, and a control group. The group intervention for the adolescents included teaching specific skills to increase pleasurable activities, techniques to control depressive thoughts, relaxation, and skills to improve social interaction. Both group treatment interventions were found to be effective in reducing the adolescents' level of depression both at the end of treatment and at a two-year follow-up. This study replicated the short- and long-term effects of an earlier study by Lewinsohn, Clarke, Hops, and Andrews (1990). Group treatment may be useful for victims and bully-victims who are depressed. However, previous research suggests that group interventions are not useful for aggressive youth (Dishion et al., 1999); therefore, group approaches should be used cautiously with bullies. In order to identify and implement appropriate and efficacious interventions for bullying and victimization, the status a student endorses along the bully-victim continuum must be considered. Students who both are bullied and bully others (bully-victims) have been reported to be the most at-risk for depression (Kaltiala-Heino et al., 1999; Kumpulainen et al., 2001; Swearer et al., 2001). Interventions for bully-victims need to address the internalizing symptomatology, as well as the aggressive (i.e., bullying) behaviors (Kaltiala-Heino et al., 1999). A treatment manual such as *Taking Action: A Workbook for Overcoming Depression* (Stark, Kendall, McCarthy, Stafford, Barron, & Thomeer, 1996) in combination with the *Keeping Your Cool: The Anger Manage-*

ment Workbook (Nelson & Fitch, 1996) can be a useful strategy for working with bully-victims who are experiencing depressive symptomatology.

Suggested Interventions for Anxiety

Interventions targeted for individuals experiencing victimization should be appropriate to the characteristics the victim displays. A passive victim is likely to express symptoms of depression and would benefit from a therapeutic intervention addressing the development of increased self-esteem (Carney & Merrell, 2001) and alternative coping skills (Batsche, 1997). Depression might be a reflection of the victim's coping style (Craig, 1998). Therefore, utilizing bullying interventions that teach alternative coping methods, such as assertiveness training, could help in reducing continued victimization (Smith, Shu, & Madsen, 2001). A provocative victim is more likely to benefit from an intervention aimed at reducing his or her level of aggression (Batsche, 1997). This approach should teach students skills that can be used in place of the aggressive behaviors (i.e., aggression replacement training).

It is also important to distinguish between depressive and anxious symptoms when intervening with students along the bully-victim continuum. Lonigan, Carey, and Finch (1994) conducted a study that examined self-reported depression and anxiety among 233 inpatient children aged 6 to 17, who were diagnosed with either an anxiety disorder or a depressive disorder. The authors reported that although there was some overlap between self-reports of depression and anxiety, there were characteristics that distinguished between children diagnosed with depression and those diagnosed with anxiety. Children who were diagnosed with a depressive disorder reported less satisfaction with themselves and more difficulties with loss of interest and motivation than anxious children. Anxious children endorsed more distress about the future, their happiness, and how others respond to them. It is important that interventions address the different needs of individuals possessing depressive or anxious symptomatology.

Currently, there are no interventions that have been designed to specifically target children who are both involved in victimization and display symptoms of anxiety. However, two recent studies were found that evaluated an intervention that targeted or included victims of bullying and assessed anxiety. Furthermore, general strategies from the literature on anxiety can be applied to this population. It is often important to include peers in the treatment of socially anxious children in order to provide practice as well as naturalistic exposure opportunities. Peer relations research showing greater improvement for treatments including non-problematic peers versus those that have not (Bierman & Furman, 1984) provide further support for these proposals.

Fox and Boulton (2003) developed a Social Skills Training (SST) program specifically for victims of bullying. There were two intervention groups and two wait-list groups across four schools with a total of 28 participants (treatment group mean age of 9.5 years, control group mean age of 9.8 years). Participants were chosen from a larger study and had to meet the following selection criteria: chronic victim of bullying, demonstrated problems with social skills, and not being a bully-victim. The youth were taught to use social problem-solving skills and relaxation skills, increase positive thoughts, how to change non-verbal behaviors, and introduced to different verbal strategies. Findings revealed a significant increase in global self-worth for youth in the treatment group, gains that were maintained at three-month follow-up. No significant effects were found for the other psychosocial variables, though trends were found for a decrease in reported symptoms of anxiety and depression.

A recent study by DeRosier and Marcus (2005) examined a program called the Social Skills Group Intervention (S.S.GRIN; DeRosier, 2002), a school-based group social skills training program that targets children who experience poor relationships. The program includes cognitive-behavioral strategies and social learning to help children develop appropriate social skills and

healthy peer relationships. The study included 749 children from 11 different schools; 274 of the youth were identified as having significant problems with peers (specifically experiencing peer rejection, victimization, or social anxiety) and were randomly assigned to a treatment or control group. Children in the treatment group demonstrated significant improvement across several areas, including lower social anxiety, increased self-esteem, greater self-efficacy in social situations, and fewer antisocial relationships. One-year follow-up data demonstrated treatment maintenance with continued reports of lower levels of social anxiety and depression and higher self-efficacy. While no immediate changes were seen in peers' negative views of these children, data at one-year follow-up revealed that peers rated these youth as more likable and less aggressive. Interestingly, almost a fourth of the children in the study were identified as highly aggressive youth and these individuals demonstrated the strongest treatment effects. This suggests that social skills training programs that include both cognitive and behavioral components might be effective for all individuals involved in bullying who express symptoms of anxiety.

Specific treatments for generalized as well as social anxiety have been developed and empirically supported for children and may be applicable to victims of bullying who display these characteristics. For example, the Coping Cat (cf. Kendall, Kane, Howard, & Siqueland, 1990) is an empirically supported treatment developed for children with generalized anxiety. Similarly, treatment manuals are available for working with children who have social anxiety, such as Cognitive-Behavioral Group Treatment for Social Phobia in Adolescents (cf. Albano, Marten, Holt, Heimberg, & Barlow, 1995) or Social Effectiveness Therapy for Children (cf. Beidel, Turner, & Morris, 1996; 1999). These approaches are generally designed for individual or small group treatment, but could also be utilized by school counselors. Likewise, components of these interventions could be incorporated into larger school-based efforts to provide children with anxiety reduction skills.

Similarly, it seems that most children can benefit from learning strategies used in the treatment of anxiety. Relaxation training teaches children a skill that could be applied at any point when they might feel tense or anxious. For example, children can be taught to relax muscle groups in order to release tension from their body (i.e., progressive muscle relaxation). In addition, breathing retraining exercises can be taught to reduce anxiety and calm the child during times of stress. Scripts for these procedures are available and can be used to teach progressive muscle relaxation and breathing retraining skills that help the child feel more relaxed in anxiety-producing situations. Younger children may benefit from scripts that include imagery (e.g., pretend you are squeezing a lemon to illustrate muscle relaxation) or facilitate appropriate practice of the skill (e.g., placing a plastic cup on the stomach to demonstrate diaphragmatic breathing). Anxiety management strategies can be taught individually or in small groups to maximize cooperation and minimize disruption.

Summary

Bullying prevention and intervention strategies developed at the school-wide level have demonstrated limited empirical support and effectiveness, particularly in the United States (Ttofi, Farrington, & Baldry, 2008). Current work needs to continue in the development of prevention and intervention for youth involved in bullying at the individual levels and it is important that these interventions include components that address comorbid mental health issues. Future research is needed to determine which treatment strategies are most successful (either alone or in combination) to respond effectively to psychological precursors and/or consequences of bullying.

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