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Classification of Symptoms in Victims of Bullying

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Abstract

Although Western societies have begun to take bullying more seriously in the past few decades, the negative effects of bullying on victims remain in a diagnostic limbo, making access to adequate treatment difficult. Currently, a debate is taking place among psychologists as to whether bullying should be established as a causal precursor of Post-traumatic Stress Disorder – if bullying were established as a causal precursor of PTSD, victims could more easily receive treatment for their symptoms through PTSD treatment methods. To determine which side of the debate is correct, this literature review analyzed research that links bullying effects with PTSD symptomology and assesses whether the arguments of each side of the debate are valid. Analysis of literature revealed that symptoms of bullying victimization satisfy the diagnostic criteria for PTSD as stated by the DSM-V, and that while arguments against the establishment of bullying as a causal precursor of PTSD are flawed, arguments for the establishment are better supported. This literature review concludes with a discussion on best possible treatment methods for victims of bullying.

Introduction

Houbre et al. (2006) define bullying as "all forms of repeated physical or mental violence performed by an individual on another person who is not capable of defending him/herself" (p. 183). Although people have been familiar with bullying for centuries, the phenomenon of bullying only began to be systematically researched in the 1970s (Olweus, 1977). Over the next few decades, this research spread globally and has changed the perspective on bullying: once considered merely an annoying social factor, bullying is now called a global epidemic (Olweus, 1994; Zeligs 1945; Blood, Boyle, Blood & Nalesnik, 2010). The consequences of this epidemic include anhedonia, negative cognition, and substance abuse (Shakoor, McGuire, Cardno,

Freeman & Plomin, 2015; Kumulainen, Rasansen, Henttonen, Almqvist & Kresanov, 1998; Dill, Vernberg, Fonagy, Twemlow & Gamm, 2004; Wolke & Lereya, 2014; Fisher, Moffit, Houts, Belsky & Arsenault, 2012; McMahon, Reulbach, Keeley, Perry & Arensman, 2012; and Radliff, Wheaton, Robinson & Morris, 2012).

All of these consequences of bullying are also symptoms of PTSD, which the National Institute of Mental Health defines as "a disorder that develops in some people who have seen or lived through a shocking, scary, or dangerous event" (2016). Specifically, the DSM-V lists the diagnostic criteria for PTSD as: exposure to actual or threatened death, serious injury, or sexual violence; intrusion symptoms beginning after the traumatic event occurred; persistent avoidance or efforts to avoid external reminders of the trauma; negative alterations in cognitions and moods; and alterations in arousal and reactivity.

While many studies associate bullying with PTSD symptoms, ongoing debate in the field of psychology has prevented the APA from establishing bullying as a causal precursor of PTSD. Currently, bullying has only been established as a prevalent traumatic stressor (Nielsen et al., 2015).

If bullying were established as a causal precursor of PTSD, both bullying prevention measures and treatment for victims of bullying would improve: schools would likely take bullying more seriously and conduct research and implement programs to reduce bullying. Moreover, more victims may receive adequate treatment.

One group of researchers in this debate believes that bullying should not be classified as a precursor of PTSD and should remain only a prevalent traumatic stressor, while the other group believes that bullying should be classified as a precursor of PTSD. Those opposed argue:

1. 1. Bullying is rarely a *single* traumatizing event (Nielsen et al., 2015).

2. 2. It is difficult to determine whether bullying is a *causal* precursor of PTSD since confounding sources of trauma may be responsible for an individual's PTSD-like symptoms (Nielsen et al., 2015).

Alternately, proponents argue that bullying *should* be an established precursor of PTSD because psychosocial events that occur over a prolonged period should still qualify for a PTSD diagnosis if the distress is great enough (Weaver, 2000).

While investigating the debate, Nielsen et al. (2015) conducted a literature review and meta-analysis on research literature on workplace and school bullying, and concluded that a lack of controlled longitudinal research and structural clinical interview studies indicated a lack of evidence for or against bullying as a causal precursor of PTSD. Upon review, Nielsen et al. (2015) contains flaws and its conclusions are questionable. For instance, in opposition to establishing bullying as a precursor of PTSD, the authors claim that the DSM-V defines PTSD as requiring a single traumatic event (Nielsen et al., 2015) – and since bullying is rarely a single event, the authors imply that it should not be considered a precursor. However the DSM-V never states that requirement in its definition. Each time the APA writes about a hypothetical traumatic event in the diagnostic criteria, it is written as "traumatic event(s)" (American Psychiatric Association, 2013), allowing for the possibility of multiple events leading to trauma.

Thus, it is questionable whether Nielsen et al. (2015) have accurately settled the debate. More analysis is needed.

This literature review argues that bullying should be considered a causal precursor of PTSD. By reviewing literature on bullying and PTSD, I have determined the validity of the arguments voiced by each side of the debate, as well as by Nielsen et al. (2015), and have found that the arguments *for* establishing bullying as a causal precursor of PTSD are better supported

by existing literature than the arguments against it.

Methods

The sources used for this literature review were found through the databases PsycINFO and PILOTS. I began my research by first reading the diagnostic criteria for PTSD given by the DSM-V, and then researching whether each criterion and symptom of PTSD had been linked to bullying.

Bullying Symptoms in PTSD Diagnostic Criteria

Before delving into research on the arguments of the debate, it is important to illustrate whether bullying victimization fulfills the diagnostic criteria of PTSD described by the DSM-V. The DSM-V lists the following symptoms as criteria for a PTSD diagnosis:

A. A. Exposure to actual or threatened death, serious injury, or sexual violence [by] directly experiencing the traumatic event(s).

B. B. Intrusion symptoms.

C. C. Avoidance of stimuli associated with the trauma.

D. D. Negative cognition or affect.

E. E. Self-destructive behavior.

F. F. One-month or longer duration of symptoms.

G. G. Impaired functioning caused by the symptoms.

H. H. Symptoms cannot be attributed to the physiological effects of a substance or other medical condition.

Exposure to Trauma – *Criterion A*

Research on bullying reveals that bullying can involve any or all three of the events listed in Criterion A. Garaigordobil (2015) found that cyberbullying commonly involves death threats,

and Singer & Flannery (2000) found that frequent threats are significantly associated with violent behaviors. Moreover, Garaigordobil (2015) found that cyberbullying also often involves sexual harassment, and Viljoen, O'Neill & Sidhu (2005) found that females report bullying that occurred in the form of unwanted sexual groping, comments, and jokes. Clearly, this literature supports the basic argument that bullying can involve *events* worthy of causing PTSD.

Intrusion Symptoms – *Criterion B*

Not only are intrusion symptoms found in victims of bullying, intrusion symptoms (re-experiencing, especially) occur more often in victims of bullying than in people who have experienced other traumas (Tehrani, 2004). Tehrani (2004) argued that this is not surprising, considering the nature of bullying: personal and, oftentimes, emotionally defeating. Moreover, the long-term hopelessness experienced by victims of bullying becomes associated with many situations through conditioning, thus increasing the number of possible triggers that may elicit re-experiences (Tehrani, 2004). So, not only does research support the existence of intrusion symptoms in victims of bullying, analysis of the findings suggest that their existence is completely logical.

Another intrusion symptom, distressing dreams, has also been found in victims of bullying (Tehrani, 2004; Wolke & Lereya, 2014). Wolke & Leyera (2014) found that being bullied predicted having nightmares or night terrors, and being a chronic victim of bullying predicted both nightmares and night terrors.

Avoidance – *Criterion C*

Multiple studies have found that bullying victimization is a causal factor in avoidance. Houbre, Tarquinio & Lanfranchi (2010) found that students who experienced an increase in bullying victimization during one school year developed avoidant strategies that included

withdrawing from others and showing low social skills. These avoidant behaviors resonate with avoidant symptoms in PTSD patients: both are efforts made to avoid people, activities, and situations that arouse distressing memories, thoughts or feelings (American Psychiatric Association, 2013).

A more physical type of avoidance, attrition, has also been found to be causally associated with bullying victimization. Townsend et al. (2008) found that girls who were bullied were at greater risk for school attrition and dropout. Hutzell & Payne (2012) found that students who had been bullied were more likely to avoid locations in or around schools than students who were not bullied. These three studies should adequately establish avoidance as a symptom of bullying victimization.

Negative Cognition or Affect – *Criterion D*

The DSM-V requires that two or more of the following forms of negative affect or cognition be met for a PTSD diagnosis: dissociative amnesia, persistent and exaggerated negative beliefs, distorted blame given to him/herself or others, diminished interest in activities, feelings of detachment, and the inability to express positive emotions (American Psychiatric Association, 2013). With dissociative states as the exception, six of these seven symptoms have been reported to have a causal correlation with bullying victimization (Dill et al., 2004; Cole et al., 2010; Schacter & Juvonen, 2015; Kumpulainen et al., 1998; Shakoor et al., 2015).

Cole et al. (2010) found that bullying victimization was positively correlated with negative self-cognitions. Similarly, Dill et al. (2004) found that elevated levels of negative affect lasting over two years were found in children who experienced frequent peer victimization. These bullied children were also likely to believe that the bullying was legitimate and warranted (Dill et al., 2004), signaling self-blame. Schacter & Juvonen (2015) found that bullied youth

showed both characterological and behavioral self-blame.

Heller et al. (2009) jointly define the remaining forms of negative affect (diminished interest in activities, feelings of detachment, and the inability to express positive emotions) as *anhedonia*: the inability to sustain positive affect across time. Kumpulainen (1998) found that bullied children self-reported anhedonia when asked to complete a survey including the items: lack of friends, school dislike, reduced appetite, and indecisiveness. These bullied children also reported statistically significant levels of reduced social interest and sadness (Kumpulainen, 1998). Shakoor et al. (2015) also found associations between bullying victimization and anhedonia. Research clearly indicates that victims of bullying suffer from these three symptoms.

Self-Destructive Behavior – *Criterion E*

In regards to self-destructive behavior, McMahon et al. (2011) found that the risk of lifetime self-harm was four times higher for male students who had been bullied than for male students who had not been bullied. Fisher et al. (2012) reported similar findings.

Along with self-harm, substance abuse is another form of self-destructive behavior correlated with bullying victimization. In a longitudinal study, Sourander et al. (2007) found that frequent bullying victimization predicted substance abuse. Similarly, (2007), Radliff et al. (2012) reported that high school-aged victims of bullying were more likely to use cigarettes and alcohol than students not involved in bullying, and Rospenda et al. (2014) found that bullying at school predicted higher levels of alcohol consumption, intoxication, and binge drinking, even when controlling for baseline drinking and other school stressors. All three of these studies work together to strongly suggest that being bullied predicts self-destructive behavior in the form of substance abuse.

One-Month (or Longer) Duration of Symptoms – *Criterion F*

Most of the studies referenced in this literature review disclose that the symptoms experienced by the studies' participants persisted for at least one month, thereby satisfying Criterion F of the DSM-V diagnosis for PTSD.

In documenting rates of re-experiencing in victims of bullying, Tehrani (2004) did not indicate any length of symptoms. However, in their longitudinal study on bullying and its effects on parasomnias, Wolke & Lereya (2014) found that being bullied predicted parasomnias at ages 12 and 13, suggesting that this form of intrusion symptom can persist for more than one month, if not years.

In the study measuring avoidance behaviors, Hutzell & Payne (2012) did not disclose how long the behaviors persist. Meanwhile, in the study that measured avoidance in school by Houbre, Tarquinio & Lanfranchi (2010), the researchers cited increases in bullying and avoidance behaviors over the course of one year. Moreover, the study by Townsend et al. (2008) measured the relationship between bullying and school dropout rates, which is clearly a consequence of bullying that persists for at least one month.

The study by Dill et al. (2004), which measured negative affect in bullied children, found that negative affect increased over two years. Conversely, Cole et al. (2010) did not conduct a longitudinal study, thus information on the persistency of negative cognition can only be drawn from Dill et al. (2004).

The study by Schacter & Juvonen (2015), which measured self-blame in victims of bullying, was a longitudinal study that lasted one year, thus the increases in self-blame observed in the victims persisted for at least one year. The Shakoor et al. (2015) study on anhedonia was another longitudinal study, suggesting that the anhedonia observed in bullied children persisted for longer than one month. Meanwhile, the Kumpulainen et al. (1998) study was not

longitudinal, and cannot attest to duration.

In regards to self-destructive behavior, the study on self-harm by Fisher et al. (2012) used longitudinal methods to indicate persistency of symptoms, while the study by McMahon et al. (2012) did not indicate symptom duration. Additionally, while the studies by Radliff et al. (2012) and Sourander et al. (2007) did not explicitly state the duration of their participants' substance abuse problems, the study by Rospenda et al. (2014) revealed that many of the participants' substance abuse lasted for at least one year.

With the exception of studies that used a single survey for their research, the nature of all the literature analyzed in this review support the fact that victims of bullying experience aversive symptoms for more than one month.

Impaired Functioning Due to Symptoms – *Criterion G*

Although it easy to merely imagine how the symptoms of bullying victimization described above would impair functioning, existing literature reports the effects that these symptoms have on functioning.

In regards to intrusion symptoms, Tehrani (2004) reported that re-experiencing includes trouble falling and staying asleep.

In regards to avoidance symptoms, Hutzell & Payne (2012) reported that school avoidance behaviors (as a result of bullying) can adversely impact academic achievement and the decision to drop out of school. Townsend et al. (2008) reported that school avoidance caused by bullying can lead to stunted academic progress. Moreover, Houbre, Tarquinio & Lanfranchi (2010) reported that bullied students who developed avoidance were less likely to seek social support and attempt problem solving, thus allowing their debilitating symptoms to persist.

All forms of negative affect symptomatology described above are reported to cause

impaired functioning. Dill et al. (2004) reported that children who develop negative affect as a consequence of bullying experience depressed mood over time, and Cole et al. (2010) included depressive symptoms as a criterion of negative affect. Dill et al. (2004) also reported that self-blame can lead to the development of negative cognition in bullied children. Finally, Heller et al. (2009) reported that anhedonia also involves depressive symptoms, which is widely understood to be debilitating.

In regards to self-destructive behavior, Fisher et al. (2012) interviewed bullied children and adolescents whose modes of self-harm included pulling out clumps of their own hair and banging their head against the wall. As these behaviors have both negative social and physical consequences, they should be considered functionally impairing. Moreover, Radliff et al. (2012) reported that substance abuse (as a result of bullying victimization) presented health risks and can have negative impacts on social confidence. Expanding on this, Rospenda et al. (2013) reported that high levels of alcohol consumption as a consequence of bullying led to problems with relationships and problems fulfilling work and school responsibilities.

Symptoms Cannot be Attributed to Substances or Other Medical Conditions – *Criterion H*

Many of the studies referenced in this literature review controlled for confounds when measuring for specific symptoms in victims of bullying, thus attributing the symptoms solely to bullying, and satisfying Criterion G of the DSM-V diagnosis of PTSD. In regards to intrusion symptoms, Wolke & Lereya (2014) found that bullying predicted parasomnias in victims even when controlling for pre-existing sleep problems and nightmares, other trauma, emotional and behavioral problems, and diagnosable psychiatric disorders, ruling out the potentially confounding effects of depression, anxiety, and ADHD.

In regards to avoidance, Townsend et al. (2008) found that bullying positively predicted

school attrition and dropout rates when controlling for substance abuse, age, socioeconomic status, race and ethnicity, being raised by a single parent, and repeating a grade. Moreover, Hutzell & Payne (2012) found that bullying predicted school absenteeism in victims even when controlling for gender, age, race and ethnicity, academic achievement, and school type.

In regards to negative affect, Cole et al. (2010) found that bullying predicted negative cognition in victims even when controlling for pre-existing individual differences in negative cognitions. And Shakoor et al. (2014) found that bullying predicted anhedonia in victims even when controlling for anxiety and depression.

Finally, in regards to self-destructive behavior, Fisher et al. (2012) found that frequent bullying predicted self-harm behavior in victims even when controlling for pre-morbid effects and possible genetic influences. Rospenda et al. (2014) found that bullying consistently predicted increased alcohol consumption and problematic drinking in victims even when controlling for prior drinking habits and other stressors.

Validity of Arguments Stated by Opponents

The analyses above show that, overall, bullying victimization fulfills the criteria of PTSD symptomology. Now, evidence from literature addresses the validity of the arguments made by researchers opposed to establishing bullying as a causal precursor of PTSD.

Duration and Severity of Trauma

In their own literature review Nielsen et al. (2015) argued against establishing bullying as a causal precursor of PTSD. When presenting the first reason for their argument, the authors claimed that the DSM-V definition of PTSD requires that the traumatic event be a single event which causes a threat of death or serious injury (Nielsen et al., 2015). The authors went on to assert that bullying is rarely, if ever, a single event, and that it is unclear whether bullying can be

considered life-threatening.

As mentioned in the introduction of this literature review, the first half of Nielsen et al.'s (2015) reasoning is flawed, if not entirely incorrect. The second half of the authors' reasoning is also questionable. First, it is worth noting that the DSM-V actually lists *three* possible types of trauma that can lead to PTSD: exposure to actual threatened death, *or* serious injury, *or* sexual violence. Bullying can involve any or all three of these events (Garaigordobil, 2015; Singer & Flannery, 2000; Viljoen, O'Neill & Sidhu, 2005).

It is evident that review of the DSM-V and analysis of literature the first argument made by Nielsen et al. (2015).

Cause of Trauma

The second reason for the argument made by Nielsen et al. (2015) concerns causation and confounding variables. Nielsen et al. (2015) concluded that more experimental or longitudinal studies are needed to draw conclusions about causal factors of PTSD symptoms. For instance, the authors cited a study by Shields & Cicchetti (2001), which showed that parental maltreatment can predict peer victimization in some children. Nielsen et al. (2015) used this finding to suggest that PTSD symptoms in bullied children could be due to confounding variables, rather than bullying.

Out of the 19 studies that Nielsen et al. (2015) analyzed to draw information about the associations between bullying and PTSD symptoms, all 19 were cross-sectional studies. Conversely, this current literature review found five longitudinal or controlled studies and one case study that suggested a causal correlation between bullying and PTSD symptoms (Fisher et al., 2012; Wolke & Lereya, 2014; Townsend et al., 2008; Hutzell & Payne, 2012; Cole et al., 2010; Rospenda et al., 2014; and Weaver, 2000). So, multiple studies on the causal relation

between bullying and PTSD *do* exist, despite what Nielsen et al. (2015) report.

Still, to credit Nielsen et al. (2015), one non-controlled study analyzed in this literature review creates definite doubt as to whether bullying can be considered a causal factor of PTSD. In their study on bullying and self-harm, McMahon et al. (2012) found that among bullied self-harming teenagers, indicators of self-harm included: problems with schoolwork, serious physical abuse, worries about sexual orientation, and low self-esteem. All of these indicators can be explained as consequences of bullying, while some (low-self esteem and serious physical abuse) can be explained as both possible antecedents and consequences (McMahon et al., 2012). Nielsen et al. (2015) might use this ambiguity to argue that bullying cannot be established as a *causal* precursor because it is unknown whether low-self esteem and serious physical abuse was caused *by* bullying or whether it was the cause of bullying.

However, the longitudinal study by Fisher et al. (2012) both strengthens *and* weakens this hypothetical argument by Nielsen et al (2015). In their study on bullying and self-harm, Fisher et al. (2012) found that, in comparison to bullied children who do not self-harm, bullied children who do self-harm are more likely to have a family history of attempted or completed suicide, concurrent mental health problems, and a history of physical maltreatment by an adult. This finding supports Nielsen et al.'s (2015) argument: possible confounds make causally attributing PTSD to bullying impossible. But, that was not the only finding made by Fisher et al. (2012). The authors also found that bullied twins were more likely to self-harm than their non-bullied twin (Fisher et al., 2012). The twin study approach to this research provides an even playing field for participants. This finding suggests that, even with a family history free of mental health and abuse issues, bullied children are more likely to self-harm than non-bullied children. This finding demonstrates that, although third variables are capable of influencing PTSD symptoms in victims

of bullying, bullying is independently capable of causing symptoms of PTSD.

Validity of Arguments Stated by Proponents

Now, evidence from literature addresses the validity of the arguments made by researchers in favor of establishing bullying as a causal precursor of PTSD.

Level of Distress Caused by Bullying

Rosen, Spitzer & McHugh (2008) argue that psychosocial events that occur over a prolonged period of time (like bullying) should qualify for a PTSD diagnosis if the distress caused by the events is great enough. Research conducted by Weaver (2000) supports this argument. In his case study of a teenage girl with bullying-induced PTSD symptoms, Weaver (2000) found that the subject, called J, exhibited behaviors that filled all the criteria of a PTSD diagnosis after being repeatedly bullied at school. Furthermore, J's parents (who were described as caring) reported that she had normal early development, is academically bright, and has no family history of mental illness (Weaver, 2000). Thus, it appears that there were few, if any, confounding variables that might have incited J's PTSD symptoms.

Weaver (2000) argued that if PTSD symptoms that developed due to prolonged emotional trauma satisfy the criteria for the PTSD diagnosis stated in the DSM-V, bullying should be established as a sufficient causal precursor of PTSD. His main reason concerns treatment of trauma. He asserted that receiving a PTSD diagnosis from a professional (a) refers to a definite cause of the symptoms and justifies the symptoms in a way that brings some relief to the patient, and (b) allows for adequate treatment. Based on the findings by Weaver (2000), it appears that diagnosing victims of bullying - who present symptoms of PTSD – with PTSD greatly helps the victims.

Discussion

Overview

This review has demonstrated that (a) victims of bullying display all PTSD symptoms necessary for a PTSD diagnosis, as defined by the DSM-V, (b) arguments stated by Nielsen et al. (2015) against establishing bullying as a causal precursor of PTSD are flawed and not strongly supported, and (c) the major argument stated by proponents is moderately supported by existing literature, and is made with the benefit of victims in mind.

Simply by satisfying the diagnostic criteria stated in the DSM-V, bullying should be logically established as a causal precursor of PTSD. Cautionary questioning that takes place before any official diagnostic ruling, however, is wise, as it protects against the dangers of mis- or over-diagnosis. The questioning by Nielsen et al (2000), though, is illogical: their arguments were easily countered by reviewing the DSM-V and a handful of existing literature. Moreover, the failure by Nielsen et al. (2015) to find any longitudinal and controlled studies when conducting their literature review (while some did exist) should cast doubt on their conclusion to not establish bullying as a causal precursor of PTSD.

Conversely, the major argument stated by proponents is supported by research and focuses on helping victims of bullying. Moreover, the supporting research has found that treating victims of bullying with PTSD treatment methods is very effective (Weaver, 2000).

The reviewed literature indicates a clear support for establishing bullying as a causal precursor of PTSD.

Implications

As the case study by Weaver (2000) shows, treating victims of bullying with PTSD treatment methods is effective in reducing and even eliminating their symptoms. Meanwhile, keeping victims in a diagnostic limbo does not offer them the needed support (Weaver, 2000).

By establishing bullying as a causal precursor of PTSD, more victims would receive necessary treatment. These treatment methods could include methods already known to work effectively against PTSD – including cognitive behavioral therapy, group therapy, psychodynamic psychotherapy, and medication (U.S. Department of Veterans Affairs, 2015).

Furthermore, if bullying were officially determined to be a causal precursor of PTSD, the attached connotation of PTSD would cast bullying as a more serious mental health issue than it is viewed as now. This severity might lead to funding for widespread bullying prevention programs. With programs in place, bullying prevention might lead to PTSD prevention.

Limitations and Future Research

One major limitation of this literature review is the fact that an *overwhelming* amount of evidence was not found to support the arguments made by either side of the debate, particularly in regards to longitudinal and controlled studies. However, it did find more of these types of articles than previous literature reviews did, which indicates that more research must be conducted before bullying is written off as a causal precursor of PTSD. Moreover, the articles analyzed in this literature were all reputable, peer-reviewed research, so while evidence may have lacked in quantity, its quality was strong.

Future research should include testing alterations to existing PTSD treatment methods to determine whether treatment of bullying-induced PTSD should be modified for best results. Moreover, it would be interesting to know if specific types of bullying (physical, verbal, isolation, etc.) cause specific PTSD symptoms to be exacerbated, and if so, how treatment can be personalized from victim to victim.

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