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Cyberbullying in Children and Youth: Implications for Health and Clinical Practice

La cyberintimidation chez les enfants et les adolescents : implications pour la santé et la pratique clinique

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Abstract

We review the recent literature on cyberbullying and its effects on victimised youth, identifying key points. We conclude that cyberbullying, while following many of the underlying dynamics of more traditional forms of bullying, features some unique qualities that can both magnify the damage caused and make it more difficult to detect. These features include the pervasive, never-ending nature of cyberbullying and the ability to quickly reach large audiences. The potential for anonymity and the related distance afforded by screens and devices compared to in-person interaction allow the cruelty of cyberbullying to go unchecked. Despite the perceived anonymity of cyberbullying, cyberbullying can be perpetrated by friends, who often have intimate knowledge about the victimised youth that can be devastating when made public. Given the difficulty schools face in preventing or even detecting cyberbullying, health care providers are an important ally, due to their knowledge of the youth, the sense of trust they bring to youth, and their independence from the school setting. We conclude by calling for routine screening of bullying by health care providers who deal with paediatric populations.

Abrégé

Nous examinons la littérature récente sur la cyberintimidation et son effet sur les adolescents victimisés, et identifions les principaux points. Nous concluons que la cyberintimidation, même si elle suit des dynamiques sous-jacentes de nombreuses formes d'intimidation plus traditionnelles, présente certaines qualités uniques qui peuvent à la fois magnifier les dommages causés et les rendre plus difficiles à détecter. Ces traits sont notamment la nature envahissante, sans fin de la cyberintimidation et la capacité de joindre rapidement un vaste public. Le potentiel d'anonymat et la distance relative que favorisent les écrans et les machines comparativement à l'interaction en personne, permettent à la cruauté de la cyberintimidation de passer sans être contrôlée. Malgré l'anonymat perçu de la cyberintimidation, celle-ci peut être perpétrée par des amis, qui ont souvent des connaissances intimes au sujet de l'adolescent victimisé, lesquelles peuvent être dévastatrices quand elles sont rendues publiques. Étant donné la difficulté qu'éprouvent les écoles à prévenir ou même à détecter la cyberintimidation, les prestataires de soins de santé sont un allié important, en raison de leur connaissance des adolescents, du sentiment de confiance qu'ils inspirent aux jeunes, et de leur indépendance du cadre scolaire. Nous concluons en demandant un dépistage routinier de l'intimidation par les praticiens de la santé qui travaillent auprès des populations pédiatriques.

Keywords

cyberbullying, prevention, mental health, screening, youth

Defining Cyberbullying

Bullying is defined as aggressive behaviour that is intentionally and repeatedly directed at an individual who holds less power than the aggressor.[1] Bullying takes many forms, including physical (e.g., hitting, shoving, spitting), verbal (e.g., taunting, name calling, threatening), and social (e.g., rumour spreading, peer group exclusion). These forms are

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commonly referred to as traditional bullying, which typically occurs face-to-face and takes place at school.[2] With the advent of the Internet and the proliferation of technological devices such as mobile phones, a new form of bullying has emerged. Cyberbullying, the focus of this review, is distinguished by the use of information and communication technology as the means through which to embarrass, threaten, sexually harass, or socially exclude.[3,4] Examples include posting embarrassing images or comments about somebody or impersonating someone to cause harm. Early research suggested that cyberbullying was fundamentally different from traditional bullying. More recent evidence suggests that cyberbullying is best conceptualised as another form of bullying. Indeed, most targets (and perpetrators) of cyberbullying are also bullied in traditional ways,[3,5-7] although there are some individuals who are only cyberbullied.[8-10]

Applying the core definitional criteria of bullying (i.e., intentionality, repetition, and power imbalance) to cyberbullying is challenging.[11] First, it is difficult to establish intent when important socioemotional cues such as prosody and vocal tone are absent. Second, establishing repetition is difficult because while the harmful act may have been committed only once, the Internet allows for the potential for that act to be shared or viewed in perpetuity. Third, establishing power imbalance is difficult because technology can afford the vehicle that creates the power imbalance. This stands in contrast to traditional bullying, which usually involves a preexisting power imbalance. Nevertheless, other factors that contribute to power imbalance in cyberbullying include perceived anonymity, the social status of the perpetrator derived by the number of online supporters, and/or the victimised individual being part of a marginalised group.[12]

If cyberbullying is just another type of bullying, why is there so much concern about this particular form? For example, an education poll conducted by the Canadian Teachers' Federation indicated that teachers ranked cyberbullying as their primary concern, with 86% stating that bullying and violence are serious problems in public schools.[13] One reason for concern is because the online context where bullying occurs is now being accessed by more and more children and is almost universally accessed by adolescents and young adults. With increased access to and use of information and communication technologies comes an increased risk of being cyberbullied.[14] The nonstop nature of cyberbullying, which can continue outside of school hours, including nights and weekends, and the potential for harassment and abuse to "go viral" with large audiences across geographic borders are also causes for concern. Perhaps in part due to these factors, experiencing cyberbullying victimisation is uniquely associated with mental health issues and academic problems over and above what is found for traditional bullying. And of particular concern is the strong and independent association between cyberbullying and suicide,[15] the second leading cause of death among Canadian adolescents and young adults.[16]

Scope of the Problem

In the UNICEF's[17] most recent report on child well-being, Canada ranked 17th out of 29 economically advanced countries (higher rankings indicated better scores). Five dimensions of children's lives were assessed—material well-being, health and safety, education, behaviours and risks, and housing and environment. Exposure to bullying was assessed in the "behaviours and risks" category. Specifically, 11-, 13-, and 15-year-old children were asked to indicate the extent to which they were bullied by peers in the past couple of months. Italy and Sweden, ranked 1st and 2nd, has the lowest percentage of children who reported being bullied, whereas Canada, ranked 21st, has one of the highest percentages of children who reported being bullied at school. Disconcertingly, the high prevalence of bullying among Canadian children has been noted in all of UNICEF's child well-being reports. In fact, while most economically advanced countries saw decreases in bullying rates over 12 years, in Canada, the rates increased slightly.[18]

Other population-based studies confirm that bullying is a serious problem among Canadian children. In a study of 16,799 Ontario students in grades 4 to 12, Vaillancourt et al.[2] found that 37.6% of students reported being bullied by others, with girls reporting being bullied by their peers at a higher rate than boys. Results also indicated that being bullied verbally was the most common form of abuse endured by students, especially for those in elementary and middle school (i.e., over 50% indicated that they had been repeatedly called names by other students). Being bullied through an electronic context occurred less frequently—10.0% for elementary students, 13.3% for middle school students, 13.7% for early secondary students, and 10.2% for late secondary students. These cyberbullying rates are similar to the rate of 14% obtained by Beran et al.[19] in their nationally representative sample of 1001 Canadian children aged 10 to 17 years. In another large ($N = 2186$) school-based study of Canadian youth in middle and high school, close to half (49.5%) of the participants indicated that they had been bullied online.[20] One reason for these differences in cyberbullying rates is methodological. Vaillancourt et al.[2] and Beran et al.[19] provide a definition to students before asking them about their experience with cyberbullying using one general behaviour-based question, whereas Mishna et al.[20] did not provide a definition of bullying before asking participants a series of questions about specific online behaviour (i.e., calling someone names, threatening, spreading rumors, sending a private picture without consent, pretending to be someone else, receiving or sending unwanted sexual texts or photos, or being asked to do something sexual).

Consequences of Cyberbullying

Being the victim of bullying, including cyberbullying, is associated with significant short- and long-term mental and physical health issues and academic achievement

problems.[21] Like traditionally bullied youth, cyberbullied youth report higher levels of depression and anxiety, emotional distress, suicidal ideation and attempts, somatic complaints, poorer physical health, and externalising problems such as increased delinquency and substance abuse than their nonbullied peers.[9,22-29] A dose-response effect is commonly found between being cyberbullied and the severity of its consequences—youth who are bullied the most are the ones who suffer the most.[30]

When cyberbullying is compared to traditional bullying, negative outcomes appear to be worse for the victims of cyberbullying. Using data from a total population survey of Swedish adolescents aged 15 to 18 years and controlling for exposure to traditional bullying, Låftman et al.[9] found that being the victim of cyberbullying was associated with poorer subjective physical health. That is, cyberbullied youth were more likely to have headaches, stomach aches, poor appetites, and sleep disturbances than their nonbullied peers. Perren et al.[26] found a unique association between being the victim of cyberbullying and poor outcomes. In their study of Swiss and Australian teens, they found that cyberbullying explained a significant amount of unique variance in depression when controlling for exposure to traditional forms of bullying. In another study, Bonanno and Hymel[31] reported that cyberbullying was independently associated with Canadian adolescents' suicidal ideation and depressive symptomology. Schneider et al.[32] compared cyberbullying and traditional bullying in relation to psychological distress in a large study of 20,406 American high school students. Results indicated that students who were both cyberbullied and bullied at school fared the worst on all outcomes examined—depressive symptoms, suicidal ideation, self-injury, suicide attempt, and suicide attempt requiring medical treatment. However, they also found that the negative effects of cyberbullying were greater than the effects of traditional bullying. For example, cyberbullied youth were 3.44 times more likely to have attempted suicide compared to nonbullied youth, whereas traditionally bullied youth were 1.63 times more likely to attempt suicide than nonbullied peers. In a recent meta-analysis, in which van Geel et al.[27] examined the relations between traditional bullying, cyberbullying, and suicide among children and adolescents, cyberbullying was more strongly associated with suicidal ideation than traditional bullying. Finally, in a rare longitudinal study examining the effects of cyberbullying over time, Machmutow et al.[33] investigated whether cyberbullying was an additional risk factor in depression beyond the risk of being traditionally bullied by peers. Swiss seventh-grade students were assessed twice in 6 months. Controlling for prior symptoms of depression and traditional bullying, results indicated that higher rates of cyberbullying victimisation predicted an increase in depression symptoms over time.

In addition to the negative impact on physical and mental health, there is evidence that cyberbullying adversely affects other aspects of functioning. Using 2 large independent samples of American students in grades 6 to 12, Giumetti and Kowalski[34] found that cyberbullying uniquely predicted academic problems such as greater absenteeism and poor grades in school (as well as increased depression, anxiety, and poor self-esteem) over and above traditional bullying. In another American study of students in grades 6 to 12, Wigderson and Lynch[35] found that being the victim of cyberbullying was negatively associated with grade point average (and positively associated with emotional problems), even after controlling for exposure to traditional forms of bullying.

These studies raise the question about why cyberbullying seems to be more harmful to children and adolescents than traditional bullying. It has been suggested that the effects of cyberbullying may be greater than the effects of traditional bullying because the attack can be viewed by a wider audience, who can access the material repeatedly and in turn share it to an untold number of people.[29] Moreover, in the case of traditional bullying, the target typically knows who is bullying him or her, whereas with cyberbullying, the identity of the perpetrator(s) can remain anonymous,[36] creating a greater sense of insecurity, lack of control, and hopelessness. Still, in some cases, cyberbullying is perpetrated by the target's own friends,[20,37] who may have more intimate and potentially damaging information about the target.

Cyberbullying may be particularly detrimental to youth because individuals who cyberbully can access their victims more readily.[15,20] In the case of traditional bullying, most aggression takes place at school,[2] whereas with cyberbullying, the aggression can be perpetrated at any time of the day or any day of the week and without the direct presence of the victim. Children and adolescents who are bullied through electronic means are also less likely to report their abuse or to seek help than victims of traditional bullying.[20,38] Cyberbullied youth who suffer in silence perceive that they are supported less, which is related to adverse outcomes such as suicidality.[31] Finally, cyberbullied youth can be targeted by adult harassers,[28] who can also exploit youth sexually. Fifteen-year-old Amanda Todd of Port Coquitlam, British Columbia, took her life in 2012 after being harassed and exploited by a 35-year-old Dutch man who, after threatening to do so, distributed a topless photograph of Amanda to her classmates. Her classmates in turn bullied her ruthlessly (face-to-face and online), which included encouraging her to take her own life.

The Role of the Health Care Providers

The World Health Organization has stated that "bullying is a major public health problem that demands the concerted and coordinated time and attention of health-care providers, policy-makers and families" (p. 403).[39] To date, most anti-bullying efforts are initiated and directed by the education system[40] even though 1) bullying is associated with significant health problems,[21] 2) bullied youth want the help of health care providers,[41] 3) bullying of any type can be

difficult for adults to witness or detect, and 4) many schools have decided that cyberbullying in particular falls outside of their mandate for intervention, although they are increasingly recognising that this is not the case. Given that both bystanders[42] and targets alike[43] are unlikely to report bullying to adults, health care providers may play a vital role in uncovering bullying that would otherwise be missed. Indeed, a recent study of British youth suggests that most adolescents (90.8%) and their parents (88.7%) think it is important that their general practitioners are able to recognise bullying and help bullied youth.[41] The adolescents in this study were "overwhelmingly in favour" of their family physician being able to identify and help them with their bullying problems and thought that the independence of the family physician from the school setting was a particular advantage.

Beeson and Vaillancourt[40] have suggested that in the absence of established guidelines on what health care providers should do, the following can be done in the interim: screening, validation, and advocacy. In a recent study, Ranney et al.[44] surveyed adolescents aged 13 to 17 years who presented to an urban emergency department for any reason. Of the 353 adolescents screened, many reported symptoms consistent with posttraumatic stress disorder (PTSD; 23.2%), depression (13.9%), and past-year suicidal ideation (11.3%), all known outcomes of bullying.[21] Strikingly, adolescents reported in their screening questionnaire high levels of exposure to physical peer violence (46.5%), cyberbullying (46.7%), and community violence (58.9%). Results further indicated that being the victim of cyberbullying correlated strongly with symptoms of PTSD, consistent with others studies demonstrating such a link.[45] This study highlights that asking youth about involvement with cyberbullying is informative. Knowing that a patient is being bullied by peers and knowing that cyberbullying in particular has a uniquely negative impact on their well-being can and should be used in their treatment plan.

When screening for bullying involvement, Lamb et al.[46] suggest that physicians routinely ask their patients 4 questions: 1) How often do you get bullied (or bully others)? 2) How long have you been bullied (or bullied others)? 3) Where are you bullied (or bully others)? and 4) How are you bullied (or bully others)? However, when screening for bullying, it may be better to ask youth about their exposure to bullying and cyberbullying using a questionnaire rather than asking them directly, as per the strong suggestion of youth.[41] If bullying is present, health care providers should partner with the school and family to help youth develop positive social relationships.[40]

Since targets of bullying and cyberbullying often do not voluntarily discuss their predicament, particularly with adults, health care providers should be equipped with information regarding possible signs and symptoms about which to be alert. Health care providers can then raise and discuss such concerns with patients and, when appropriate, their parents. Signs and symptoms can include the following[24]:

- Avoiding school (more truancy and absences, leaving school due to reported health problems, less willing to attend; other academic problems)
- Lower self-esteem, increased depression and/or anxiety
- Reporting health problems (e.g., stomach aches, headaches)
- Trouble sleeping or frequent nightmares
- Detachment from friends
- Sudden withdrawal at home
- Sudden anger/rage
- Self-destructive behaviour such as cutting

In addition to screening for bullying, Beeson and Vaillancourt[40] suggest that if parents or children present to their health care provider with concerns about bullying, health care providers should validate their concerns as "legitimate, significant, and worthy of as much careful attention and necessary intervention as the biomedical impairments" (p. 98).[47] The social lives of children should not be ignored as the current state of knowledge supports a causal link between exposure to bullying and poor health and academic outcomes.[21] Moreover, adults' lack of validation regarding youth's bullying experiences can prove traumatic.[48]

Finally, Beeson and Vaillancourt[40] urge physician groups and organisations such as the Canadian Psychiatric Association, the Canadian Psychological Association, the Canadian Pediatric Society, the College of Family Physicians of Canada, and the Canadian Mental Health Association to advocate for bullied children and youth. Our mandate is to promote the health and well-being of children, which, unfortunately, is far too often thwarted by bullying. Some organisations such as the Canadian Psychological Association have a position statement about bullying in children and youth, whereas others do not. In particular, the Canadian Psychological Association[49] states that "bullying is wrong and hurtful" and that "being safe in relationships is a fundamental human right." They further add that "all adults have a shared responsibility to promote healthy relationships and eliminate bullying in the lives of children."

Conclusion

Bullying significantly affects far too many Canadian children. Cyberbullying in particular has a powerful negative effect on young people's health and well-being. Bullying and cyberbullying typically go unreported, at least to adults, as children are concerned about the consequences of telling their parents or teachers. It is therefore vital that we improve our ability to detect and intervene in these situations. Given that antibullying initiatives have relied almost exclusively on school-based approaches,[11] we point to health care providers as a potential new resource in bullying identification and prevention. Although many victimised children and youth do not feel comfortable telling their teachers or even their own parents about the pain they are experiencing, they might

be willing to talk to their health care provider, in part because of their distance from school.[41] If youth do not volunteer their bullying/cyberbullying involvement, health care providers are still in a unique position to detect peer victimisation. We suggest that practitioners learn the signs and symptoms of bullying and routinely screen youth for their involvement. By so doing, health care providers can provide a crucial line of defense for youth who are experiencing the worst feelings of isolation and depression as a result of being bullied and/or cyberbullied.

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