

Running head: BULLYING AND TRAUMA

Bullying And Adolescent Girls: An Exploration Into The Relationship Between Bullying And
Trauma

By

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ABSTRACT

Research suggests that adolescent girls who have been bullied often experience correlating depression and anxiety, sleep problems, as well as a lack of self-esteem. In this thesis I offer a detailed exploration into the effects of female adolescent bullying. Research on trauma theory and its practical applications will also be reviewed. The central assertion being made in this thesis is that trauma theory can assist counsellors, teachers, and community workers who are working with adolescent girls who have been bullied as a way of reducing symptoms and long term negative ramifications of existing and past bullying situations. An exploration into the benefits of existing school programs and preventative measures that can be taken in schools and community to reduce harm in bullying situations will also be offered.

Keywords: trauma, bullying, schools, peers, adolescent

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INTRODUCTION

In this thesis I will explore the impact of bullying on adolescent girls and discuss ways in which using trauma informed care can assist healing as well as reduce symptoms for girls who have experienced bullying related trauma. The purpose of this thesis is to explore an approach to counselling adolescent girls who have experienced bullying, and to offer an approach to counselling that can reduce symptoms and prevent long-term damage for adolescent girls who have been bullied.

Statement of the Problem

Adolescent girls who have been bullied often experience serious long-term problems such as low self-esteem, depression, anxiety, and possible suicide ideation, associated with the bullying that they have endured in high school (Pepler et al., 1997). The damages incurred for an individual that has been bullied may show up at the time, or show up much later (Shariff, 2008). Bullying behaviour is experienced within a relationship, whether it is at school, online or in the community, and according to Pepler et al. (in press),

the lessons learned in bullying within peer relationships generalize to other developmentally significant relationships. We contend that the combined use of power and aggression found in playground bullying is a key component of sexual harassment, dating aggression, workplace harassment, marital aggression, and elder abuse. (Pepler et al., in press, p. 1)

Relevance of the Thesis

Bullying is a serious problem within school systems and our society, according to a nation-wide online survey conducted by Angus Reid in 2012. From a representative sample of 1,006 Canadian adults, 65% of the respondents considered bullying a serious crime, regardless of

whether physical violence is involved (Angus Reid, 2012). Of those surveyed, 94% felt that bullying was a serious problem in middle school and high school, and 88% of respondents felt that it was a serious problem in elementary school. According to the Government of Canada, 8% of Canadian teens have experienced online bullying and 35% of adolescents have witnessed mean or inappropriate behaviour online by peers (Government of Canada, 2015). According to a survey done by Statistics Canada in 2012, 83% of Canadian households had access to the Internet at home (statcan.gc.ca) and according to a report from the Department of Justice in 2013, more than half the population of Canada, 19 million Canadians, are on Facebook at least once a month (Department of Justice, 2013). According to Hinduja and Patchin (2010), online usage by adolescents has created a societal gap in knowledge that we are struggling to keep up with in regards to laws, crime, safety, and the well-being of youth.

Theoretical Orientation

According to PrevNet (Promoting Relationships and Eliminating Violence Network), Canada's online authority on research and resources for bullying (PrevNet, 2015), bullying is a relationship problem and needs to be solved in a relational context. From a theoretical perspective, understanding the damage bullying causes has been explored from an attachment perspective, with an emphasis on the importance of connection and belonging, which is a primary need of all human beings (Bretherton, 1992). Trauma-informed care is suggested in this thesis as an effective approach to assessing adolescent girls who have experienced bullying and trauma counselling is explored from a strength-based perspective, with various trauma intervention techniques presented. In order to uncover the relevant issues that are related to bullying and the associated trauma, I have attempted to answer the following questions: How can we identify victims of bullying? How can we help victims heal? How can we try to ensure that

problems associated with the experience of being bullied do not lead to long-term problems and possible mental health diagnoses for the victim? I have used these questions to guide my review of the research and to assist my understanding of the complexity of bullying issues, the history and current relevance of trauma theory, as well as advocating for a trauma-informed approach for assessment and intervention of victims of bullying.

Personal Interest

I decided to explore bullying research as a result of my recent work with adolescent girls in my clinical counselling work, as well as teaching assertiveness and violence prevention workshops to grade 10 girls in high schools throughout the province. What I was noticing in my work was a common theme around adolescent girls who had experienced bullying, many of the girls experienced psychological and emotional damages as a result of being bullied, even though the bullying may have ended. There were lingering feelings of low self-esteem, a lack of social confidence, and sometimes, both depression and anxiety had developed. Adolescent girls were repeating a common message: Most revealed incidents of online bullying, saying the bullying was relentless, the posting of mean and humiliating photos was deeply upsetting and took a long time to recover from, and the exclusion, exacerbated by online communication, was causing anxiety and a severe lack of confidence and self-worth amongst them. In my workshops I was often asking the girls to adopt communication and assertiveness skills that I believed could help them to stand up to bullies or partners in intimate relationships. Although I always felt that the adolescent girls that I was teaching appreciated the skills, I was left with a feeling that there was something left undone, a hurt and a sadness that could not be resolved with just the new assertiveness skills. I believed that counselling and support for victims of bullying was necessary, and yet this often was not happening. This was the impetus behind this research. I

wanted to not only uncover why so many girls who had been bullied were not getting the help and support they needed, but what I could do to help change this.

Structure of the Thesis

This manuscript thesis offers an introduction to the topic as well as an overview of relevant literature pertaining to the problem, a second essay discussing the history and relevance of trauma theory, and a third essay describing how to use trauma theory and trauma informed care to help victims of bullying. Implications for counsellors, concluding comments, and suggestions for further research are offered at the end of the paper.

Essay one will primarily address how the problem of girls being involved in bullying has been addressed through research that has often been done for both adolescent girls and boys. For the purposes of this thesis, I have presented the relevant research available in relation to bullying with adolescents, and have reflected on how it impacts adolescent girls specifically. Bullying is described within three realms for adolescent girls: cyberbullying, relational aggression, and verbal bullying. Research has been reviewed for each type of bullying behaviour and a discussion on the impact of the bullying on victims is presented. Concepts regarding bullying are reviewed and discussed including work from Olweus (1993), Espealage and Swearer, (2011), Hinduja and Patchin, (2010), Shariff, (2008) as well as Pepler, Craig, Ziegler, and Charach (1993). These researchers have led the field in providing relevant and effective analysis of the problem of bullying, as well as preventative and appropriate intervention methods for schools and community. Consequences for the victim are discussed, including low self-esteem, depression, anxiety, and suicide ideation.

Essay two focuses on trauma and its relationship to bullying. Recognizing that an individual's reactions to bullying, may be traumatic, an overview of trauma theory as well as outlining trauma informed care is provided in this second essay. A brief history of trauma theory is provided, including the initial work of Charcot (Ringel & Brandell, 2012), Ferenczi (1933), Freud, (1962), van der Kolk (1996), Meszaros (2010), Herman (1992), Terr (1992), and Levine (2005). These researchers have made significant contributions to the practice of trauma counselling and have developed theory and practice that has been beneficial to clients who have experienced trauma. Further definitions of trauma within the DSM-5 (APA, 2013) are provided and post-traumatic stress disorder (PTSD) is defined and concerns about using the specific diagnosis as outlined in the DSM-5 (APA, 2013) are discussed. The controversial ideas in relation to trauma counselling, in regards to repressed memories and dissociation are explored (Sulieman, 2008). Symptoms of trauma are discussed, with specific attention to the symptoms of numbing and avoidance. The likelihood of trauma developing is explored and attention is given to what makes an individual more susceptible to having trauma symptoms, after having experienced a traumatic event.

Essay three discusses trauma-informed care. In this chapter, using trauma-informed care in counselling is suggested as an appropriate assessment and intervention approach for victims of bullying. According to Carney (2008), adolescents are more vulnerable to developing long term consequences when they are bullied because of the developmental tasks that are required during adolescence that can be interrupted when bullying occurs. What makes bullying traumatic for an individual depends on many factors. Assessment strategies for assisting victims to disclose bullying are explored, and prevention strategies are offered. Horner and Ross (2009) have

developed a three-tier approach that is discussed in detail, as well as other prevention techniques that can be used in schools and individually with potential victims. Herman (1992) has outlined the three stages of recovery that are required to heal from a traumatic event and these are explored within the context of an individual who is experiencing trauma related symptoms as a result of bullying. Intervention techniques including solution-focused therapy, ARC, EMDR, as well as Levine (2005)'s 12 step trauma-healing program are explored.

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ESSAY 1 BULLYING

In this essay I will discuss why bullying amongst adolescent girls is a problem that has many damaging consequences for the victims. Bullying takes place within the female adolescent population in many forms including cyberbullying, relational aggression, and verbal bullying. Other forms of bullying such as physical bullying, prejudicial bullying and sexual harassment also exist and affect adolescent females, but for the purpose of this essay I will be discussing the first three types of bullying and their associated consequences. I will discuss how resiliency, relationships with parents and teachers, as well as personality temperament all contribute to an adolescent girl's response to the bullying, whether it be a negative or a positive response. In this essay I review literature and research about bullying behaviour as well as symptoms that may develop for adolescent females affected by bullying. An exploration as to what aspects of school programs, family support, and teacher awareness contribute to reduce the negative effects of bullying will be provided.

Bullying Defined

Mitchell (2011) provides a definition for bullying, stating the main idea is that power is gained and sustained by those in the majority . . . and that there are four main themes that exist in literature relating to bullying: intention, harm, repeated occurrence, and an imbalance of power. (p. 9)

According to Olweus (2001), who provided ground breaking research on bullying prevention in Norway and has been responsible for bullying prevention programs throughout North America, bullying consists of three components: 1) the bully commits negative actions intended to harm 2) the bully's actions are repeated over time, and 3) there is a power differential between the bully and the victim. Olweus goes on to further explain that arguments amongst individuals of equal

power and status are not considered bullying, and emphasizes the differences of power between the involved parties as the defining factor, including situations where the bullied is either unable or finds it very difficult to stand up for herself (Olweus, 2001). Mitchell (2011) suggests that victims of bullying may experience an interruption of emotionally healthy adolescent development. The imbalance of power suggests that individuals who have power within their social group are desperate to sustain it, and adolescent girls in particular, are looking to be part of a group and sustaining a sense of belonging is important to them (Gonsalkorale & Williams, 2007). It is the exclusion and isolation that comes from bullying that often make it so difficult for adolescent females (Espelage & Swearer, 2011).

Prevalent Types of Bullying: Cyber-bullying

Hinduja and Patchin (2009) suggest that when an adolescent girl uses a cell phone, her computer, the Internet, a chat room, a blog, or any other form of technology to harass, embarrass, or target another adolescent girl, this is cyberbullying. Hinduja and Patchin claim in their most recent research that 93% of teenagers spend time on the Internet and he suggests that 75% of teenagers are using smart phones (Hinduja, et al., 2013). Hinduja further suggests that with a small computer at a teenager's fingertips during the school day as well as at home in the evening, parents and teachers are unable to supervise and monitor the kind of activity that takes place on smartphones and tablets (Hinduja et al., 2013). Bandura (2001) asserts that teenagers are prone to making mistakes and taking risks as well as shifting to focus more on peers and less on parental influence. The pressure to gain status and peer acceptance may be related to an increase in bullying (Espelage, 2013). According to the American Society for the Positive Care of Children (2014), bullying increased between 2011 and 2013 by 8% (American SPCC, 2014). In 2011, the youth risk surveillance report indicated that 20% of students reported they had experienced

bullying and the same report in 2013 showed that 28% of students reported they experienced bullying. The 2013 Youth Risk Behaviour Surveillance report, which is done on average across 39 states, revealed that 7.2% of students skip school because they are concerned about their personal safety, and the same survey concludes that 70.6% of students claim to see bullying take place in their schools (American SPCC, 2014). There is a rising concern that as a generation that didn't grow up with computers, educators and parents are at a loss to keep up with the technology that today's children have always had as a part of their lives; Hinduja et al. claim this contributes to the problem, positioning adolescents in the position of "digital natives" and the parents of "digital immigrants" (Hinduja et al., 2013).

In a recent regional consensus of high school students in Massachusetts (Schneider, O'Donnell, Stueve, & Coulter, 2012), 20,406 students in ninth through twelfth grade were surveyed to assess how cyber-bullying and school bullying victimization correlated with psychological distress, depression, self-injury, and suicidality. The students were given surveys assessing their level of bullying victimization, their depressive symptoms—including suicide ideation and self-harm—as well as psychological distress. Schneider and his colleagues reported in their results that victims of school bullying reported lower school performance and school attachment (Schneider et al., 2012) and concluded that distress was highest amongst victims who shared equal amounts of cyber bullying and school bullying. This study indicated that 15.8% of students were cyberbullied and 25.9% reported school bullying (Schneider et al., 2012). One of the issues that were highlighted in this study is the problem of enforcing cyber bullying policies. The researchers state, "although almost all states now mandate schools to address cyber bullying in their anti-bullying policies, there is great flexibility in how much emphasis schools place on efforts to prevent cyber bullying, which occurs mostly outside school" (Schneider et al., 2012, p.

175). Schneider wrote another article for the American Journal of Public Health, summarizing her research in Massachusetts, stating “perpetrators may feel reduced responsibility and accountability when online compared with face-to-face situations. This may suggest that youth who may not be vulnerable to school bullying could, in fact, be targeted online through covert methods” (Schneider, 2011, p. 1). Shariff (2008) discusses the problem that school officials face when deciding which kinds of online behaviour are school responsibility, and which are not. Shariff also states that the popularity of social media sites used by teenagers has made the issue harder to manage, and parents and teachers are sharing the frustration that not enough is being done to help students at school who are being bullied online. She goes on to suggest that things are changing so quickly that it is an ongoing issue to keep up with the new technology, and also, we are still in the very early stages of researching the phenomenon of cyber-bullying.

Sexual harassment is a specifically painful form of cyberbullying (Hinduja & Patchin, 2008). In recent work with sexual assault and sexual harassment of female adolescents, the government is responding positively by enforcing new laws in regards to sexual content being shared on the Internet. The idea that “no means no” tends to suggest there is no third option. There is no defense or implied consent to sexual assault in Canadian law” (Makin, 1999). Recently, the federal government of Canada changed the law to incorporate that posting a sexual image of another person or to be found receiving and sharing that image to be a criminal offense (Globe and Mail, 2013). The government of Canada passed a new law as of November 20, 2013, *The Protecting Canadians from Online Crime Act*, which states that it is a federal offense to commit an online crime such as “sexting”—posting, sharing a nude photograph of anyone, whether they are underage or not, storing, sending, or sharing with others photos of someone that are threatening or abusive to that person’s reputation and well-being. The crime is punishable up

to five years in prison (Cohen, 2013). Hinduja and Patchin (2008) claim the “perceived anonymity on-line and the safety and security of being behind a computer screen, aids in freeing individuals from traditionally constraining pressures of society, conscience, morality, and ethics to behave in a normative manner” (Hinduja & Patchin, 2008, p. 134). Hinduja and Patchin (2010) have also focused on school-based efforts to prevent cyber bullying and they suggest that the following actions should take place in order for the school to be considered successful in preventing cyber bullying:

1. Ensure teachers are teaching students about safe Internet use.
2. Ensure that students know that all forms of bullying are wrong and that those who engage in harassing or threatening behaviours will be subject to discipline.
3. Enforce the discipline policy for any student who has participated in bullying behaviour.
4. Ensure that students and parents know that although cyber bullying may not take place on school campus, it is disruptive to the school’s learning environment and therefore still under the school’s authority to discipline students.
5. Work with the teachers and students to foster a positive school environment that promotes healthy peer relationships.

Mitchell (2011) analyzes the relationship between academic achievement and cyberbullying. By using data collected from a questionnaire that was distributed to 847 middle school students in a North Eastern city, Mitchell assesses the rates of incidence, knowledge of consequences, and behavioural patterns of cyber bullying. In relation to the number of incidences of bullying, she found that academic achievement is negatively correlated to incidences of cyberbullying, and that there is no difference whether the child is in a gifted program or a regular

program to the level of cyberbullying that they might encounter as a student (Mitchell, 2011). Mitchell found that the most “statistically significant factor in predicting involvement with cyberbullying was a history of involvement with traditional bullying” (Mitchell, 2011, p. 72). Espelage (2013), a professor of educational psychology at the University of Illinois and recipient of the Lifetime Achievement Award in Prevention Science of the American Psychological Association, has dedicated 20 years on research into bullying, sexual harassment, and dating violence. She summarizes her research on the need for a sense of inclusion and belonging, by saying that adolescents perceive group belonging as a primary goal, which can prevent good decision-making because sustaining that group connection comes before keeping character and values for many adolescents (Espelage, 2013). Espelage concludes that the desire to stay connected as a group makes the exclusion that comes from cyberbullying and relational aggression that much more painful (Espelage, 2013).

Prevalent Types of Bullying: Relational Aggression

Relational aggression, also known as emotional bullying, was initially defined by Crick and Grotpeter (1995) as behaviour intended to harm someone by targeting and harming their relationships with others. This type of bullying is associated with adolescent girls and is the type of bullying that can go unnoticed and is insidious in nature. This type of bullying is used by adolescent girls as a:

type of social manipulation where tweens and teens try to hurt their peers or sabotage their social standing. Relational bullies often ostracize others from a group, spread rumors, manipulate situations, and break confidences. The goal behind a relational aggressive bully is to increase their own social standing by controlling or bullying another person. (Gordon, 2014, p. 2)

An adolescent girl who is being bullied in this way will likely be subject to teasing, exclusion, intimidation, and insults (Gordon, 2014). Historically underestimated, researchers are now focusing on the damage this type of bullying can cause for young adolescent girls. First, it is important to remember that the need to belong is a fundamental human motivator (Baumeister & Leary, 1995). According to attachment theorists, infants are born with an innate drive to form emotional bonds with others and further research in neuroscience has provided evidence that our brains are wired to function optimally when needs for social interaction and connection with others are met (Goleman, 2006). Consequently, not belonging and being excluded by peers is likely to have a significant negative impact on adolescent girls. Gorrese and Ruggieri (2012) suggest that adolescence is a critical time for peer attachment and even though traditional attachment theory has been focused on the bond between child and parent, Gorrese and Ruggieri (2012) claim in their recent meta-analytic review of peer attachment, the relationships established between peers are likely to be influential sources of social and emotional support. Gorrese and Ruggieri (2012) assessed a sample of 551 adolescents between the ages of 13-21 for peer and parental attachment quality, as well as to assess associated post-traumatic stress, depression, and anxiety symptoms. Their results revealed that parental relationships with strong attachment predicted lower levels of anxiety and depression, but not post-traumatic symptoms. Peer relationships that were secure were positively associated with reduced symptoms for post-traumatic stress, but did not correlate with lower levels of depression and anxiety (Gorrese & Ruggiere, 2012). According to Vaillancourt, Hymel, and McDougall (2010), humans thrive in social connectedness, and when children are bullied and excluded:

the chance of meeting the need to feel a sense of belonging in the peer group is dangerously thwarted. Perhaps even more damaging is the fact that some will internalize

these experiences. They blame themselves, believe that they are at fault, and think that poor treatment will be long lasting such that their future prospects for belonging look extremely grim. (p. 25)

Lieberman and Eisenberger, (2009) assert that parts of the cortical physical pain network is activated when a person is socially excluded and that the pain associated with physical injury is similar to the pain associated with loss and rejection, activating very similar brain regions (Lieberman & Eisenberger, 2009). Masten et al. (2009) also found that teenagers reacted to social pain in a similar way to being physically injured. In the Masten study, brain activation was measured in a group of 19 13-year-olds with autism spectrum disorder and 17 typically developing adolescents. Masten et al. concluded that for both groups of participants, the teenage brain reacts to social pain the same as physical pain (Masten et al., 2009). Vaillancourt et al. (2010) summarized Masten and colleagues' work in their review of *Why bullying hurts so much* and concluded that a 13 year old showed the greatest brain activation when they were the most distressed by social exclusion (Vaillancourt et al., 2010). Vaillancourt and colleagues asserted that the stress of bullying and exclusion from peers likely disrupts the immune system and contributes to the link between poor health and peer victimization (Vaillancourt et al., 2010).

Prevalent Types of Bullying: Verbal Bullying

Relational aggression with adolescent girls as a form of bullying can overlap with traditional verbal bullying; these types of bullying behaviour can be seen with both adolescent boys and girls, but for the purposes of this thesis I look at the research in regards to adolescent girls. Verbal bullying is defined as using “words, statements and name-calling to gain power and control over a target. Typically, verbal bullies will use relentless insults to belittle, demean and hurt another person” (Gordon, 2014, p. 2). Gordon states that most verbal bullying is targeting

victims for the way they look, act, or behave and often children with disabilities or different personalities from the norm are targeted by verbal bullying. Storch et al. (2004) did a retrospective study examining the relationship between childhood taunting and teasing and current psychological distress. The study was administered to 414 undergraduate students and they were given several assessments including the TQ-R, the Beck Depression Inventory–II, State-Trait Anxiety Inventory–Trait Version, the Brief Fear of Negative Evaluation Scale, and the UCLA Loneliness scale. Storch et al. (2004) concluded that children who were bullied had higher rates of anxiety, social anxiety, worry, and anxiety sensitivity in adulthood.

One of the more established ideas about the cause of verbal bullying behaviour, is that the bully is lashing out due to a lack of self-esteem or confidence, and is using the opportunity to put another person down as a way to make him or her feel better (Olweus, 2001; Espealage & Swearer, 2011; Espealage, 2013). Yet interestingly, students who are anxious are often more aggressive as a way of compensating for felt weaknesses (Swearer et al., 2011). Kashani, Dueser, and Reid (1991) found a correlation between anxiety and verbal aggression. They examined the relationship between anxiety and aggression by assessing 201 subjects, ages 8, 12, and 17. The Conflict Tactics Scale was used to measure participants' verbal aggression and the revised children's manifest anxiety scale was used to measure anxiety. Their findings concluded that there was more anxiety in the highly verbal participants (Kashani et al., 1991).

It appears that the long lasting effects of verbal bullying cannot be ignored, and can result in maladaptive psychological responses well into adulthood, even if the adolescent girl has outgrown middle school or high school, where the bullying took place (Gordon, 2014). In 2006, a large scale study was completed with 2086 German students in grades 5-10 to examine gender differences in youth's experience of bullying in three regards: physical, verbal and relational

(Scheithauer, Hayer, Petermann, & Jugert, 2006). The youth were given a revised version of the Bullying/Victim questionnaire that was originally designed by Olweus in 1991. Of these youth, 11.1% reported victimization, and of the 2086 students surveyed, the results were as follows: 7% claimed only physical bullying, 37% only verbal bullying, 23%, only relational bullying, and 33% had experienced a combination of two or more types of bullying. One of the criticisms of the study is that there could possibly be a discrepancy between the definitions used by the youth and the researchers around what verbal and relational bullying is (Bradshaw, Waasdorp, & O'Brennan, 2013). Nevertheless, adolescent girls were more likely to report being victims of relational and verbal bullying and boys were more likely to report being victims of physical bullying (Bradshaw et al., 2013). Bradshaw, Wasadorp, Goldweber, and Johnson (2013) conducted a study to examine the different subtypes of bullying and co-current association with significant health-risk behaviours such as violence, substance use, and gang membership. Self-reported data was gathered from 16,302 adolescents (50.3% female, 62.2% Caucasian, and 37.8% African American) from 52 high schools. Bradshaw et al., (2013) examined distinct forms of bullying which were either, physical, verbal, or relational, among middle and high school students, and whether being victimized was associated with internalizing problems and aggression. They concluded that victimization was less among high school students and more common in middle school students, as well as that students who were experiencing multiple forms of bullying, specifically relational forms, had the most difficulty coping with the bullying (Bradshaw et al., 2013). Bradshaw and colleagues reference a study done by Graham and Juvonen (1998), in which respondents completed questionnaires that assessed self-perceptions of their personal victim status, as well as reasons for hypothetical incidents of being victimized. Middle-school students were assessed for the relationship between bullying behaviour attribution

to either self-perceived victimization versus peer-perceived victimization. According to Bradshaw et al., youth who blamed themselves for the bullying tended to “experience heightened social-emotional difficulties when these multiple forms of bullying related to characteristics innate in their personality, thus further instilling their identity as a victim” (Bradshaw et al., 2013, p. 221).

Bullying and Aggression

A comprehensive literature review of bullying and aggression could go back hundreds of years and include many well-known characters such as Lucy from Charles M. Schulz’s *Peanuts*, Curley in John Steinbeck’s *Of Mice and Men*, or Mr. Bumble from *Oliver Twist*. However, serious scholarly interest did not develop until the last few decades with a major contribution made initially by Olweus’ work (1993) in Norway in the 1970s. Olweus focused explicitly on bullying as an aggressive act with the intention to harm. Olweus also asserted that aggression and bullying are different, and he saw aggression as a negative act with the intent to harm (Olweus, as cited in Coie & Dodge, 1998), whereas bullying behaviour must also include two other criteria: repeated acts and a distinct power imbalance (Olweus, 2001). Hawley, Stump, and Ratcliff (2011) quote Olweus in their summary by stating that “all bullying is aggression regardless of form or function, but not all aggression is bullying” (p. 102). Aggression in females provides a challenging dilemma for many parents and educators who are encouraging young women to stand up for themselves and to assert themselves to ensure that they are seen as equally capable and strong as their male counterparts. Parents who positively encourage assertive behaviour may unknowingly be enabling aggressive behaviour in young developing adolescent girls, without a clear boundary being drawn to separate the two distinct attributes of standing up for one’s self. According to Coie and Dodge (1998), developmental research has traditionally

suggested that aggressive behaviour is related to social incompetence, low levels of information processing, as well as peer rejection, resulting in poor connectedness amongst peers. However, researchers are currently looking to challenge this assertion that social incompetence is always the result of aggressive behaviour, and are now looking at the possible positive outcomes related to aggressive behaviour such as social competence and needs satisfaction (Bokowski et al., 2003). Hawley, Stump and Ratliff (2011) suggest in their research that we can consider social competence to be positively related to competition, and that not only does competition involve power and drive, it also requires an ability to maintain friendships and connection within the group. Hawley et al. propose that the concept of Resource Control Theory (RCT), which explains that people adapt to their environments and local experiences, and secondary to this primary outcome of adaptation, is the definition of their group experience. The group experience for an individual highlights her or his ability to manage resources, whether they are social, informational, or material resources (Hawley et al., 2011). Research does seem to confirm that “aggression, when balanced with prosociality, can play a role in the competent pursuit of human needs satisfaction” (Hawley et al., 2011, p. 110).

Bullying Behaviour: Impact on the Victims

Exploring the relationship between female adolescent peer development, and bullying, and understanding how it develops in relationships, and what the possible motivators are, may help form a framework around why bullying takes place. Once bullying has started towards a victim, whether it is verbal, relational, or cyberbullying, and in the situations where the victim has difficulty coping with the bullying, what is it that makes the bullying difficult for the victim? Humans have an innate need to belong to a group, and although attachment forms in infancy, the ongoing drive to form emotional bonds with others exists through our lifetime (Bowlby, 1997).

For some individuals, the need for a sense of belonging can be so strong that even being rejected by a group that is not well regarded can be hurtful. Gonsalkorale and Williams (2007) examined whether being ostracized by a group such as the Ku Klux Klan can create feelings of ostracism, and they found that members of both unacceptable and acceptable groups felt ostracism in the same regard, showing that ostracism is powerful (Gonsalkorale & Williams, 2007). If everyone has a human need to belong, then what makes the bullying manageable for some adolescent girls and for some it is too much to handle and in worse-case scenarios suicide is considered or attempted? Bullying takes place along a continuum and adolescent girls can participate in a variety of roles within their time in high school including the bullying of others, being bullied, being bullied and bullying others simultaneously, witnessing bullying/being a bystander to bullying, and not having any involvement in bullying at all (Swearer, Collins, Radlife, & Wang, 2011). These roles are not static and can come and go for teen girls and their personal experience within a certain role and the extent of the bullying or witnessing of the behaviour and the outcome for the individual may be related to concurrent psychological conditions, as well as sensitivity to others and the ability to cope with stressful situations.

Schneider concludes, after examining a large school-based census of over 20,000 students that there is a correlation between psychological distress and the co-occurrence of cyberbullying and school bullying (Schneider, 2011). Schneider (2011) concludes that several groups were particularly susceptible to victimization, most particularly, non-heterosexual youth. The research concludes that 23% of the LGBTQ population were victims of both cyber and school bullying compared to 9% of the heterosexual population (Schneider, 2011). Schneider concludes that there is a distinct relationship between psychological distress and cyberbullying for all victims, not just those of a different sexual orientation. He claims that:

victims of cyberbullying alone reported more distress than did victims of school bullying alone . . . and victims of both cyber and school bullying, were more than 4 times as likely to experience depressive symptoms and more than 5 times as likely to attempt suicide as were nonvictims. (Schneider, 2011, p. 175)

One of the most damaging aspects of bullying to the victim is the helplessness it can create, and how this is caused by the anonymity of cyberbullying and can be particularly damaging to adolescent girls' self-esteem and confidence (Hinduja & Patchin, 2008). According to Hinduja, the anonymity of being online is a major factor in aiding individuals to act in ways that they might otherwise not, the traditional societal pressures of morality and conscience being forgotten behind the safety of a computer screen (Hinduja & Patchin, 2008). The freedom that an offender can have on the Internet by using a pseudonym can create a frustration for the victim, in not knowing who is harassing them, and the anonymity creates an opportunity for the offender to do and say things online that they would likely never do in person and this is what creates the possibility of negatively affecting victims' ability to function well socially and emotionally (Hinduja & Patchin, 2008). With maturity, some of the problems of physical and verbal bullying may be diminished. According to Bradshaw et al. (2013), research shows that all forms of victimization appeared to be much less common in high school, than in middle school, except for cyberbullying and sexual harassment. One aspect of what makes the bullying difficult for the adolescent is when the victim blames her or himself for the bullying. In Bradshaw et al.'s (2013) compilation of research, reference is made to Graham and Juvonen's (1998) attribution theory of peer victimization:

youth tend to experience heightened social-emotional difficulties (i.e., social anxiety, low self-worth, loneliness) when they blame themselves for their chronic victimization.

Youth . . . may attribute these multiple forms of bullying to be related to characteristics innate in their personality, thus further instilling their identity as a victim. (Bradshaw et al., 2013, p. 841)

Along with self-blame, Bradshaw et al. (2013) conclude that relational aggression, on or off-line, is the most difficult for adolescent girls as they prioritize their social relationships and connections with others as a primary aspect of school life.

Anxiety and Depression

Depression and anxiety both appear to be increasing within the adolescent population, and according to Ossola (2015) technology is partly to blame. Ossola states that teachers and researchers in the field “fear that greater access to technology could exacerbate social anxiety among teens, particularly as smartphones, tablets, and computers become omnipresent in and out of the classroom” (Ossola, 2015, p. 1). The need to be constantly connected and keeping up on multiple sites such as facebook, snapchat, twitter, instagram and my story, can create anxiety for many students who are trying to juggle social connectedness with school work and extracurricular activities, and according to Ossola (2015), “teens are using social media as a crutch, a replacement for the in-person interactions that help them develop socially” (p. 1). In a compilation of current research regarding internalizing behaviours of students who are involved in bullying, Swearer et al. (2011) found that children who have a “high level of social anxiety misinterpret ambiguous situations in a negative fashion” (p. 49). Swearer et al. also concluded that “individuals reporting higher levels of childhood behaviour inhibition were more likely to meet criteria for an anxiety disorder” (p. 49). Bosworth, Espelage, and Simon (1999) also found an association between bullying victimization and depression in their research. This research

entailed assessing 558 middle school students with a survey to examine the continuum between mild to extreme behaviours associated with bullying (Bosworth et al., 1999).

Two recent examples of adolescent girls who have been tormented by social media include two high profile Canadian legal cases of cyberbullying—the Rehtaeh Parson (2013) and Amanda Todd (2014) cases. In both these cases, sexual images of the girls were spread on the Internet, and it is their respective parents' belief that it was the shame and humiliation created for these girls that led to their serious depression and inevitably their deaths by suicide. Although these cases are extreme, they remind us of the vulnerability of an adolescent girl who is being tortured on social media whether it is for a decision others don't approve of, something about them that is different than other people, gossip or lies, or for no reason at all. It is not the act that starts the onslaught that is the issue, it is what happens to the adolescent girl who cannot escape the ongoing harassment and how she handles it, that is the challenge for the victim herself, as well as the problem for school counsellors, teachers, parents, and community workers to solve (Swearer et al., 2011). According to Swearer et al. (2001), researchers identified an association between depression and bullying and asserted that all members of the bully-victim continuum, including bully, victim, and bully-victim, are likely to experience higher levels of depression than their peers. In another study, Vossekuil, Fein, Reddy, Borum, and Modzeleski (2002) presented an analysis of school shootings put forward by the United States Secret Service and the Department of Education, and noted that over two thirds of attackers had been victimized prior to the school shootings and 61% had a history of serious depression. Because of the nature of bullying, and victims feeling helpless to the victimization, hopelessness becomes a contributing factor to depression. Abramson, Metalsky, and Alloy (1989), suggest that the Hopelessness Theory of Depression is a significant subtype of depression and their research asserts that

individuals feel hopelessness when they (1) attribute negative events to stable and global causes, (2) catastrophize negative events, or (3) attribute negative events to self (Abramson et al., as cited in Swearer, Espelage, & Napolitano, 2009). Gibb and Alloy (2006) recently researched the mediating role of attribution style between being verbally victimized and depression. They examined over 400 4th and 5th grade students who were given a test similar to the Childhood Trauma Questionnaire-Emotional Abuse subscale, the revised Children's Attributional Style Questionnaire, and the Children's Depression Inventory (Gibb & Alloy, 2006). They found a correlation between developing a negative attributional style with verbal victimization, leading to depressive symptoms, negative attributional styles, and victimization, producing a cycle that perpetuates the depression, as well as creating possibilities for further maladaptive behaviours such as anxiety (Gibb & Alloy, 2006).

Depression is not the only maladaptive symptom that can develop as a result of bullying, anxiety is also prevalent for victims of bullying (Swearer et al., 2011). A Statistics Canada (2002) Mental Health and Well-Being Survey (Canadian Community Health Survey (CCHS), Cycle 1.2) found that 4.7% of Canadians 15 years of age and over reported symptoms that met the criteria for one of the following anxiety disorders in the previous 12 months: 1.6% panic disorder; 0.7% agoraphobia; and 3.0% social anxiety disorder. Over 1 in 10 adults (11.5%) reported symptoms that met the criteria for having had one of these anxiety disorders during their lifetime: 3.7% panic disorder; 1.5% agoraphobia; and 8.1% social anxiety disorder. According to Swearer et al. (2011), "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 can typically experience social anxiety" (p. 47). In response to being bullied and the corresponding anxiety, the most common problems that go along with

anxiety are the inability to form meaningful relationships, low self-worth, loneliness, and depression (Lewinsohn, Zinbarg, Seeley, Lewinsohn, & Sack, 1997). Starr and Davila (2008) found that social anxiety was specifically related to peer variables in adolescence, contrasting the variety of other contributing factors to depression and anxiety overall. Further, “students who exhibit anxious behaviours as well as other internalizing behaviours (withdrawal, shyness) are often victimized” (Gladstone, Parker, & Malhi, as cited in Swearer et al., 2011, p. 48). In these situations, a cycle is born in which anxiety is then maintained or increased due to victimization, and social situations become more difficult, reducing the victim’s ability to form and maintain friendships, as well as the likelihood for them to avoid social and school situations, further isolating them, and likely increasing anxiety (Swearer & Espealage, 2011).

Conclusion

In this chapter I have discussed bullying as it refers to adolescent girls, with a particular emphasis on three types, cyber bullying, verbal bullying and relational aggression. I have also outlined the effects of these types of bullying on this population. Referencing popular culture, existing movies and literature, we do not have to look far to find stories of bullying and the sadness that often prevails for a child who is being picked on. The concern today, with adolescents spending a great deal of their time online, is that a culture is being created amongst teens where accountability for words spoken online may not be required, and the consequences of these actions for both the bully and the person being bullied can be extreme. There can be long lasting impacts on an adolescent female who has been bullied, excluded, and disregarded by her peers at school, potentially resulting in long lasting issues of low self-esteem, social anxiety, depression, and in some cases suicide ideation or suicide attempts (Hinduja & Patchin, 2010). The impact of the bullying behaviour needs to be mitigated. The next two essays will address the

way in which understanding how an individual experiences trauma, may be an effective way to help to heal victims of bullying, through trauma informed therapeutic interventions.

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ESSAY 2- TRAUMA

In this essay I will discuss trauma theory and trauma. I will explore the definition of post-traumatic stress disorder and explain common symptoms of traumatized clients, and how they often present in adolescent girls. I will also explore what the long-term effects of trauma can be, specifically trauma that has been experienced by female adolescents.

Levine, psychologist, author, and researcher in trauma and pain defined trauma as “the debilitating symptoms that many people suffer in the aftermath of perceived life-threatening or overwhelming experiences” (Levine, 2005, p. 7). Levine highlighted the common confusion around what trauma is and isn’t by distinguishing important aspects of trauma: (a) no two people will experience trauma the same way, (b) all traumatic events are stressful but stressful events do not cause trauma, and are not necessarily traumatic, (c) a person’s response to trauma has a lot to do with their genetics, their upbringing, their current life situation, their previous experience with trauma as well as their family relationships, (d) a series of small events can lead to a traumatic response and trauma does not have to arise from one major catastrophe, and e) trauma can manifest many months or years after a traumatic event has taken place. Levine further asserts “we become traumatized when our ability to respond to a perceived threat is in some way overwhelmed. This inability to adequately respond can impact us in obvious ways, as well as ways that are subtle” (p. 9).

History of Trauma Theory

Trauma theory has evolved since Freud first spoke of the trauma of sexual abuse (Freud, 1962) and in this section I explore the etiological developments of trauma theory. According to contemporary psychologists, Ringel and Brandell, (2012), it was neurologist Charcot while working with women late in the 19th century who were suffering from hysteria, and he began to

challenge the common belief that the symptoms of hysteria were coming from the uterus and suggested instead that hysteria could be psychological rather than physiological. Freud was influenced by Charcot, stating that: “a precocious experience of sexual relations . . . resulting from sexual abuse committed by another person . . . is the specific cause of hysteria . . . not merely an agent provocateur” (Freud, 1962, p. 195). However, current researchers Ringel and Brandell (2012) have commented on Freud’s ideas that developed after these initial thoughts, and stated that Freud eventually felt that “it was not memories of external trauma that caused hysterical symptoms but rather the unacceptable nature of sexual and aggressive wishes” (p. 2). According to Ringel and Brandell (2012), several psychologists including Ferenczi, Kardiner, and Spiegel, further developed ideas about trauma, including the concept of re-enactment. Psychologists van der Kolk et al. (1996) pointed out that this team of psychologists developed the concept of treating the client as if the trauma still exists, and therapy was offered by teaching coping methods that the client did not possess during the original trauma, and by using these coping methods in the present, the original trauma could be healed. According to contemporary psychologist and researcher, Meszaros (2010), Ferenczi was establishing significant ideas in the 1920s and 1930s about trauma and stressed in his work the importance that addressing trauma must be founded on real events, and that it occurred within the realm of interpersonal dynamics, and not imagined events. Meszaros (2010) also states that Ferenczi “stressed the significance of the presence or lack of a trusted person in the post-traumatic situation” (p. 328) and commented that it was the loneliness and isolation that caused further trauma for the victim. In Ferenczi’s work, *Confusion of Tongues between Adults and the Child* (Ferenczi, 1955), he states some of his core ideas including the concept of the victim identifying with the aggressor, and the role of the therapist to assist a victim of trauma to heal within a therapeutic atmosphere of trust, in which

the trauma can safely be relived, with the hope of instilling therapeutic change. Ferenczi also differentiated in his work the dynamic of person against person trauma in contrast to trauma that is caused by natural disasters or mass accidents (Ferenczi, 1955).

It was not until after WWII, when studies on the impact of trauma and stress were done on concentration camp survivors and new discoveries were made in regards to trauma theory including the work of Parad and Caplan (1960), who identified five components that influence the victim's ability to respond to traumatic events:

1. Stressful events are problematic because they are not perceived as going away in the near future.
2. The problem is too much for the individual or family to manage.
3. The problem is perceived by the individual or family as threatening or dangerous.
4. The period of crisis has increasing tension, followed by a moment of high intensity.
5. The problem or crisis situation brings forward unresolved issues from the past.

After the Vietnam War, even more research was done with combat survivors, and a new movement developed amongst understanding the trauma of women of domestic violence (Ringel & Brandell, 2012). According to author and activist Judith Herman (1992), the women's movement of the 1970s created a platform for women to start speaking out about the abuse that was taking place in the home and issues were raised publically that had not been spoken of previously. Herman published her ground-breaking book, *Trauma and Recovery* in 1992, speaking of the trauma women have suffered from domestic violence as well as combat survivors and spoke of trauma sharing groups as the groups that were used to "overcome barriers of denial, secrecy and shame" (Herman, 1992, p. 29). She states that at the time the groups were used as both a political movement of social change as well as for psychological healing. Other

psychologists were also expanding trauma theory including Russell (1984), who was actively researching and publishing work about sexual violence against women and girls and has since spent the last 40 years researching and advocating against rape, incest, and other forms of sexual violence. The contributions of Terr (1979) were also fundamental in developing a framework for treating children who experienced trauma, and she developed this framework after working with children who had survived a school bus kidnapping in Chowchilla, California. She published a book, *“Too Scared to Cry”* (Terr, 1992) in which she advocated for trauma recovery for children as she found that children did not simply forget the event, but rather replayed it in their minds and experienced recurring and intrusive images. These psychologists and advocates for women and children helped develop and further trauma theory.

Trauma Theory Defined

Trauma theory is now explained in a hopeful format. Levine (2005) claims that humans have the instinctual ability to heal and the intellectual capacity to work through the healing process and that trauma can impact individuals in ways that does not manifest for many years. He discusses trauma in the realm of connection, or the loss of connection that comes as a result of trauma, and can show up subtly over time, and calls this lack of connection to ourselves, to family, to our bodies and the world we live in, as the “hidden effects of trauma” (p. 9). Levine also highlighted in his work the concept of subjective trauma, and notes especially that children, “can be overwhelmed by what we usually think of as common everyday events” (p. 8). He has argued that trauma should not be defined solely within the realm of massive life catastrophes such as murder, war, or severe abuse or violence, but recognizes that “over time, a series of seemingly minor mishaps can have a damaging effect on a person. Trauma does not have to stem from a major catastrophe” (Levine, 2005, p. 8). He lists several more common events that can

take place in childhood and trigger a traumatic reaction including car accidents, falling off a bike, medical procedures, and the loss of a loved one and suggests that although some may have a reaction directly to the event, many people will have a reaction that is delayed or that manifests in subtle ways that are harder to define. According to Levine's earlier work (1997), the traditional definition used by psychologists to diagnose trauma was that it was caused by a stressful occurrence:

that is outside the range of usual human experience, and that would be markedly distressing to almost anyone . . . and encompasses the following unusual experiences: serious threat to one's life or physical integrity; serious threat or harm to one's children, spouse, or other close relatives or friends; sudden destruction of one's home or community; seeing another person who is or has recently been seriously injured or killed as the result of an accident or physical violence. (p. 24)

Levine also suggested that the definition is useful only as a starting point and that the list does not include many events that may cause trauma.

Defining psychological trauma under the diagnostic condition of Post-Traumatic Stress Disorder (PTSD) was not included in the Diagnostic and Statistical Manual of Mental Disorders (DSM) until 1980 (Ringel & Brandell, 2012), and has been changed considerably in the new (5th) edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). According to psychologists Jones and Cureton (2014), the new diagnosis has created controversy in regards to defining the condition, diagnostic criteria, assumptions about PTSD and clinical assessment. According to Breslau and Kessler (2001), nearly 80% of clients seen in mental health clinics in the USA have experienced trauma at least once in their lifetime. According to researchers Briere and Scott (2006), trauma survivors are a unique population of clients who require a specialized

and knowledgeable approach from counsellors (Briere & Scott, 2006). Before the latest revision of the DSM, psychologists were advocating for new and improved trauma diagnosis and additions to the diagnostic evaluation of trauma and stressor-related disorders (Ringel & Brandell, 2012). Ringel and Brandell state that although the PTSD diagnosis:

addresses the symptoms of posttraumatic stress, it does not focus on causes in a patient's early developmental history, which may include childhood abuse and neglect; nor does it offer a more complex and comprehensive view of psychosocial stressors and daily functioning that exert influence over all areas of adult life. (p. 6)

Herman (1992) was advocating for the term, complex PTSD, to be a diagnosis that would address the origin of trauma and how it had impacted a person's development, including women with borderline personality disorder diagnoses, who had not been treated for childhood trauma. Ford and Courtois (2009) developed a comprehensive diagnosis of complex trauma as "associated with histories of multiple traumatic stressors and exposure experiences, along with severe disturbances in primary care giving relationships" (Ford & Courtois, 2009, p. 18). van der Kolk (2003) also felt that the diagnosis of trauma needed to include all aspects of a developing child's life, and suggested a new diagnosis of developmental trauma disorder for children who had experienced complex trauma throughout their development. van der Kolk (2005) felt that this diagnosis would specifically address the developmental consequences of early trauma, including neglect and abuse and suggested that "multiple exposures to childhood traumas, including abandonment, betrayal, physical or sexual assaults, or witnessing domestic violence" (p. 406) have negative results for the developing child, and can impact the child, adolescent and eventually adult life experience. This connection of early trauma resulting in negative results for the developing adolescent is discussed further in the final chapter of this thesis.

The diagnosis for PTSD in the DSM-IV-TR (2000) included the diagnosis amongst anxiety disorders, and required the presence of six out of 17 symptoms that were distributed amongst three core clusters of symptoms. Clients who were suffering from symptoms in relation to trauma, with trauma being defined as an event that included fear, helplessness, or horror (Jones & Cureton, 2014), were assessed for at least one symptom of persistent re-experiencing (criterion B), three symptoms of avoidance or emotional numbing (criterion C), and at least two indicators of increased arousal (criterion D), and these symptoms must be present for one month (American Psychiatric Association, 2000). Finally, clinicians were required to assess whether the condition was chronic, acute, and/or with delayed onset (American Psychiatric Association, 2000). The fifth edition of the DSM, DSM-5 (American Psychiatric Association, 2013) contains many changes including a complete re-organization of Trauma and Stressor-Related Disorders (TSRDs) into a new and independent category, separate from other anxiety disorders and including a new type of PTSD for children (Jones & Cureton, 2014). There are four disorders under the heading of Trauma and Stressor-Related Disorders including acute stress disorder, adjustment disorder, reactive attachment disorder and posttraumatic stress disorder (DSM-5) and according to the American Psychiatric Association (APA, 2013), there are significant changes to the criteria required for diagnosis (Grohol, 2013).

The fourth disorder, under Trauma and Stressor-Related Disorders, PTSD, has changed quite significantly in the criteria, most specifically “language stipulating an individual’s response to the event, intense fear, helplessness, or horror, according to the DSM-IV, has been deleted because that criterion proved to have no utility in predicting the onset of PTSD” (Grohol, 2013, p. 1). The diagnosis criteria now includes specific language about what constitutes a traumatic event (American Psychiatric Association, 2013), explicitly stating sexual violence, and separate

developmental criteria has been developed for children and adolescents, with lower diagnostic thresholds and a specific PTSD preschool subtype, with criteria for children under the age of six. There is also a PTSD dissociative subtype, which includes PTSD symptoms as well as significant dissociative symptoms (American Psychiatric Association, 2013). There are now four clusters instead of three, including:

1. Re-experiencing of the event: including intrusive memories, recurrent dreams, and flashbacks;
2. Heightened arousal: including aggressive or self-destructive behaviour, sleep disturbances, and hyper-vigilance;
3. Avoidance: including distressing memories, thoughts and feelings; and
4. Negative thoughts, mood or feelings: including blame of self or others, estrangement, diminished interest in activities, or inability to remember events.

(American Psychiatric Association, 2013)

There are also changes to Other Trauma Related disorders including Acute Stress Disorder, Adjustment Disorders and Reactive Attachment Disorders. The Acute Stress Disorder has been updated similarly to the PTSD criteria (DSM-5) and Adjustment Disorders and re-

conceptualized now as a stress-response syndrome . . . and takes them out of their residual, catch-all category and places them into a conceptual framework that these disorders represent a simple response to some type of life stress (whether traumatic or not). (Grohol, 2013, p. 2)

Reactive Attachment Disorder now has two separate subtypes including reactive attachment disorders as well as disinhibited social engagement disorder (DSM-5).

PTSD is a significant part of trauma, and trauma theory can be summarized as representing a fundamental shift in thinking from the idea that those who have experienced psychological trauma are deficient and sick, and not able to manage, to a reframing that suggests having experienced trauma is an injury that needs to be healed (The Center for Nonviolence and Social Justice, 2014). The aspect of trauma theory that is debated most frequently is the aspect of repressed memory, and this is the result of many legal cases that came forward in the 1980s in regards to recovered memories of sexual abuse (Suleiman, 2008). According to Suleiman,

there are two very hostile camps here, as far as I can see, and both of them are linked in interesting ways to Freud. Members of the first camp, which includes clinicians such as Judith Herman as well as researchers, among them Bessel van der Kolk, believe firmly in the theory of dissociation, which is related to (though not identical with) the concept of repressed memory, or traumatic amnesia. According to this view, the more horrific and prolonged the trauma, the more the subject has a tendency to dissociate and therefore have no conscious memory of the traumatic event. Thus, a child or even an adolescent who is subjected to repeated sexual abuse by a family member may very well not remember it until he or she (the overwhelming majority being girls) enters into therapy as an adult; at that point, the patient may recover memories in a gradual process, sometimes with the help of hypnosis. Only by finally remembering the repressed trauma can the patient move on to recovery, that is, to “mastery” and healing. (Suleiman, 2008, p. 276)

According to Suleiman (2008), other psychologists argue that this same process can create false memories. According to the American Psychological Association (2013) false memories cannot be distinguished without validating evidence of their existence. Repressed memories are found within the dissociative amnesia diagnosis, which is defined in the DSM-5 with the following

symptoms:

1. Unable to recall autobiographical memory associated with a traumatic event.
2. The recall of traumatic events is usually unconscious.
3. The inability to recall traumatic events creates distress.
4. The memory dysfunction does not have a physiological cause.
5. The memory dysfunction is not dissociative identity disorder.
6. The memory loss is not a result of substance abuse or other substance.

(American Psychiatric Association, 2013)

Symptoms of Trauma

The specific symptoms of dissociative amnesia represent one aspect of diagnosing trauma in clients. There are many other presenting symptoms that can occur for survivors of trauma, and according to Levine (2005), these symptoms may not happen all at once. Levine states,

it can happen slowly, over time, and we adapt to these subtle changes sometime without even noticing them. These are the hidden effects of trauma, the ones most of us keep to ourselves. We may simply sense that we do not feel quite right, without ever becoming fully aware of what is taking place; that is, the gradual undermining of our self-esteem, self-confidence, feelings of well-being, and connection to life (Levine, 2008, p. 9).

Levine (2008) states that other symptoms include avoidance of feelings, people, situations, and places more specifically defined in the DSM 5 in two separate criteria in the diagnosis of PTSD as both avoidance and numbing. For a PTSD diagnosis, along with meeting the criteria for the identified stressor, as well as intrusive thoughts, changes in arousal, duration of symptoms, and functional significance (DSM 5), the symptoms of avoidance include meeting one requirement for either: 1) persistent effortful avoidance of trauma related thoughts or feelings or 2) persistent

effortful avoidance of trauma related people, places or things (DSM 5). The symptoms for numbing, defined in the DSM 5 as negative alterations in cognitions or mood requires two of the following symptoms to meet the PTSD diagnosis requirements:

1. Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol, or drugs).
2. Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., "I am bad," "The world is completely dangerous").
3. Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences.
4. Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest in (pre-traumatic) significant activities.
6. Feeling alienated from others (e.g., detachment or estrangement).
7. Constricted affect: persistent inability to experience positive emotion.

(American Psychiatric Association, 2013)

These symptoms outline the requirements for a diagnosis for PTSD, but may also outline the symptoms that many clients can have who are experiencing trauma related stress symptoms, but who may not meet all the criteria for a PTSD diagnosis.

The DSM 5 provides a thorough and clinical diagnosis for different types of trauma, and how it has been caused. According to Levine (2008), "trauma is trauma, no matter what caused it" (p. 11) and he also asserts "people can be traumatized by an event they *perceive* (consciously or unconsciously) to be life-threatening. This perception is based on a person's age, life experience, and even their constitutional temperament" (Levine 2008, p. 11). He states that consistent shouting of angry adults, although not perceived as life-threatening, can traumatize

children and affirms that the critical factor in defining trauma is the perception of threat, and the inability to deal with the threat. Levine states “when you are threatened, your body instinctively generates a lot of energy to help you defend yourself against the threat” (p. 14) and this energy, when not properly released, gets trapped in the body and shows up in a variety of symptoms.

According to Herman (1992), certain experiences increase the likelihood of harm from a traumatic event, including: being surprised, being trapped, being exhausted, physical violation or injury, exposure to physical violence, and witnessing death. Similar to Levine, (2005), Herman claims that traumatic symptoms have a unique trajectory for each person. She also claims that because children acquire basic trust in their primary relationships, when trauma occurs, there is damage to the survivor’s sense of community and faith (Herman, 1992). Herman also claims that symptoms can show up in terms of outbursts of anger, intolerance of rage, desperate pursuit of intimacy as well as complete disconnection from being close to anyone, and negative self-worth as a result of shame and helplessness. She also suggests that symptoms of trauma come out most significantly within other relationships and trauma survivors often have a difficult time establishing boundaries, handling conflict, and they frequently denigrate self and others, they may also unconsciously submit to strong personalities and positions of authority, as well as potentially miss cues of danger due to dissociative tendencies causing patterns of unstable relationships. Levine (2005) claims:

that we hold our trauma in our bodies and that when our bodies are feeling uneasy, they give us messages. The purpose of these messages is to inform us that something inside doesn’t feel right, and it needs our attention. If these messages go unanswered, over time, they evolve into the symptoms of trauma. (p. 14)

Levine (2008) outlines the initial symptoms that can arise after a trauma and he includes the following: hyper arousal, constriction, dissociation, and feelings of helplessness. He describes the hyper arousal symptoms to be as follows: increased heart rate, sweating, rapid or shallow breathing, muscular tension, cold sweats, and tingling (Levine, 2008). He describes constriction as the reaction of our body to stress, which is by constricting blood vessels and internal organs to produce more blood to the muscles that are tensed and ready for action, and the digestive system shuts down. Dissociation and denial is described by Levine as occurring between the person and the memory or feelings about the event and can often represent itself within the body as chronic pain. He describes feelings of helplessness and numbing as a reaction to an overwhelming situation. Following the initial symptoms, he suggests three distinct groups of symptoms that can present after the trauma and that can be used to help examine how trauma is currently affecting a survivor. The first group occurs after the initial symptoms and can include hyper vigilance, flashbacks and intrusive thoughts, hyperactivity, sensitivity to light and sound, startle responses exaggerated, nightmares, mood swings, shame, lack of self-worth, difficulty sleeping, and inability to deal with stress (Levine, 2008). The second grouping occurs later, perhaps even years later and may include panic attacks, anxiety, phobias, feeling spaced out, avoidance behaviour, being attracted to dangerous situations, addictive behaviours, high sexual activity or low sexual activity, amnesia, inability to bond and love others, self-mutilation, and loss of faith (Levine, 2008). The third group of symptoms take longer to develop and can be sometimes present, be triggered by stress, or be present all the time. These symptoms are: shyness, inability to make commitments, chronic fatigue, immune system problems, psychosomatic illnesses, chronic pain, asthma, skin disorders, and depression. The last symptom is the “compulsion to repeat” (p. 19) or re-enactment, which is described as the “compulsion to repeat the actions that caused the

problem in the first place . . . we are inextricably drawn into situations that replicate the original trauma in both obvious and less obvious ways” (p. 19). We see examples of this in children of sexual abuse who go on to abuse, as well as female victims of domestic violence who choose similar partners again. The other possibility is avoidance, which he suggests, is simply staying away from what caused the trauma, such as avoiding swimming if there was a near-drowning trauma.

The Long-Term Effects of Trauma

Trauma can have long-term effects, such as hyper-vigilance and anxiety, or as Herman (1992) suggests in the way one functions within relationships after trauma has occurred. Psychiatrist McFarlane (2010), who worked in the centre for Military and Veteran Health at the University of Adelaide in Australia, claimed that without treatment, trauma can have long-term costs to the individual physically and psychologically. He advocates for the timely “dysregulation of cortical arousal and neurohormonal abnormalities following exposure to traumatic stress” (p. 3). McFarlane suggests “one of the greatest challenges to the field of traumatic stress has been the observation that many individuals who coped at the time of their traumatic exposure became unwell at a later date” (p. 3). Levine (2008) echoes this argument in his work and suggests that the healing of trauma is primarily a biological process that takes place in the body and can be accompanied by psychological effects. He suggests that when a threat is perceived, both mind and body react and release energy in order to fight or to escape the situation (flight) and when the threat diminishes, and the body has physically reacted by either running or fighting, the energy that was sent to the body is released, and the individual is able to return to a regular functioning state. For trauma survivors, when the energy is not released, and the threat is not diminished, high levels of adrenaline and cortisol continue to be released and

become trapped in the body. This state of being “frozen” is described as an immobility response and an appropriate response to a situation where fight or escape are not options; however, he also feels that the individual has trouble normalizing after the frozen state and that this “difficulty in normalizing ourselves is very important. “I believe that the ability to return to equilibrium and balance, after using the immobility response is the primary factor in avoiding being traumatized” (Levine, 2008, p. 29).

The long-term impact of trauma has been recently understood better through neuroscience and researchers now suggest that “the impact of trauma on brain structure is quite significant” (Ringel, 2012, p. 90). The brain is composed of three interdependent sections: hypothalamus and brain stem (internal homeostasis), the limbic system (balance between external reality and internal world) and the neocortex (analysis of the external world) (Ringel, 2012). The right hemisphere of the brain is linked to the amygdala, which regulates hormonal responses, and is processing nonverbal emotional expression, and the left hemisphere processes verbal communication and problem solving tasks (Ringel, 2012). According to van der Kolk (2003), during a traumatic experience the left hemisphere of the brain may fail to function properly. People who suffered from PTSD demonstrated a physical change in brain structure, such as reduced volume in the hippocampus, which results in a reduced ability to process information.

Other long-term effects of trauma have been studied in relation to quality of life, health, and functioning. According to the Substance Abuse and Mental Health Services Administration (2014) most types of physical ailments commonly associated with PTSD are the results of repeated trauma exposure. According to Jovanovic et al. (2011) family relationships and the behaviour of family members involved or witnessing the trauma can be effected. According to

the Substance Abuse and Mental Health Administration (2014), children of mothers who experienced abuse in childhood have more physiological anxiety responses than mothers who were not abused as children. Other disorders that can be related to trauma include: mood disorders such as depression and dysthymia, other anxiety orders including generalized anxiety disorder and obsessive compulsive disorder, as well as impulse control disorders including oppositional-defiant disorder and intermittent explosive disorder, as well as alcohol use and dependence (Kessler et al., 2005). Kessler et al. also suggested that a PTSD diagnosis significantly increased the risk of developing a substance use disorder.

According to research done by McFarlane (2010), there is a link between PTSD and the risk of developing hypertension, and that there was also an increased rate of cardiovascular disease associated with PTSD. He further suggests that there is a link between trauma and obesity, hyperlipidemia, coronary heart disease, as well as psychosomatic syndromes.

McFarlane states,

in essence, the internal physiological environment of an individual adapts to external demands. This dynamic regulatory process involves a continuous adaptation of physiology in response to environmental demand. When the body is repeatedly stressed, the consequent allostatic state has the capacity to disrupt an individual's health. (p. 8)

Conclusion

Trauma theory can assist practitioners when assessing clients for trauma and trauma related behaviour. The research that has been developed in recent years about the brain system and how different areas of our brain respond to stress and trauma helps us to understand the long-term effects that trauma can have on an individual's brain development and functioning. Understanding the impact of trauma and how it appears symptomatically is a process of recovery

and healing, whether those symptoms are physical, somatic, physiological, or expressed as depression or anxiety. McFarlane (2010) states “in some individuals, the apparent adverse consequences of the stress exposure lie dormant for a long time before some intercurrent adversity leads to its manifestation” (p. 9). As Levine (1997) states in his initial work:

the key to healing traumatic symptoms in humans is in our physiology. When faced with what is perceived as inescapable or overwhelming threat, humans and animals both use the immobility response. The important thing to understand about this function is that it is involuntary. This simply means that the physiological mechanism governing this response resides in the primitive, instinctual parts of our brains and nervous systems, and is not under our conscious control. (p. 17)

In the next essay, I will explore how one might apply the knowledge obtained through trauma theory and trauma research in order to assist victims of bullying.

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ESSAY 3 TRAUMA INFORMED CARE FOR VICTIMS OF BULLYING

In this third essay, I explore how counsellors and mental health professionals can assist victims of bullying in order to reduce short and long term negative physical and psychological problems that are associated with bullying by applying trauma theory and trauma interventions. I address how to assess for trauma and how to use trauma informed assessments with victims of bullying. I explore barriers to reducing the traumatic impact of bullying on the victim and suggest some preventative options as well as explore possible trauma-based interventions that will assist victims of bullying.

Assessing for Trauma

Defining whether a bullying episode or an ongoing history of bullying is traumatic for the individual can be difficult because it is the “individual’s perception of an event,” which defines the trauma (Roberts, as cited in Hopson & Kim, 2004, p. 95). Assessing for trauma takes place as soon as an individual comes in for counselling, however, disclosing trauma can take some time for a client (Bedard-Gilligan, 2012). In order to assess for trauma, counsellors need to ask questions about a wide range of life events and assess for severity, impact, as well as determine if there are any impairments to developmental stages (National Child Traumatic Stress Network, n.d.). The network also suggests that counsellors will need to assess for symptoms, and if any risk behaviours are present, and will need to do this by using a variety of techniques, including clinical interviews, observation, as well as standardized measurements. This thorough initial assessment allows the counsellor to make an initial assessment that will continue to be re-evaluated during therapy. Bullying may be experienced traumatically for adolescent girls “although not all children and youth experience bullying as traumatic, research is needed to explore the individual, interpersonal, and ecological factors and conditions that contribute to

bullying when it is experienced as traumatic” (Mishna & Sawyer, as cited in Ringell & Brandell, 2012, pp. 150-151). Hopson and Kim suggest that there are many factors that affect an adolescent’s perception of trauma including: developmental stage, personality, life experiences, maturity level, resiliency, and other protective factors, including ability to cope, which can impact one’s ability to respond to an event as traumatic or not (Hopson & Kim, 2004). Mishna and Sawyer (2012) suggest that being a victim of bullying can be experienced as traumatic and van der Kolk, McFarlane and Weisaeth (1996) suggest that repeated verbal and emotional abuse and neglect can result in individuals developing strong emotional reactions that cause psychological changes that are troublesome to them. According to Stolorow and Atwood (1992), trauma is a relationship issue and they state “pain is not pathology. It is the absence of adequate attunement and responsiveness to the child’s painful emotional reactions that renders them unendurable and thus a source of traumatic states and psychology” (p. 54). McFarlane (2010) suggested that trauma symptoms appear to be more severe with repeated exposure to injury.

Briere and Scott (2006) suggest that trauma survivors require an approach whereby specialized and knowledgeable counsellors are applying multifaceted considerations on behalf of the client. According to Fallot and Harris (2006), “significant trauma concerns are frequently overlooked in professional settings. In the assessment process, two broad factors contribute to this relative neglect: underreporting of trauma by survivors and under recognition of trauma by providers” (p. 23). When a counsellor is assessing a client and attempting to understand the extent of a bullying experience, and if there has been trauma, the approach “requires including applying both informal and formal approaches, using multiple sources of information, and conducting initial and ongoing screenings” (Jones & Cureton, 2014, p. 10).

It can be difficult to assess for trauma with clients, as it requires skill and sensitivity to

solicit this information in the early stages of counselling work (Jones & Cureton, 2014). Jones and Cureton also suggest that it may be difficult for some clients to disclose trauma while other clients may reveal detailed stories of their traumatic experience. Nevertheless, “developing and continually fostering the therapeutic alliance are essential to client disclosure and in conscientiously deciphering such information” (p. 11). If a bullying experience has been disclosed by the client, it would be essential to examine the following factors: frequency of the bullying, nature of the bullying, severity, type of bullying as well as the response of the adults involved, including whether adults believe the youth who is disclosing the bullying, whether they were given support, or whether the bully was challenged and held responsible for the experience (Mishna, 2004; Mishna, Pepler, Scarcello, & Wiener, 2005). Once the bullying has been identified, it is crucial for the victim’s experience to be validated, and “to recognize and acknowledge the potentially devastating effects of peer victimization” (Mishna & Sawyer, as cited in Ringel & Brandell, 2012, p. 153).

An ecological systems approach should be used when assessing bullying and trauma, which includes “prioritizing influencing factors” (Mishna, 2012, p. 103) and making an assessment where in the system to intervene, and to determine if the bullying is still ongoing. It is important to know whether the problem for the individual is based on experiences at school, with friends on line or with strangers, and where the child would benefit the most from support and training. When bullying is ongoing, communication skills and assertiveness training may be helpful to a child and these can be learned at home within the family context (Mishna, 2012). However, in some cases a child may need support and intervention at school as the problem may lie with a difficult friend group, or with youth that may need training and intervention about inclusion and kindness to others (Mishna, 2012). When assessing for trauma, there is always a

risk of re-traumatization and sessions must be paced with this in mind (Jones & Cureton, 2014). Counsellors should be observing their clients for non-verbal clues—particularly symptoms of numbing, avoidance, or dissociation—that may suggest that there has been trauma (Jones & Cureton, 2014). Reckless behaviour or self-harm should be noted as well (Jones & Cureton, 2014).

Trauma Informed Care

Trauma informed care requires screening and focused inquiry (Fallot & Harris, 2006). They suggest trauma informed care assists counsellors and practitioners to identify trauma survivors who need specialized care and helps clients know they are in a safe place where trauma is recognized as real and significant. Hopper, Bassuk, and Olivet (2010) summarized common themes about trauma informed care including: creating an awareness of how symptoms are related to the trauma, an emphasis on safety, assisting individuals to develop a sense of control over their life, and an emphasis on strengths. Hopper et al. (2010) provide a definition of trauma informed care, which is as follows:

trauma informed care is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, which emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment. (p. 82)

An extensive review of trauma literature done by Substance Abuse and Mental Health Services Administration (2014), references the seminal work of Harris and Fallot (2001), where trauma informed care is described as a system:

in which administrators and staff understand how traumatic experiences negatively affect behavioural health in multiple ways and are committed to responding to those needs through universal trauma screening, staff education and training regarding trauma and its effects, and willingness to review and change policies and procedures to prevent the (re) traumatization of clients. (p. 8)

Trauma informed care is relevant when working with adolescents as “adolescents seem particularly vulnerable to trauma” (Carney, 2008, p. 179). Carney interviewed 91 sixth grade students (55 females and 36 males) from a rural school district in the middle of the United States, and asked the students questions regarding repetitive bullying experiences and predicted trauma levels, using a hypothetical bullying scenario. Fifty percent of the students responded to his questions, and Carney states, “the most significant outcome from this study is that frequency of exposure to bullying events was the greatest factor in predicting trauma level” (p. 184). Hopson and Kim (2004) assessed the efficacy of solution-focused therapy for adolescents in crisis, which is defined as trauma in the way that it is used in their work, and found that “adolescents may be at greater risk than adults for experiencing a crisis because the developmental tasks associated with adolescence and daily environmental stressors can require sophisticated coping strategies” (Hopson & Kim, 2004, p. 94). An adolescent is at risk of feeling in crisis when she or he does not feel in control over her or his daily life and as a result she or he may be having conflicts with parents and peers, mood fluctuations, and be experimenting with various risky behaviours (O’Halloran & Copeland, 2000). They assert that this time in adolescent development makes adolescents more vulnerable to crisis and trauma as they are often already in a state of disequilibrium (O’Halloran & Copeland, 2000).

Obstacles to Reporting and Treating Victims of Bullying

One of the reasons for adolescent girls not reporting bullying situations is that they are given the message that bullying is just one of those hurtful parts of growing up, and they can become unsure about whether what is happening is worthy of reporting, and can often doubt their perception of the events, an attitude that can minimize the potentially traumatic effects of bullying (Mishna & Sawyer, 2012). Children are also often asked by adults to solve bullying problems on their own, which leaves the victim to resolve their own feelings of helplessness (Craig, Pepler & Blais, 2007). Female adolescents “may experience traumatic reactions to bullying through different pathways such as avoidance or intrusion of triggering stimuli” (Carney, 2008, p. 179). Female adolescents who react to the bullying with avoidance are less likely to report the event or seek counselling, and may develop a diminished interest in school, people, and relationships as a result of the trauma (Carney, 2008). The school environment could be another obstacle to reporting depending on the attitude of school counsellors and teachers. Psychologists Craig, Henderson, and Murphy (2000) suggested that the common belief that indirect bullying is not as damaging as physical bullying is still deeply entrenched in the school system. Despite the inclusion of language in anti-bullying school policies the same intolerance exists for indirect bullying, Craig et al. found that common forms of indirect bullying such as social exclusion and verbal aggression are often overlooked, or unrecognized, and often not considered bullying or requiring intervention. In a study by Hazler, Miller, Carney, and Green (2001), 251 professional counsellors and teachers were asked to differentiate between bullying and other forms of conflict. The study included 21 scenarios that were presented to the participating professionals. Findings revealed that professionals were able to more easily identify physical altercations as bullying, and also rated these scenarios as more severe than verbal abuse or social and emotional bullying scenarios (Hazler et al., 2001). Hazler et al. (2001) concluded

that adults do not know with certainty what constitutes bullying and that is why they are hesitant to interfere.

Female youth who are already marginalized may also not report bullying behaviour because they have developed an untrusting attitude towards school professionals and fear further victimization (Fontaine, 1998). LGBTQ adolescents, for example, are vulnerable to bullying and this vulnerability is “exacerbated by conditions that foster victimization across their entire social ecology, including peers, siblings, parents, teachers, religious authorities, coaches, as well as in social policies, the law, societal institutions, and the media” (Mishna, 2012, p. 113).

Marginalization reduces the individual’s chances for reporting trauma and bullying as their lack of faith in the system and people in positions of authority is diminished (p. 113).

Another obstacle to reporting bullying and related trauma is fear for retaliation—“victimized children may perceive more risks than benefits in telling” (Mishna, 2012, p. 112).

Female adolescents who consider themselves to be competent and able to solve their own problems may also avoid telling teachers (Mishna, 2012). She also suggests that other factors that may prevent children and youth from speaking up include self-blame, fear of losing friendships, not expecting a helpful response, and secrecy.

Another obstacle for reporting bullying is impairment in the traumatized victim: positive school achievement, for instance, may require cognitive ability but also hinges upon the capacity to concentrate, ability to modulate arousal levels, ability to regulate behavior and control impulses, frustration tolerance skills, and interpersonal relationship capacities. Children who have experienced trauma may have impairments in any or all of these domains. (Blaustein & Kinniburgh, 2010, p. 15)

Female adolescents in stressful environments and who may have experienced failure or exclusion may develop a negative self-concept and helplessness and hopelessness may emerge, making asking for help a difficult task (Blaustein & Kinniburg, 2010). Also, when an adolescent already considers herself to be different from her peers, and possibly self-critical, social exclusion is reinforcing the belief that she is unwanted and not worthy of support and friendship—girls who are already struggling socially at school may develop the belief that “others are examining them as intently as they are examining themselves and can lead to self-consciousness and crystallization of a negative self-identity” (Blaustein & Kinniburg, 2010, p. 16). After bullying and the resulting trauma, it is also difficult for female adolescents who have not developed advanced coping skills or cognitive development to handle the situation—individuals who have been traumatized typically use primitive coping skills which can lead to further problems and isolation (Blaustein & Kinniburg, 2010). Some traumatized adolescents use control methods such as perfectionism and restricting their emotional experiences with others, while others may use more external forms of coping including substance abuse, cutting or other methods of self-harm, or sexual interaction (Kilpatrick et al., 2003). These coping methods may separate adolescents from their parents, their peers, and their identity “may involve splintered aspects of self, which are not integrated into a coherent whole” (Blaustein & Kinniburg, 2010, p. 17).

Prevention

Bullying prevention programs have shown poor levels of success—the difficulty lies in measuring and conceptualizing bullying behaviour (Griffin & Gross, 2004). Hinduja and Patchin (2014) suggest that in order to help reduce the incidences of bullying, students should have a clear understanding of the types of behaviour that will not be condoned at schools and be aware of the associated discipline. They also advocate for communication with parents, preventatively,

ensuring that parents are aware that all bullying behaviour will be dealt with seriously, and will not be trivialized. The Olweus Bullying Prevention Program was developed in Norway by Olweus in 1993 in response to a national campaign to reduce bullying (Olweus, 1993). The program had three distinct goals: reducing existing bullying in schools, preventing the development of new bullying problems, and improving peer relationships at schools (Olweus, 1993). Olweus believed that the program would counteract risk factors, which he defined as: lack of parental warmth and involvement, poor supervision, lack of rules and discipline, and harsh or abusive punishment of children (Olweus, 1993). Olweus suggested that adults in school systems should be following four guidelines:

1. Show warmth towards students and take an interest in them.
2. Set limits that are firm and understood by students for behaviour.
3. Use non hostile and non-violent consequences for poor behaviour.
4. Act as positive role models and authority figures.

Olweus implemented his program in the hope that it would be used indefinitely in all schools and would alter school environments as well as meet individual needs for repair and reconciliation of bullying events (Olweus, 1993). The above mentioned program was successful in Norway, but not as much in the US (Limber, as cited in Espealage & Swearer, 2011) with the largest barriers to its success being lack of awareness of school staff of bullying behaviour taking place at school, and getting school staff to commit to prevention strategies. Lack of consistency and the need for a school wide approach and policy at the national level to replace the piecemeal and situational approach that has been the norm for most schools, may be the reasons that bullying is not being solved adequately (Limber, as cited in Espealage & Swearer, 2011). Bob Chase, President of the National Education Association (Chase, as cited in Limber, 2002), stated that

single school assemblies and a curriculum taught by the health nurse will not change bullying, but adjusting the school climate and reinforcing positive behaviour in schools are the way to alter violent and aggressive bullying behaviour (Limber, 2002). Noddings, (1988), an advocate for relational care within the school system, recognized that ethical caring requires deliberate effort that is not required in natural caring. She felt that “we are not justified, we are obligated, to do what is required to maintain and enhance caring” (Noddings, 1984, p87). Noddings proposed that all schools adopt an ethics of caring model, including an approach that connects teachers and students by encouraging that both parties spend time together outside of the teaching dynamic, so that a solid relationship of trust can be established. She suggested that in order to encourage a moral education as well as an academic one, four components of caring need to be included in the school culture: modeling, dialogue, practice, and confirmation (Noddings, 1988). Although Noddings work is not directly related to preventing bullying, she is suggesting that a school culture of caring for one another, and teachers modeling an environment of caring, is the best practice for creating a positive school environment. Hinduja and Patchin, (2014) have stated that “the benefits of a positive school climate have been identified through much research over the last thirty years. It contributes to a more consistent attendance, higher student achievement, and other desirable student outcomes. Though limited, the research done on school climate and traditional bullying also underscores its importance in preventing peer conflict” (Hinduja & Patchin, 2014, p7). They also state the need for educators to develop and promote an environment that is safe, and respectful, including a shared feeling of “connectedness, belonging, peer respect, morale, safety, and even school spirit” (p7).

Bullying prevention requires an “operational definition and identification of casual variables over which parents, educators, and professionals have control” (Horner & Ross, 2009,

p. 3). Horner and Ross (2009) conducted a study with six students across three elementary schools in the Oregon school district of varying socioeconomic status in order to evaluate their ground breaking intervention, which they called bully prevention in positive behaviour support (BP-PBS). The students were identified by their principals as highly aggressive, either physically or verbally, to peers. The results of the study confirmed reduced incidents of bullying at the respective schools and staff rated the program as effective and efficient (Horner & Ross, 2009). This prevention practice included a three-tier prevention model, with a focused on respectful behaviour. The first tier focused on creating positive and predictable environments for students by teaching all students a clear three step (stop, walk, talk) response when they encountered difficult behaviour, as well as teaching teachers an appropriate response to the students when this skill was used by students, and training staff universally on appropriate responses to the individual who had been reported for their behaviour as well. The secondary tier includes more specific training for select students who appeared to be at risk or were struggling with the primary tier objectives. The third tier was suggested for students who had negative behaviour patterns and needed a more thorough response and analysis in order to reduce negative behaviour patterns. The third tier may require outside resources, school counsellors, and family involvement (Horner & Ross, 2009). The study provides a prevention model that identifies what may be one of the key issues in reducing bullying behaviour and associated trauma for victims, and that is reducing the positive social impact that the bully receives from bullying. This is just one example of how to prevent bullying in schools. Other ideas include effectively identifying peer group issues within the school system. Gest (2006), in his study on teachers' ability to accurately report peer group systems, found that teachers vary widely in their ability to identify peer systems, popularity, kindness, and exclusion and he also found that many teachers had a

very low level of awareness for the social ecology of their students (Gest, 2006). This is another aspect of prevention that could be helpful, having teachers be accountable for understanding the social context of their classrooms, in a more reliable way. Bullies often pursue “power, popularity or domination more so than non-bullying peers” and identifying these youth and guiding them to better behaviour patterns within the school and community could be a very helpful form of prevention (Hawley, Stump, & Ratliff, as cited in Espealage & Swearer, 2011, p. 105).

Interventions

Although obstacles to reporting bullying behaviour and associated trauma appear to exist throughout schools and systems, and while many schools do have bullying prevention programs in place, it appears that when bullying is reported, different approaches are used to help victims of bullying to heal and move on. According to Mishna (2012), bullying is a relationship issue and the interventions must take place within a relational context. Mishna (2012) states “the relationship is the underpinning for all interventions, regardless of their nature, target or goal” (Mishna, 2012, p. 120), and Olweus asserted that interventions must encompass all levels of the system including school, classroom, parents, teachers, individual youth, and broader structural initiatives must support the individual’s healing and recovery (Olweus, 1993). In order to identify whether trauma has occurred within the bullying episode, an assessment for trauma needs to take place to determine the level of trauma, if there is trauma, and trauma-informed care needs to be used to offer trauma counselling for the victim where trauma has occurred. While there may be similarities and patterns, adolescent females’ responses to similar bullying experiences are unique. If trauma has been identified through assessment, three stages of recovery must be used to stabilize and ground a trauma victim: establishing safety, reconstructing

the traumatic story, and restoring the connection between the survivor and his/her community (Herman, 1992). Herman suggests different stages of recovery for victims of bullying. In order to complete the first stage of recovery the victim needs to no longer feel vulnerable and at risk, develop social supports, and self-regulate her symptoms that have developed as a result of the trauma. Second stage recovery includes constructing what happened and how the victim felt during the time of the trauma, and to help the victim to rebuild her life and her view of humankind. There may be a period in which the victim is mourning lost friendships, or loss of social status, or loss of a sense of belonging, and eventually reclaim her new life with hope, energy, and engagement. The third stage of trauma recovery is about reconnecting to the world, developing new relationships, developing a new sense of self, and finding personal empowerment, as well as letting go of the aspects of one's self that were formed as a result of the trauma. The final task is for the individual to turn attention away from recovery to the tasks of ordinary life.

The most significant issue identified for some time in preventing positive interventions is the tendency for victims to not disclose their traumatic bullying situation (Hinduja & Patchin, 2014). According to Mishna (2012), there are seven guidelines that can help practitioners to assist a victim who they may suspect is in a bullying situation, and may need trauma counselling and intervention. They are:

1. Recognizing that naming and defining bullying is a complex task.
2. Listen and validate the child's experience.
3. Offer empathy to the victim.
4. Recognize and address the impact of the whole range of bullying that has occurred.
5. Address any biases against telling, or naming the behaviour as bullying.

6. Reduce misconceptions about how victims of bullying need to present.
7. Help children and youth to see that turning to adults for help can make the situation better.

Understanding bullying from an ecological context allows us to support victims of bullying by supporting their whole experience, whether they view it as traumatic or not (Mishna & Sawyer, as cited in Ringel & Brandell, 2012). A victim is susceptible to “feeling traumatized due to her bullying experiences as a result of several coinciding and interacting elements” (p. 158) that may have been present at the same time as the bullying. Clinicians need to assess the whole ecological context in order to ensure that interventions are planned effectively to reduce further traumatization (Mishna & Sawyer, as cited in Ringel & Brandell, 2012). Such examples of interacting elements could be a lack of parental support or validation, previous bullying experiences, low self-esteem, depression, and/or anxiety (Mishna & Sawyer, as cited in Ringel & Brandell, 2012). An effective intervention to reduce further traumatization to someone who has been bullied and has other interacting elements, is to help the victim understand that depression, low self-esteem, or other maladjusted behaviours are related to the bullying, and by stopping the bullying, symptoms may improve (Mishna & Sawyer, as cited in Ringel & Brandell). Coping skills such as mindfulness, grounding, and relaxation exercises can be helpful; however, most importantly for adolescent females, it is the “clinician’s inquiry, interest and empathetic understanding provided . . . with needed mirroring and validation, which strengthened her sense of self, increased her self-esteem, and fostered her ability to increasingly recognize and identify her feelings” (Mishna & Sawyer, as cited in Ringel & Brandell, 2012, p160). The importance of believing and validating a victim’s story cannot be emphasized enough and failure to validate an experience of bullying for an adolescent or child can lead to feelings of traumatization even if the

bullying itself did not lead to such (Stolorow & Atwood, 1992)—“regardless of the nature or perceived severity of the bullying, however, a child can feel traumatized if adults do not listen, respond or intervene appropriately” (Mishna & Sawyer, as cited in Ringel & Brandell, 2012, p165).

Solution-focused therapy offers another style of intervention for victims of bullying who may be traumatized by the experience. The first challenge is determining whether the adolescent females consider themselves to be in a crisis or not and then responding appropriately (Hopson & Kim, 2008). “[D]espite the variation among approaches, there are commonalities between the different models” (Hopson & Kim, 2004, p. 96). A strength-based approach to crisis intervention has a hopeful view of intervention, with an “opportunity to develop new coping skills and leave the client with more strengths and resources after the crisis is resolved” (Hopson & Kim, 2004, p. 96). Increasing resiliency for future problems, focusing on present symptoms rather than the history of the problem, and goal setting are part of solution-focused therapy—even with clients who may be feeling overwhelmed Hopson and Kim (2004). Setting small and manageable goals can help ground a client and create a sense of safety (Hopson & Kim, 2004). Another possible goal for solution-focused therapy in a situation where a client has been bullied and has developed trauma symptoms, according to O’Halloran and Copeland (2000), is reducing feelings of self-blame. Working with a client to focus on strengths and to see problems outside of themselves are two key techniques used to reduce feelings of self-blame (Hopson & Kim, 2004). A solution-focused therapist may also ask relationship questions, which could include questions about how other people in the client’s life see the problem; scale the problem and track these changes week to week; deliver compliments; ask the miracle question, which includes asking what the client would do if she woke up one morning and the problem no longer existed, what would be

different; track exceptions to the problem; and negotiate goals for change (Hopson & Kim, 2008). During therapy, the therapist would always be focused on ensuring a supportive working relationship is in place and assist the client to develop confidence that she or he can overcome the problem (Hopson & Kim, 2008). Although not seen as traditional trauma therapy, solution focused therapy can be helpful to adolescents girls who have been bullied as it is focused on setting small and achievable goals, which can reduce anxiety and help adolescent girls to start moving forward with increased coping skills and resiliency (Roberts, 2000).

Another intervention that has been used in the field of trauma that can be applied to adolescent girls who have been bullied is the attachment, self-regulation, and competency treatment framework (ARC) (Blaustein & Kinniburgh, 2010). ARC is a components based model that outlines three areas of intervention, attachment, self-regulation, and competency, and suggests that clients work through nine building blocks of intervention within the framework, with the involvement of parents and/or caregivers. The initial stage focuses on securing the bond between the parent and adolescent girl by using psychoeducation about trauma, building skills for the caregiver to self-monitor, and enhancing the supports and resources available to the caregiver so that he or she can optimally support the adolescent female. The next few stages within the attachment component include attunement (consisting of understanding triggers and building listening skills), consistent response, and setting up routines and rituals. The self-regulation component includes affect identification (connecting emotions to body sensations and linking feelings to both internal and external factors), modulation (helping youth to maintain a comfort zone during arousal), and affect expression (sharing of emotional experiences with others). The final component of ARC is building competency, which includes executive function (developing a sense of self that includes a belief that the adolescent has the ability to make an

impact on the world), and self-development and identity. After the three components of ARC have been completed, the final step is integrating the trauma experience in to the adolescent's life. Blaustein and Kinniburgh (2010) explain: "the integration of both specific memories and fragmented self-states is framed as a process that occurs over time within treatment, and which is embedded within the caregiving system" (p. 41).

Cognitive behavioural therapy (CBT) and EMDR (eye movement desensitization and reprocessing) are proven to be effective treatments for dealing with PTSD and trauma related symptoms (Iribarren, Prolo, Neagos & Chiappelli, 2005). CBT therapists use a variety of approaches including systematic desensitization, cognitive reprocessing training, assertiveness training, and exposure therapy to help alleviate symptoms (Iribarren et al., 2005). EMDR has been proven effective in reducing trauma symptoms by "stripping troubling memories of their vividness and the distress they cause" (Rodriguez, 2012, p1). EMDR initially uses three phases, which include traditional therapeutic techniques such as building rapport, uncovering early life events and goal setting, a second phase that includes preparing to revisit the traumatic event, and learning self-soothing methods, and the third phase that includes eye movement and memory processing (2012). The overall results of EMDR is a distancing in the associated emotional levels of the trauma, the memory of the trauma stays, but the power it has on the client is reduced (2012).

Another intervention that can be used for victims of bullying who have experienced trauma is described by Levine (2005) as a "gentle and gradual approach to healing trauma" which focuses on accessing body memories through what Levine calls our felt sense, the way we feel things naturally in our bodies, and beginning to "discharge the instinctive survival energy that we did not have a chance to use at the time of an event" (p. 31). Levine suggests a 12-step

healing trauma program that focuses on releasing the trauma through physical and mental exercises that help “cleanse the body and mind of the debilitating effects of trauma” (p. 3). The stress that we experienced during trauma becomes trapped in the body, and unlike animals in the wild who release that stress naturally after an attack, when we haven’t used our adrenaline and stress to fight off an attacker, it stays unreleased, and becomes locked in our bodies, causing us long term traumatic symptoms. Levine’s 12-phase process begins in the first phase with providing safety and containment by connecting to our body by using exercises that help the client become connected to bodily sensations and “begin to feel your skin and your muscles as boundaries holding and containing your sensations and feelings” (Levine, 2008, p. 38). The second phase includes exercises for grounding and centering which “reconnects you directly with resources naturally available in your own body” (p.42). The third phase includes building external and internal resources, and the fourth phase is moving from “felt sense” to tracking specific sensations. Felt sense is

a felt sense is not a mental experience but a physical one. Physical. A bodily awareness of a situation or a person or event. An internal aura that encompasses everything you feel and know about the given subject at a given time. (Gendlin, as cited in Levine, 2008, p. 47)

This phase includes becoming consciously aware of one’s body and becoming aware of tracking the location and feelings within the body. The fifth phase is titled tracking activation: sensations, images, thoughts, and emotions and includes connecting thoughts and feelings to bodily sensations. The sixth phase is pendulation, tracking rhythms of expansion and constriction in the body and the seventh phase is becoming comfortable with natural aggression. He suggests that “by beginning to get a sense of what healthy aggression feels like, the extremes of numbness and

rage can begin to give way to a healthier middle ground” (p. 59). The eighth phase is connecting with one’s flight response, and creating a healthy sense of confidence that one can escape when necessary. The ninth phase is about building strength and resiliency and the tenth phase addresses uncoupling fear from the immobility response. The eleventh and twelfth phase address moving towards social engagement and settling and integrating one’s healing in to daily life. This 12-phase process of healing trauma focuses on addressing the pain that is trapped in the body, becoming aware of it, addressing the body sensations that come up with triggers, feelings, and events and healing the traumatic experience through gentle mindfulness and body awareness exercises.

Conclusion

Addressing the needs of victims of bullying who are experiencing traumatic symptoms requires a multi-faced approach that first assesses if there indeed is trauma caused by the bullying, addresses the trauma, helps to heal the trauma, and helps victims to develop resiliency, coping skills, and inner strength. Although theorists may differ slightly in their approaches to trauma, the idea that trauma needs to be addressed for victims that have developed symptoms and are suffering is agreed on. Adolescent girls who have been bullied may or may not experience traumatic symptoms; this is something that is unique to each individual. However, when a victim of bullying has been traumatized, it is important and beneficial to address the symptoms within a trauma-informed approach to ensure the victim can heal the trauma and not be at risk of life long complications.

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CONCLUSION

In this thesis I have explored the impact of bullying on adolescent girls and discussed trauma-informed care as an option for treating and assisting victims of bullying when trauma has occurred. Applying trauma-informed care to an assessment process can be beneficial to adolescent girls who have experienced bullying because they may not be coming in to counselling with developed trauma symptoms and they may not be aware of the association between the symptoms that they are experiencing and the bullying that they have endured (Hopson & Kim, 2004). Bullying is a serious problem in schools and community (Angus Reid, 2012) and addressing the problem with prevention, intervention, as well as follow-up care for the adolescent girls who have been bullied, is critical in order to reduce the damages that may occur for individuals that have been bullied. But assessment of the degree of crisis or trauma is essential before any treatment method is used.

Summary of Work Presented

Three types of female adolescent bullying were discussed in this paper: cyberbullying, relational bullying, and verbal bullying. In reference to cyberbullying, the studies presented in this thesis suggest that the largest indication that an adolescent girl is at risk for cyberbullying is an association with school bullying or exclusion (Mitchell, 2011).

Bullying has and continues to be, a relationship issue that needs to be solved within relationships (Pepler et al., in press). Relational bullying causes considerable problems for adolescent girls (Gordon, 2014)—this type of bullying where adolescent females are excluded, intimidated and humiliated socially through relationships is particularly damaging to adolescent females who are looking for secure peer attachments (Gorrese & Rugliere, 2012). Adolescent females who internalize this experience without addressing it are at risk for long term problems

including relationship problems, lack of self-esteem, anxiety, and depression (Vaillancourt, et al., 2010).

Verbal bullying is also discussed in this thesis, and one of the significant issues raised with this type of bullying is the concept of self-blame (Bradshaw et al., 2013). According to Bradshaw et al., (2013) victims who are the recipients of verbal bullying often feel that there is something wrong with them, and the bully often reinforces this feeling by accentuating things that are different about the individual and out of the normal adolescent experience, drawing attention to insecurities that may have already developed before the bullying. As discussed, this experience often leads to a heightened anxiety, leading to further social problems and instilling the identity of the youth as a victim of bullying (Bradshaw et al., 2013).

A discussion on bullying and aggression and the difference between the two is offered in this thesis. According to Hawley et al. (2011), we need to understand more specifically whether aggression leads to bullying and what the correlation is. This has not been proven in the research but the question is this: “if aggression can underlie need fulfillment then should we as child professionals, strive to eradicate all aggression in all children? (Hawley et al., 2011, p110).

The symptoms that can develop as a result of ongoing bullying discussed in this paper include anxiety and depression, feelings of hopelessness, lack of self-worth, lack of confidence, socio-emotional difficulties, as well as possible suicide ideation. The impact of technology and the increase in adolescent anxiety and depression was also discussed (Ossola, 2015).

Trauma theory and trauma are discussed in the second essay; post-traumatic stress is explained and other common symptoms of trauma are identified. The long-term effects of trauma were discussed. The history of trauma is discussed and the initial understanding from psychologists about symptoms that developed after a trauma (Freud, 1962) is explained. Much

of the work that has been done towards understanding trauma survivors and their potential symptoms has evolved and the contemporary understanding of trauma is that symptoms may develop long after the trauma occurred, and the individual may or not be aware that they are related to their traumatic experience (Levine, 2005). Levine (1997) stresses that trauma “is outside the range of usual human experiences (Levine, 1997, p24) and that it would be seen as distressing to almost anyone, and would likely involve threat to life, or threat of harm to others, and would involve injury. This definition is described by Levine as a starting point, and is used in this paper as a starting point to understand what trauma is. Trauma is explained in this thesis as an individual, personal experience. Discussion as to why some adolescents are more vulnerable to traumatic experiences and develop related symptoms is explored. Post-traumatic stress is discussed and a detailed explanation of the DSM-5 diagnosis is presented (American Psychiatric Association, 2013). The long-term effects of trauma were presented in this second essay.

In the third essay, ways that counsellors and mental health professionals can assist victims of bullying, by using a trauma-informed approach, is discussed. The process that is used to assess trauma is based on a strength-based perspective (Hopper et al., 2010) and trauma informed care is explained as a way of responding to clients through universal screening, staff education, and training in order to ensure trauma related symptoms are discovered and intervention plans can be made to assist with healing and recovery (Fallot & Harris, 2001). Obstacles to reporting and treating victims of bullying are discussed, and school wide prevention methods are outlined as well. Interventions including ARC, EMDR, CBT, solution-focused therapy as well as Levine’s 12 step healing process (2005) are discussed in detail. In summary, addressing the needs of victims who have been bullied and are experiencing traumatic symptoms requires a trauma-informed assessment and approach to intervention.

Implications for Further Research

One of the problems in trying to solve cyberbullying, according to Hinduja et al. (2013), is that the field of research on cyberbullying is changing so rapidly and applying current research to new technology is not always a fit. A few years ago researchers (e.g., Hinduja & Patchin, 2009) discussed a prevention technique for cyberbullying, which was keeping a computer at home in the kitchen, so that parents could see what was happening online. The idea was that not having a computer in the child's bedroom would reduce negative behaviour both from senders and receivers. However, just a few years later, 75% of teens are carrying smart phones (Hinduja et al., 2013) and their communication with their online world is at their fingertips wherever they go. This increase in access to online communication for teenagers has only exacerbated the problems associated with cyberbullying (American SPCC, 2014). There have also been historic problems with the enforcement of bullying, and cyberbullying makes this even more difficult, with so much of the bullying taking place online and anonymously (Swearer et al., 2009). More research is needed to ensure we are effectively solving the issues that arise from cyberbullying, as technology continues to advance and change, and significantly impact adolescent females' social and personal worlds. More research can be done to measure the effectiveness of trauma based therapeutic interventions for victims of bullying, as well as to assess whether universal trauma informed screening approaches could reduce long-term effects of bullying situations on affected adolescent youth.

Personal Response to the Work

In working through the research in regards to bullying as well as trauma, I am left with a feeling of hopefulness about assisting victims of bullying. The reality of adolescent females who have taken their own lives due to bullying is something that has been at the forefront of my mind

in the research. I have realized that it is not the bullying itself; it is the response of the individual's environment, peers, teachers, strangers, parents, school, counsellors, and other people in her community that can make the difference. As counsellors, using a trauma informed approach in therapy could help ensure that we are uncovering symptoms that are related to bullying in adolescent females, which may not be at the forefront of presenting symptoms. Educating school personnel, including counsellors and teachers, about the vulnerability of adolescent females that may be at risk for relational, verbal, or cyberbullying is something that can make a difference at school; just educating appropriate staff to the nature of the problem could be beneficial. In terms of intervention, the work of applying trauma-based therapeutic interventions to victims of bullying is something I believe can be highly beneficial to the affected adolescents who have been bullied.

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