

AN INVESTIGATION OF POSSIBLE DIFFERENCES BETWEEN BULLIED AND NON-
BULLIED ADOLESCENTS IN A CLINIC GROUP

AND RESEARCH PORTFOLIO

Doctor of Clinical Psychology Degree

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of the degree of Doctor of Clinical Psychology**

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of Medicine, University of Glasgow

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ANALYSIS OF THE...
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AND RESEARCH BUREAU

Submitted in partial fulfillment of the degree of Doctor of Philosophy
of Medicine, University of Glasgow

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1. SMALL SCALE RESEARCH PROJECT

(Submitted in the format of Clinical Forum. See Appendix 1 for notes for contributors)

STRESSPROOFING - THE EVALUATION OF AN ANXIETY MANAGEMENT GROUP: A

WAITING LIST INITIATIVE

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STRESSPROOFING- THE EVALUATION OF AN ANXIETY MANAGEMENT GROUP: A WAITING LIST INITIATIVE

There is currently a high demand for clinical psychology input which has led to long waiting lists. This situation is unfortunate for patients as they often have to wait many months before being seen (DCP, 1993; White, 1992). However, it is also of concern to psychologists. There is presently a 'buyers market' for health provision and long waiting lists may deter potential purchasers from buying psychological services. There is evidence that long waiting times are viewed by GP's as a sign of a poor service (McAuliffe and MacLachlan, 1992) and that they result in reduced referral rates (Startup, 1994). Secondly, there is a danger that purchasers may find other alternatives to psychological services for their patients (Kat, 1993), for example, counsellors, which may or may not be the most suitable option.

One approach which has been taken to attempt to reduce waiting lists is group work. One of the most common types of psychological disorder is anxiety or stress complaints (Brown and Barlow, 1992). Anxiety management groups have become a standard therapeutic intervention and have been shown to be effective in reducing clinical anxiety (Powell, 1987; White and Keenan, 1990).

Waiting List Management Procedure

An anxiety management group, known locally as the "stressproofing" group was started for patients with anxiety or stress complaints in an attempt to reduce the waiting list and to offer some help for patients while they were waiting to be seen individually. It was hoped that the group would lead to more patients being seen in less time and in a more cost efficient way i.e.

involving less psychology hours per patient. Patients were selected for the group on the basis of information in their referral letter, according to whether an anxiety/stress related problem was indicated although this may only have been a component of the whole picture. Suitable patients were offered a place on a group but were asked to contact the department if they did not wish to attend. It was made clear to patients who did attend that coming to the group did not affect their place on the waiting list but was an attempt to provide them with some help while waiting to be seen. They were also informed that they could drop out of the group at any time and this would not affect their place on the waiting list as long as they contacted the department. Patients who completed the group were asked to fill in a form in order to request an individual appointment. They were then seen when they reached the top of the waiting list. Patients who did not request an individual appointment were discharged.

The Stressproofing group

The stressproofing group consisted of four weekly meetings each lasting for a period of 90 minutes. The groups were didactic and were described to patients as classes. Patients were told that they did not have to divulge any personal information unless they wished to do so. Each week a different aspect of anxiety/stress was covered, namely, week 1) 'What is anxiety and how to cope with it' covered the nature of anxiety on body, thinking and behaviour and relaxation training; week 2) 'Panic Attacks' covered the relationship between overbreathing and panic. Patients were involved in a hyperventilation experiment and were taught methods of breathing control. The principles of exposure therapy for anxiety provoking situations were also described; week 3) 'How to stand up for yourself' covered assertiveness training; and week 4) 'How to worry properly' covered how to identify and deal with negative thinking errors, and the principles of

problem solving. Each week patients were required to complete a homework diary which related to what they had been taught in the class. The diaries were reviewed at the start of each class. Patients completed the Beck Anxiety Inventory (BAI: Beck et al., 1988) and the Beck Depression Inventory (BDI: Beck et al., 1961) at the beginning of week one and at the end of week four. The groups were run by one principal clinical psychologist.

The main purpose of the present study was to carry out a retrospective assessment of the stressproofing group to examine whether it met its objectives.

Method

A retrospective analysis was carried out of 15 stressproofing groups run during the years of 1992-1994, involving 238 patients. This involved data collection, collation and analysis using the statistical package SPSS.

The specific questions asked in this research were:

- 1) What proportion of patients attend a stressproofing group when it is offered?
- 2) What is the attendance like over the four weeks of the class?
- 3) Is there any change in self-reported anxiety and depression following group attendance i.e. were there differences in anxiety and depression scores (BAI and BDI) pre- and post- treatment?
- 4) How many patients do not require an individual appointment after attending a stressproofing group?
- 5) How many patients request individual therapy after completing a stressproofing group?
- 6) If stressproofing attenders request individual treatment do they require fewer appointments?

7) What proportion of patients who opt out of a stressproofing group attend for individual treatment?

8) How much therapist time was involved per patient in the stressproofing group?

Participants

All of the 238 patients offered a stressproofing group were new referrals. The mean age of the sample was 37.34 years (SD: 12.83). There were 108 (45.4%) males and 130 (54.6%) females. The majority of referrals came from G.P.'s, 220 (92.4%), but there were 17 (7.1%) psychiatric referrals and one (0.4%) patient was referred by a health visitor.

Results

Out of the sample of 238 patients, 39 patients (16.4%) opted out of attending a group; and 49 patients (20.6%) failed to attend. However, the majority of the sample, 150 patients (63%) attended.

Out of the 150 attenders, 43 (28.7%) dropped out of the group, 1 patient decided to return to the waiting list (0.7%) and 106 patients (70.7%) completed the group.

In order to assess whether attending a stressproofing group led to changes in self-reported anxiety and depression, two related samples two-tailed t-tests were carried out involving the 106 patients who completed the group. Anxiety (BAI) and depression (BDI) scores pre- and post- treatment were compared. The mean BAI score pre-treatment was 23.4 (SD: 11.6) which is within the moderate-severe range of anxiety and post-treatment was 18.8 (SD: 10.9) which is within the mild-moderate range. There was a significant decrease in BAI scores after treatment ($t=4.27$,

df=84, p=.000). The mean BDI score pre-treatment was 18.5 (SD: 8.9) and post-treatment was 15.1 (SD: 8.6) which are both within the mild to moderate range of depression. There was a significant decrease in BDI scores after treatment ($t=5.27$, $df=87$, $p=.000$).

Out of the 106 patients who completed the group, 37 (34.9%) did not require further treatment and were discharged and 69 (65.1%) requested individual therapy.

Out of the 69 patients who requested an individual appointment, 27 (39.1%) dropped out treatment; 1 patient (1.4%) opted out of treatment saying that she "felt better"; and 41 patients (59.4%) completed treatment. The average number of individual appointments attended by the stressproofing group completers was 4.73 (SD: 4.11). However, there was a range of 18 and it may be more accurate to use the median or mode which were both 2 appointments.

As stated earlier, 39 patients opted out of a stressproofing group. Out of this number, 25 patients (64.1%) dropped out of treatment and only 14 (35.9%) completed treatment. The average number of appointments for treatment completers was 4.86 (SD: 4.47). However, there was a range of 14 and it may be more accurate to use the median or mode in this case which were 3 and 2 respectively.

The amount of therapist time involved per patient in the stressproofing group was estimated by dividing the total time taken to run the groups (4 x 90 minutes x 15 groups; plus 240 minutes of preparation time) by the number of patients who completed the group (106). Only patients who completed the stressproofing course were included in the equation. It was estimated that 53.2 minutes of therapist time was involved per patient.

Discussion

The first aim of stressproofing was to provide some intermediate help for patients while they were on the waiting list. It seems that this aim was met. The majority of the 238 patients in this sample (63%) attended stressproofing which suggests that patients were willing to undergo such group treatment. Many patients commented that they found it a helpful experience. In addition, patients became less anxious and depressed after attendance. There were significant decreases in BAI and BDI scores in group completers although, as would be expected from such a short time span, decreases were modest. It is of interest that self-reported depression decreased in group completers as this was not specifically targeted in the programme. It is possible that patients felt less demoralised after attending a group as a result of learning skills to cope with their anxiety. Also, 37 out of the 106 group completers (34.9%) did not feel that they needed individual treatment after attending a group and were discharged from the waiting list.

The second aim of stressproofing was to reduce the waiting list and to see patients in a more cost effective way. It is clear that this aim was also met. Firstly, 49 (20.6%) of the 238 sample failed to attend stressproofing and were discharged from the waiting list. This reduced the number of patients waiting to be seen, but was also a saving of up to 49 therapist hours in itself i.e. if these patients had failed to attend for individual appointments. The groups were able to continue despite patients who did not attend. Secondly, 43 out of the 150 patients who attended stressproofing (28.7%) dropped out of the group and did not contact the department. Therefore, they were discharged and removed from the waiting list. Finally, 37 out of the 106 group completers (34.9%) did not request individual treatment and were discharged from the waiting

list. It is of interest that over half (53.3%) of the group attenders (80 out of 150) did not require individual treatment in the end. Although, the reasons for this were not established for the patients who dropped out of stressproofing. It is possible that these patients only required a little help. Alternatively, they may have felt a sense of failure because they did not manage to complete the group or may have feared that they would be discriminated against because of this.

The modal number of individual appointments for stressproofing completers who required individual treatment was 2 appointments. The median number of appointments was also 2. This is markedly lower than the number of appointments advocated by Clark (1989) for individual cognitive behavioural treatment for anxiety. He proposed that patients are generally seen for between 5 and 20 weekly sessions. Although, it seems that stressproofing may result in a reduced number of individual treatment appointments, the range of the number of individual appointments for group completers was fairly large. It is clear that patients vary in severity of anxiety and in the complexity of their problems, and many patients' needs will not be met by a general anxiety management group.

Out of the 39 patients who opted out of attending stressproofing, 25 (64.1%) patients dropped out of individual treatment and only 14 (35.9%) completed treatment. It is possible that such patients were ambivalent about receiving psychological treatment and were 'weeded out'. However, interestingly the number of appointments required by opters out who completed individual treatment was 2 and the median was fairly similar to the number of individual appointments required by stressproofing completers. It is difficult to interpret why opters out required so few appointments. It may be that they were less anxious and required less help. However, no outcome

measures on this sample were taken. Alternatively, the small number of appointments required may be an artefact due to the fact that the majority of patients who opted out of group treatment also dropped out of individual treatment.

In summary, it seems that stressproofing was a generally helpful approach and cost-effective. However, a fairly large proportion of the patient sample dropped out of treatment at different stages. This suggests that group treatment may not be suitable for certain patients, for example the more severely anxious or those who find attending a group very anxiety provoking. It is not possible to establish the reasons for failure to attend. However, a survey could be carried out involving such patients in order to gain this information. Another possible reason why patients failed to attend is that they were alienated by being offered group treatment. Individual screening of patients before group attendance may reduce failure rates. The possible advantages of screening would have to be considered in relation to the considerable amount of time needed to carry out such screening.

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2. MAJOR RESEARCH PROJECT LITERATURE REVIEW

(Submitted in the format of the Journal of Child Psychology and Psychiatry. See Appendix 2.1 for notes to contributors)

AN INVESTIGATION OF POSSIBLE DIFFERENCES BETWEEN BULLIED AND NON-BULLIED ADOLESCENTS IN A CLINIC GROUP

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INTRODUCTION

Bullying among school children is a very long-standing problem. However, the subject has only become the focus of systematic research in the last 10-15 years. In Britain, public and media attention became focused on the subject in 1989 when the Elton Report 'Discipline in schools' was published. The report, which was commissioned by the government, expressed concern about the negative effects of bullying on individual students and on the school atmosphere. It recommended that teaching staff should look out for bullying and take action to protect victims.

The aims of this review are to report on the nature, classification and epidemiology of bullying within schools; vulnerability factors; the psychological effects of being bullied; a possible psychological model; and intervention strategies from the research literature. Finally, the need for future research is discussed.

DEFINITION

Bullying has been defined as "persistent aggressive behaviours designed and intended to cause distress and fear over a period of time" (Tattum and Herbert, 1990). It is generally considered to be a repeated or long-standing experience (Olweus, 1994; Mellor, 1994; Whitney and Smith, 1993). Also, Olweus (1994) proposed that it involves an imbalance of power between bully and victim and refers to it as 'peer abuse'.

CLASSIFICATION

There are four main types of bullying referred to in the literature. Verbal bullying involves name-calling and taunting. Physical bullying includes kicking and punching. Material bullying involves stealing a person's possessions, damaging his property or extortion; and psychological bullying

involves behaviours such as threatening and/or excluding an individual. More recently, a distinction has been made between direct bullying which involves open verbal or physical attacks and indirect bullying which involves behaviours that are directed towards the victim but in an indirect way, for example, trying to get others to dislike him, slandering and spreading nasty rumours (Bjorqvist, Lagerspetz and Kaukainen, 1992; Ahmad and Smith, 1994). There are age and sex differences in the types of bullying carried out. These are documented below.

EPIDEMIOLOGY

Most of the research on the prevalence of bullying has been carried out by indirect studies which ask teaching staff about bullying problems or by direct studies which question children who either bully others and/or are bullied. In direct studies, information is either collected by self-report or peer rating i.e. asking children to identify other children in their class as victims/bullies. At present, the anonymous questionnaire is the favoured method of gaining information as bullying tends to be a secret activity and children may be unwilling to answer questions on it for fear of reprisal, in the victim's case, or for fear of punishment, in the bully's case.

Research into the prevalence of bullying problems has been carried out in a number of different countries and has produced various estimates, as documented below. Sampling and methodological differences such as different time periods and criteria, make it difficult to compare the findings. However, it seems that approximately 4-6 % of secondary school pupils experience bullying and around 20% of primary school pupils. It is also possible that the figures are even higher as bullying is often undetected by teachers (Rigby and Slee, 1991) and not reported by pupils (Mellor, 1990; Slee, 1994; Sharp, 1995; La Fontaine, 1991).

In Norway, Olweus (1989) developed and administered a bullying questionnaire to more than 130,000 pupils as part of a national survey. Six percent of secondary school aged pupils, aged 13-16 years, reported being bullied 'sometimes or more often' and 2 % reported being bullied 'once a week or more often'. In Scotland, Mellor (1990) also found that 6% of pupils reported being bullied 'at least sometimes' and 3% reported being bullied 'once a week or more often' in a sample of 942 pupils, aged 13-16 years, using the Norwegian definition of bullying and methodology. In England, Whitney and Smith (1993) found that 4% of a sample of 4135 secondary school pupils, aged 13-16 years, reported being bullied 'once or several times per week' using an adapted version of Olweus's questionnaire.

In England, Whitney and Smith (1993) found that 10% of a sample of 2623 primary school pupils, aged 7-12 years, reported that they were being bullied 'once or several times a week'. Smith (1991) found that 20.1% of primary school students, aged 7-12 years, in 7 middle schools reported being bullied 'sometimes' and 6 % reported being bullied 'once a week or more often'. In a study by Boulton and Smith (1994), 17% of a sample of 158 pupils, aged 8-9 years, were identified as victims using peer nomination. Finally, in Australia, Slee (1994) found that 25.7 % of a group of 353 pupils, aged 8-13 years, were being bullied 'once a week or more' in one primary school but only 9.7% of a group of 114 pupils, were being bullied to this extent in another.

There has only been one study of the prevalence of bullying in a clinic population. Quinn (1996) carried out a retrospective postal study of 47 consecutive attenders to an adolescent psychiatry clinic in Dublin and found that the problem was under-reported in the case notes. Nine individuals (19 %) were identified as victims of bullying on analysis of the case notes. However,

36% of the 25 individuals who responded to the postal survey reported that they were experiencing bullying which is a much higher rate.

Age Differences

As noted above, the reported frequency of bullying behaviour appears to decrease with age. However, it appears that different types of bullying decrease at different rates. It is clear that bullying becomes less physical in nature with age (Rigby and Slee, 1991; La Fontaine, 1991; Bjorkqvist et al., 1992; Olweus, 1994; Ahmad and Smith, 1994; Whitney and Smith, 1993) but the relative decreases in other types of bullying are not so well documented. This is an area for future research.

Sex Differences

There appear to be gender differences in the amount of bullying carried out. It is widely accepted that boys report and are reported as bullying more than girls (Lowenstein, 1977; Arora and Thompson, 1987; Tattum and Herbert, 1990; Sharp and Smith, 1991; Rigby and Slee, 1991). In addition, boys tend to bully both girls and boys while girls generally only bully other girls (Lowenstein, 1977; Sharp and Smith, 1991; Olweus, 1994; Whitney and Smith, 1993). This difference becomes more distinct with age (Ahmad and Smith, 1994; Rivers and Smith, 1994).

There are also gender differences in the types of bullying carried out. Several studies have found that boys carry out more physical bullying than girls (Roberts, 1988; Sharp and Smith, 1991; Bjorkqvist et al., 1992; Rivers and Smith, 1994). The findings for verbal bullying are less clear. Some studies have found that girls carry out more of this boys (Whitney and Smith, 1993; Rivers and Smith, 1994) but others have found no difference (Bjorkqvist et al., 1992). However, some

researchers have included indirect bullying behaviours in their definition of verbal bullying. More recently, it has been shown that boys carry out more direct bullying than girls, and girls carry out more indirect bullying than boys (Bjorkqvist et al.,1992; Rivers and Smith, 1994). It is possible that the amount of bullying carried out by girls may have been underestimated because earlier studies did not examine indirect bullying.

VULNERABILITY FACTORS

It seems that anyone can be bullied but some children are more vulnerable than others. Several vulnerability factors have been identified namely, personality, physical, behavioural and family characteristics.

Personality

It is reported that children who experience bullying tend to have shy or weak temperaments (Olweus,1989; 1993) and low self-esteem (Boulton and Smith, 1994). Two victim personality types have been identified (Olweus, 1989; Perry et al., 1988). The passive victim is anxious, insecure, does not appear to do anything to provoke attacks and does not defend himself. The less common provocative victim is hot tempered, restless, anxious and will attempt to retaliate when attacked. Boulton and Smith (1994) found that victims scored significantly lower on athletic competence, social acceptance and global self-worth than bullies and not involved children, according to the Self-Perception Profile (Harter, 1985) and were more likely to seek help, in a sample of 158, 8-9 year old students.

Physical Appearance

There is an indication that that victims of bullying are targeted because of certain physical characteristics such as clumsiness, obesity, hair colour or social or cultural background (Stephenson and Smith, 1989; Mellor, 1990). In the study by Mellor (1990), children from ethnic minorities reported that racism was a major cause of bullying. However, Olweus (1994) compared male victims and controls on 14 external characteristics as assessed by teacher ratings and found no differences between the groups. It is possible that the importance of such features may have been overestimated as other individuals with similar physical characteristics are not bullied.

Social Factors

There is evidence that victims of bullying are less popular with their peers than non-victims. Some studies have found that victimised children were significantly more likely to be classified as rejected according to peer nominations (Perry et al., 1988; Boulton and Smith, 1994). In addition, Boulton and Smith (1994) found that victims were significantly less likely to belong to the popular group compared to non-victims.

Family Factors

There seems to be an association between victimisation and having overprotective or overinvolved parents (Bowers, Smith and Binney, 1992; Olweus, 1993; Oliver et al., 1994). Bowers et al. (1992) compared 8-11 year old victims, bullies and controls' perceptions of their families on the dimensions of cohesion and power, using the Family systems test (FAST: Gehring and Wyler, 1986). Victims perceived their families as more cohesive than bullies and controls but the groups did not differ in overall power scores. Family discord has also been associated with

victimisation (Rigby,1993; Mellor, 1990). Mellor (1990) found that children of divorcing parents or those living with their fathers only were significantly more likely to be victims than controls.

In summary, although a number of factors have been associated with victimisation, more replication of the preliminary studies is needed involving larger numbers. Also, most of the studies are correlational so it is not possible to conclude whether such characteristics are the cause or the effect of bullying.

EFFECTS OF BULLYING

There is evidence that bullying is a negative experience. It has been associated with poor educational progress. Hazler, Hoover and Oliver (1992) reported that 90% of students who were bullied stated that they experienced a drop in school grades. It is also stressful. In a sample of 723 secondary aged students, aged 13-16 years, 43% of students reported being bullied and 34% of victims reported that it was stressful while 11% reported it was extremely stressful (Sharp, 1995). The rate of bullying found in this study was higher than the prevalence rates quoted earlier as individuals were asked about bullying in the year leading up to the survey rather than within the last term as in most other studies. Bullying has also been associated with several psychological symptoms namely, anxiety, irritability, poor concentration, depression and suicidal ideation.

Anxiety

There is evidence of an association between victimisation and anxiety. Sharp (1995) found that 35% of victims complained of feeling panicky or nervous in school. In addition, it seems that the experience of peer rejection in the form of bullying may result in anticipatory anxiety in relation to interaction with peers. Slee (1994) found a significant correlation between the tendency to be

victimised and fear of negative evaluation in males and females, and social avoidance in females on the Social Anxiety Scale for Children (SASC: La Greca et al., 1988), in a sample of 114 Australian primary school children aged between 9-13 years.

Irritability

There seems to be an association between victimisation and irritability. Sharp and Thomson (1992) found that 48.6% of a sample of 455 secondary school pupils, aged 12-14 years, reported feeling irritable when under stress. Also, Sharp (1995) found that 44% of victims of bullying complained of irritability.

Poor Concentration

It has been established that children experience poor concentration when they are worried or under stress (Sharp and Thomson, 1992). Therefore, it would be expected that bullied individuals would experience concentration problems. Sharp (1995) found that 29% of victims complained of impaired concentration in school. This is likely to lead to poor performance of school work and ties in with the findings of Hazler et al. (1992) that victims of bullying experience a drop in academic performance.

Depression

There is some evidence that the effects of victimisation can lead to depressed mood in victims. Recently, Slee (1995) found that being a victim, as indicated by self report questionnaire, was significantly correlated with depression for both sexes, according to the Depression Self Rating Scale (DSRS: Birlson, 1981), in a sample of 353 primary school children with an average age of 10.3 years.

Long-Term Effects

There is also work that indicates the effects of bullying can last through to adulthood. Olweus (1993) in a sample of 87 boys found that those who were victims of bullying at school between 13-16 years were more likely to show depressive tendencies at 23 years, according to a shortened 9 item version of the Beck Depression Inventory (Beck et al., 1961), and continued low self-esteem. This study suggests that there is a causal influence from victimisation to depression but it needs to be replicated and investigated for both sexes.

There is also an indication that the effects of bullying can be life-threatening in certain cases. There have been several incidents of suicidal behaviour associated with the experience of bullying

In summary, there is support for an association between victimisation and psychological distress and some indication of a causal effect but more research is needed to replicate the findings and using larger samples.

THEORETICAL CONTEXT

Bullying can be understood from a cognitive-behavioural perspective. This approach proposes that the meaning an individual takes from his circumstances will influence his mood and behaviour. In this model, it is thought that vulnerability factors such as quiet temperament (Olweus, 1993); low self-esteem (Boulton and Smith, 1994); a distinctive physical characteristic (Stephenson and Smith, 1989); over-involved parents (Olweus, 1993); and family discord (Mellor, 1990) increase the likelihood of an individual being bullied. However, the meaning an

individual takes from the experience will influence its impact on him and his ability to cope. Schemata are the basic beliefs and attitudes held by an individual. They are active in screening and processing information about the world. An individual who holds certain negative schemas such as believing he is incompetent or defective in some way or that people are threatening or hostile, is likely to interpret the experience of bullying in a catastrophic way. The individual with a negative view of self may interpret the experience as support for his belief and may attribute the cause of the bullying to his defects. Alternatively, an individual who believes that other people are hostile is likely to interpret the experience as support for this view. Such negative thinking results in sensitivity to criticism or teasing. It also influences the individual's behaviour when he encounters bullying situations.

Having a negative view of self or others leads the individual to overestimate the threat associated with being bullied and to feelings of being powerless and helpless. This may result in passivity; lack of assertiveness; failure to recruit support from adults or peers; over-reactions such as losing one's temper or crying. It may also lead to withdrawal when with peers or avoidance of peers. Withdrawal results in the individual being perceived as unrewarding, unfriendly or aloof by peers and so he is not approached or included leading to isolation. Avoidance behaviour also leads to isolation and prevents the individual developing coping skills for peer relationships such as dealing with teasing. All of these behaviours are rewarding to the person(s) carrying out the bullying behaviour- being passive or being alone makes an individual an easy target whereas over-reacting is rewarding to the bully. Such behaviours are also likely to maintain or increase the bullying behaviour.

BULLYING INTERVENTIONS

The findings described above on the effects of bullying highlight the need for bullying interventions. School professionals can impart a strong message about the worth of the individual by developing clear and consistent strategies to stop such victimisation. Two main intervention programmes have been carried out and the results demonstrate that such interventions can reduce bullying. The general aims of both programmes were to raise awareness of bullying within staff, pupils and parents; increase awareness of the feelings of victims; and encourage pupils to actively challenge bullying and report it rather than colluding or joining in.

Olweus (1989) carried out a nationwide intervention campaign in Norway between 1983-1985 involving 2500 students, aged 11-14 years, from 42 primary and secondary schools. A resource pack was distributed to every school consisting of a videotape for class discussion, a booklet for teachers and information for parents. Following this programme, bullying reduced by 50% (Olweus, 1994) and there was found to be less anti-social behaviour such as vandalism, theft and truancy.

Smith and Sharp (1994) carried out an intervention project in Sheffield between 1990-1994 involving 23 schools, inspired by the anti-bullying campaign in Norway. The intervention followed the survey carried out by Whitney and Smith (1993) which provided a profile of bullying behaviour and a baseline for the project. Each school was asked to develop a whole school policy against bullying and to choose from a range of optional interventions to get involved in. The importance of developing a school policy on bullying has been emphasised by several researchers on anti-bullying projects as an important way of tackling the serious effects of bullying and in creating a safe pleasant learning environment (Mellor, 1990; Olweus, 1994).

There were three main areas of optional intervention, namely, working through the curriculum, direct work with pupils, and improving the school environment. Curriculum based strategies aim to raise awareness of the negative effects of bullying; encourage pupils to talk about it and discuss what should be done. Each strategy had its own monitoring procedure. Smith and Sharp (1994) found that each of the interventions were effective in reducing bullying but to a lesser extent than in Norway.

One area of direct work carried out in the Sheffield project with pupils was an assertiveness training programme for victims of bullying. The theory behind this is that restoring children's self-esteem and self-confidence will enable them to deal with bullying situations more effectively (Arora, 1991). Individuals were taught how to make assertive statements; resist manipulation and threats; respond to name calling; leave a bullying situation; enlist support from peers; and remain calm in stressful situations. The intervention was shown to result in an increase in self-esteem according to teacher ratings and a reduction in the amount of bullying experienced according to self-rating. Individuals reported that learning ways to respond to bullying made them feel more confident and less anxious in bullying situations. There was also an increased tendency to use adaptive coping responses in bullying situations especially if these had been rehearsed using role play.

FUTURE RESEARCH

Bullying causes distress and it has been associated with a range of psychological symptoms. However, the theoretical basis for this process is weak and must be developed. More work is needed to determine whether there is a particular pattern of psychological distress. Finally, it

would seem important to establish the incidence of bullying problems in clinical samples to highlight this issue and develop therapeutic strategies to use with patients with this presentation.

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3. MAJOR RESEARCH PROJECT PROPOSAL

3.1 Applicant: Angela Janet Leslie (BSc) Trainee Clinical Psychologist. Department of Psychological Medicine, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow G12 OXH.

Supervisor: Ms Christine Puckering

3.2 Title: An investigation of possible differences between bullied and non-bullied adolescents in a clinic group

3.3 Summary: The aims of this research were: 1. to assess the prevalence of bullying problems in a clinic sample; 2. to examine differences in emotional measures between bullied and control groups i.e. to assess whether there is a particular pattern of psychological distress associated with being bullied; and 3. to assess the effectiveness of a group intervention aimed at reducing emotional distress and increasing coping skills. In order to do this, young people referred to the clinic will be asked to fill in a number of self-rating questionnaires about how they are feeling and a questionnaire about bullying. The answers of patients who have been bullied will be compared with those of patients who have not. A number of patients who have been bullied will be asked to participate in a 6 week bullying group after which they will again complete the self-rating questionnaires. Their parents will also be asked to come to a parents' group. The research will be carried out in a Department of Adolescent Psychiatry in Glasgow.

3.4 Introduction: Bullying among school children is a very long standing phenomena. The fact that some children are frequently harassed and attacked by other children has been described in

literature and many adults will have personal experience of bullying from their own school days. However, it is only in the last 10-15 years that bullying has become the focus of systematic study.

Bullying has been defined as 'persistent aggressive behaviours designed and intended to cause distress and fear over a period of time ' (Tattum and Herbert, 1990). In addition, Olweus (Olweus, 1994), a leading researcher in bullying and victimisation points out that there is an imbalance of power between bully and victim which makes it a form of abuse which he terms 'peer abuse'.

There are four main types of bullying referred to in the literature- verbal (name calling and taunting); physical (kicking and punching); material (stealing a person's possessions or damaging his property); and psychological (more subtle behaviour such as threatening and/or excluding and individual from the group).

There is evidence to suggest that around 4-6% of pupils experience bullying in secondary school (Olweus, 1989; Mellor, 1990; Whitney and Smith, 1993). It is also likely that these figures are underestimates as it is often undetected (Rigby and Slee, 1991) or not reported by pupils for fear of recrimination (Mellor, 1990; Slee, 1994; Sharp, 1995).

It is clear that being bullied is a stressful experience. Sharp (1995) found that 34 % of victims reported that it was stressful and 11% found it very stressful. Bullying has been associated with anxiety and tension, irritability, loss of confidence, poor concentration, school avoidance and depression and in some severe cases suicide (Sharp, 1995; Slee, 1995). In addition, it seems that pupils who are categorised as bullies are at risk of current and future difficulties. Perry et al.

(1988) found evidence to suggest that both aggressive and victimised children in schools are likely to be unpopular among their peers. Whereas in Norway, Olweus (1989) found that young people who had bullied at school were four times as likely as non-bullies to have criminal convictions later in life.

It is clear that bullying causes distress and has been associated with a range of psychological symptoms. However, more work is needed to determine whether there is a particular pattern of distress. Also, relatively little is known about the incidence of bullying problems within clinical samples. Only one pilot study has been carried out to date (Quinn, 1996). This would seem important in order to establish therapeutic strategies to use with patients with such problems.

3.5 Aims and Hypothesis: The main aims of this study are: 1. to assess the prevalence of bullying problems in a clinic sample; 2. to examine differences in emotional measures between bullied and control groups i.e. to assess whether there is a particular pattern of psychological distress associated with being bullied; and 3. to assess the effectiveness of a group intervention aimed at reducing emotional distress and increasing coping skills.

3.6 Plan of Investigation:

3.6.1 Subjects: The subjects in this study will be recruited from an adolescent psychiatry unit upon the agreement of the interdisciplinary team. The main subject group will have experience of bullying but a comparison group of patients will also be recruited who have not experienced bullying. All subjects must agree to participate in the study and will be asked to sign a written consent form. Patients who abuse drugs and/or alcohol or suffer from a concurrent organic mental syndrome will be excluded. It is hoped to recruit approximately 50 subjects.

3.6.2 Measures: The following measures will be used in the study.

Anxiety: Beck Anxiety Inventory (Beck et al., 1974)

Depression: Beck Depression Inventory (Beck et al., 1961)

Hopelessness: Hopelessness Scale (Beck et al., 1974)

Self-esteem: Self Perception Rating Scale (Harter, 1985)

Bullying Questionnaire: developed for the study by the author.

3.6.3 Design and Procedure: The main part of this study will examine the effects of bullying within a clinic population and explore the link between bullying and psychological disorder. This has not been done before. A cross-sectional design will be adopted. The study is correlational and does not seek to establish whether adolescents are experiencing psychopathology because of bullying or are being bullied because of certain underlying psychopathology. Simply, a comparison will be made between subjects who have been bullied and subjects who have not in order to establish whether the former can be distinguished in terms of a particular pattern of distress. The groups will be matched by sex and age (within a year of the same age).

Team members will alert the author of any referrals where bullying features in the presenting problem by completing a record sheet (see Appendix 3.1). The young person will then be approached and asked to participate in the study. At entry to the study, subjects sign a written consent form and complete a number of self-rating questionnaires as listed in 3.6.2. The author will then seek to match each subject with a consecutive referral of the same age and sex who will complete the same questionnaires.

The second part of the study will assess the effectiveness of a 6 week bullying group intervention involving a smaller number of subjects. Subjects taking part will complete the self-rating questionnaires before and after the 6 week period. They will also be asked to keep a daily diary of positive and negative interactions for the duration of the group.

3.6.4 Settings and equipment: The patients will be seen in the Adolescent Psychiatry Unit in Glasgow.

3.6.5 Data Analysis: The data will be collated and analysed using the statistical package for the social sciences (SPSS).

3.7 Practical Applications : This study will: 1. Raise awareness of bullying in referrers and school teachers; 2. Examine differences in emotional measures between bullied and control groups; and 3. Attempt to develop an intervention for bullying problems.

3.8 Time scale: The data will be collected over a 6 month period (between April to September 1996).

3.9 Ethical Approval: The research protocol received ethical approval from the research ethics committee of Greater Glasgow Community and Mental Health Services NHS Trust.

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**AN INVESTIGATION OF POSSIBLE DIFFERENCES BETWEEN BULLIED AND NON-
BULLIED ADOLESCENTS IN A CLINIC GROUP**

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An investigation of possible differences between bullied and non-bullied adolescents in a clinic group

Keywords: Bullying; victim; adolescent clinic; emotional effects

Summary: The aims of this research were: 1. to assess the prevalence of bullying problems in a clinic sample; 2. to examine differences in emotional measures between bullied and control groups i.e. to assess whether there is a particular pattern of emotional distress associated with being bullied; and 3. to assess the effectiveness of a group intervention for victims of bullying in reducing emotional distress. The results revealed that the prevalence of bullying was higher in the clinic population than in non clinical studies. There was little difference between the groups in terms of psychological symptomatology. However, bullied patients scored significantly lower on the subscale of social acceptance on the Self-Perception Rating scale (Harter, 1985). The group intervention for victims of bullying was found to result in reduced depression, anxiety and hopelessness but it was not possible to test this statistically as pre- and post- data were only available for three individuals. The results are discussed with reference to the literature.

INTRODUCTION

Bullying has been defined as 'persistent aggressive behaviours designed and intended to cause distress and fear over a period of time ' (Tattum and Herbert, 1990). In addition, there is an imbalance of power between bully and victim (Olweus, 1994). It has been estimated that around 4-6% of secondary school pupils experience bullying (Olweus, 1989; Mellor, 1990; Whitney and Smith, 1993).

Bullying is clearly a stressful experience (Sharp, 1995) but there is limited information on its more specific effects. Sharp (1995) found that 44% of victims reported feeling irritable; 35% reported feeling panicky or nervous and 29% complained of poor concentration in a sample of 723 secondary school pupils. Slee (1994) found a significant correlation between the tendency to be victimised and fear of negative evaluation in males and females and social avoidance in females in a sample of 114 primary school children aged 9-13 years. Also, Slee (1995) found a significant correlation between the tendency to be victimised and depression in a sample of 353 primary school children aged 9-13 years. Callaghan and Joseph (1995) found that bullied children were significantly more depressed than non-bullied children in a sample of 120 children, aged 10-12 years. In addition, Olweus (1993) found that boys who were victims of bullying at school at 13-16 years were significantly more likely to be depressed at age 23 years than non-bullied boys according to a shortened version of the Beck Depression Inventory (BDI: Beck et al., 1961). This study suggests that there is a causal influence from victimisation to depression. Victimisation has also been associated with suicidal behaviour (Olweus, 1993) which highlights the degree of distress and hopelessness it creates. Finally, there appears to be an association between victimisation and low self-esteem. Boulton and Smith (1994) found that victims perceived themselves as significantly lower on athletic competence, social acceptance and global self-worth than bullies and not involved children according to the Self-Perception Rating Scale (Harter, 1985), in a sample of 158 primary children aged 8-9 years. Similarly, Callaghan and Joseph (1995) found that victims scored significantly lower on social acceptance, behaviour conduct and global self-worth than non-bullied children.

If bullying is associated with psychological disturbance then it is likely that a proportion of bullied children will be referred to psychological services. However, the prevalence of bullying

problems in clinical samples is unknown at present. There has only been one study (Quinn, 1996) which suggested that the problem was under-reported. It would seem important to establish the size of the problem to highlight this issue and establish therapeutic strategies to use with patients with this presentation.

Bullying can be understood from a cognitive-behavioural perspective (as described in the literature review). It is proposed that the way an individual perceives the experience of bullying will influence how he feels and copes in the situation. In turn, it is thought that the basic beliefs and attitudes held by an individual influence how he perceives his experience.

There is evidence that interventions for victims of bullying can be successful in reducing distress, for example, an assertiveness training programme carried out in Sheffield (Smith and Sharp, 1994) which taught individuals how to deal with bullying in an assertive way (as detailed in the literature review) resulted in an increase in self-esteem according to teacher ratings; and increased confidence and a reduction in the amount of bullying experienced according to self-rating. The rationale was that restoring children's self-esteem would enable them to deal with bullying situations more effectively (Arora, 1991). There have been no reports on the effectiveness of such interventions with a clinical population.

AIMS AND HYPOTHESES

The main aims of the current study were: 1. to assess the prevalence of bullying problems in a clinic sample; 2. to examine differences in emotional measures between bullied and control groups i.e. to assess whether there is a particular pattern of emotional distress associated with being bullied; and 3. to assess the effectiveness of a group intervention for victims of bullying in

reducing emotional distress. It was hypothesised that participants would score significantly less on severity measures post intervention.

Subjects

Patients were recruited from an adolescent clinic in Glasgow with the help of the interdisciplinary team. There were three parts to the study and each part involved a different set of patients. Part one, examining prevalence, involved 120 patient records. Part two, examining differences between bullied and non-bullied individuals, involved 23 bullied individuals (16 males and 7 females) and 20 matched controls (13 males and 7 females). The mean age for the bullied group was 13.9 years (range: 12-17 years) and for the control group was 14.2 years (range: 12-17 years). Comparisons were made between 19 bullied individuals matched with controls. Matches were not found for 3 bullied males and one bullied female did not complete all of the questionnaires. Part three, assessing the effectiveness of a group intervention, involved 7 of the 23 bullied individuals from part two of the study.

METHOD

Procedure

In order to establish the prevalence of bullying problems in the clinic sample, therapists completed a written record every time they saw a new patient and recorded if the patient was being bullied (see Appendix 3.1). This procedure was carried out for a period of 11 months between March 1996 to February 1997.

In order to examine differences in emotional measures between bullied and non-bullied individuals, patients who were identified as experiencing bullying problems in part one of the

study were approached and asked to participate in part two of the study. Individuals who agreed to take part signed a written consent form and completed five self-rating questionnaires. Each bullied individual was then matched with a consecutive referral of the same sex and age (or as near as possible) who had not been bullied. Patients who abused drugs and/or alcohol or suffered from a concurrent organic mental syndrome were excluded. Recruitment was carried out for a period of 15 months between March 1996 to June 1997.

In order to assess the effectiveness of a group intervention for victims of bullying, an intervention based on the group run in Sheffield (Smith and Sharp, 1994) was organised and run within the clinic. The seven individuals who took part were asked to complete the set of questionnaires they had completed at entry to the study after the 6 weeks and pre- and post severity scores were compared.

The Intervention

The group was run by two therapists, a trainee psychologist (the author) and a liason teacher. A cognitive-behavioural treatment approach was used involving both cognitive and behavioural strategies for change. The cognitive-behavioural model of bullying described earlier proposes that an individual who is vulnerable to bullying exaggerates the threat associated with bullying which leads to feelings of helplessness and ineffective coping. The model also proposes that poor coping is a maintaining factor of bullying as it reinforces the person(s) carrying out the bullying behaviour.

There were two aims of the intervention: 1) to reduce the impact of bullying on individual group members by providing information; a safe supportive environment to talk about their

experiences; and a positive peer experience; and 2) to increase individual coping skills to deal with bullying in order to increase self-confidence and reduce the frequency of bullying attacks.

It was thought that exploring other people's experiences of bullying and its negative impact would normalise group members' own experiences and increase their self-esteem. It was also thought that a positive peer experience would challenge any negative beliefs held by individuals about other people being hostile and result in reduced anxiety and avoidance behaviour.

Various aspects of bullying behaviour were covered in the group, for example, what is and is not bullying; different forms of bullying; why people bully; and why and who one should tell. The 'Sticks and Stones' video from Central Television (1990) was used for illustration. This contains interviews with victims of bullying and drama sketches of bullying incidents. Coping strategies to deal with bullying were both elicited from group members and taught and practised within the group. Individuals were taught how to use body posture as a means to convey confidence and to develop verbal response strategies towards negative/hostile remarks. They were given positive feedback about their performance. In addition, handouts were given out summarising the main points of each group.

Measures

The Beck Anxiety Inventory (BAI: Beck et al., 1974) is a list of 21 descriptive symptoms of anxiety. Each item is scored on a 4 point likert scale. Four levels of severity of anxiety have been distinguished using the scale: 0-7, minimal; 8-15, mild; 16-25, moderate; and 26-63, severe.

The Beck Depression Inventory (BDI: Beck et al., 1961) is the most widely used self-rating scale of depression. It consists of a list of 21 symptoms of depression. Four levels of severity of

depression have been distinguished using the scale: 0-9, normal; 10-18, mild to moderate; 19-29, moderate to severe; and 30-63, extremely severe.

The Hopelessness scale (Beck et al., 1974) consists of a list of 20 statements about the future. The subject rates whether each of the statements is true or false for them in the past week. High scores on this measure have been found to be associated with suicidal ideation and intent (Beck et al., 1985).

The Self-Perception Rating Scale (Harter, 1985) is a measure of self-esteem. The scale measures five areas of self-perception - scholastic competence, social acceptance, athletic competence, physical appearance and behavioural conduct; and global self-worth. The scale has been found to have good internal consistency (Harter, 1995) and test-retest reliability (Granlees and Joseph, 1994).

The bullying questionnaire (see Appendix 4.3) was adapted from that designed by Olweus (1989) and adapted by Smith (1991). It includes the main question areas in the original but differs from it in three ways—firstly, it includes questions which can be answered by giving more than one response whereas most questions in the original required only one response. Secondly, it places more emphasis on eliciting young people's feelings and opinions about the issue of bullying; and thirdly, a definition of bullying was not given. There are 24 questions in the current version compared to 26 in the original.

RESULTS

Twenty nine out of the 120 patients (24.2%) seen at the clinic during an 11 month period were found to be experiencing bullying.

Twenty two of the 23 bullied individuals recruited for part two of the study completed the bullying questionnaire. From this it was established that bullying was mostly experienced 'several times a day' (n=10: 45.5%). The next most common occurrences were 'once a day' in 7 cases (31.8%); 'once a week' in 2 cases (9.1%); 'less than once a month' in 2 cases (9.1%); and 'once a month' in 1 case (4.5%). A fairly high proportion of respondents (14/22: 63.6%) reported the bullying. Those who did not gave the following reasons: 'thought it would make things worse' (n=4); hoped it would stop in time (n=2); or did not think it would be taken seriously (n=2).

In order to examine differences in emotional measures between bullied and non-bullied individuals, mean BAI, BDI, BHS and Self-Perception scores were compared. The results are contained in Table One. The normality of the distributions for each measure was examined and although skewness was not a problem the distributions were either flattened or extended and it was decided to analyse the data using more conservative non-parametric statistics. The comparisons were made using two tailed Wilcoxon tests. There were no significant differences between the groups for anxiety, depression, hopelessness or any of the subscales of the Self-Perception Rating Scale (Harter, 1985) except that bullied individuals scored significantly lower on the subscale of social acceptance.

Table 1: Mean BAI, BDI, BHS and Self Perception Profile scores and (standard deviations) for bullied and not bullied groups by sex

	BULLIED				NOT BULLIED			
	Male (n=13)		Female (n=6)		Male (n=13)		Female (n=6)	
	mean	(SD)	mean	(SD)	mean	(SD)	mean	(SD)
BAI	15.9	(10.3)	23.3	(11.5)	14.2	(12.6)	16.0	(12.1)
BDI	11.5	(10.3)	24.7	(8.6)	10.4	(6.1)	14.7	(8.0)
BHS	6.2	(5.9)	11.8	(7.3)	6.5	(5.0)	12.2	(5.6)
Self-Esteem								
Scholastic Competence	16.5	(2.4)	17.5	(1.2)	18.0	(2.9)	17.3	(3.0)
Social Acceptance*	16.8	(2.7)	15.8	(2.1)	18.5	(2.8)	19.7	(3.1)
Athletic Competence	17.0	(2.3)	17.2	(1.2)	17.7	(3.0)	17.7	(2.9)
Physical Appearance	17.3	(3.2)	16.3	(1.6)	17.4	(3.1)	15.7	(1.2)
Behavioural Conduct	17.8	(2.3)	17.7	(3.6)	17.7	(2.5)	17.3	(2.3)
Global Score	87.2	(6.7)	84.3	(4.8)	89.8	(10.5)	86.0	(4.6)

A differential analysis was carried out to examine sex differences within and between bullied and control groups. The comparisons within groups were made using two tailed Mann-Whitney tests and between groups using two tailed Wilcoxon tests. Bullied females scored significantly higher on the BDI ($u=11.5$, $df=18$, $p=.02$) and the BHS ($u=17.0$, $df=18$, $p=.05$) than bullied males. Mean ranked scores for the BDI were 7.9 for boys and 14.6 for girls and for the BHS were 8.3 for boys and 13.7 for girls. There was a similar trend for BDI and BHS scores within the control group which failed to reach significance. No between group difference were found.

In order to assess the effectiveness of a 6 week group intervention for victims of bullying, pre- and post severity scores were compared (see Appendix 4.5). It was only possible to obtain full data for 3 of the 7 participants because of intermittent attendance and a high drop out rate. Severity scores decreased following the intervention but it was not possible to test if these were statistically significant changes because of small numbers.

Other findings

Some other relevant findings on the effects of bullying are now described (see Appendix 4.4 for complete data). Bullied individuals reported that bullying made them feel angry (n=17); sad (n=11); worried (n=10); afraid (n=7); or no emotion (n=2). They also reported that bullying resulted in a fear of rejection; loss of confidence; lack of or loss of friends; feeling suicidal; feeling ill; and a desire to avoid school. Bullying was attributed to 'physical appearance' (n=5); or being an 'easy target because of being quiet or easy to upset' (n=5). Some perceived themselves as different from their peers in some way (n=5) (e.g. 'odd one out'; 'speak differently'; 'not like other teenagers'; 'different from everyone else').

The majority of bullied individuals (16/22) and controls (13/20) reported that they had seen others being bullied at school. However, most did not report it (13/16 bullied; and 12/13 controls) because they were 'afraid of being bullied'; 'did not want to get involved/ nothing to do with me'; 'would be called a grass' or 'the person (victim) was handling it'(n=1). All of the individuals who did report seeing bullying (3 bullied and 1 control) reported that it then stopped.

DISCUSSION

The first aim of the study was to assess the prevalence of bullying problems in a clinic sample. A prevalence rate of 24.2 % was found which is much higher than the rate of 4-6 % found for secondary school based studies. The respondents in the study (n=22) also experienced a higher frequency of bullying, for example, 86.4% experienced bullying 'once a week or more' whereas only 2% of pupils in the study by Olweus (1989) and 3% in the study by Mellor (1990) experienced bullying to this extent. It is possible that a clinic population is more likely to be

bullied because of their symptomatology or that the experience of bullying results in increased symptomatology and need for specialist help. The result highlights the presence of such patients for clinicians. There is a stigma attached to experiencing bullying and some children may be unwilling to admit it. It is possible that providing a description of bullying behaviours without using the term itself may have encouraged such individuals to report it.

The second aim of the study was to examine differences in emotional measures between bullied and control groups. No significant differences in symptom scores were found between the groups except that bullied individuals scored significantly lower on social acceptance. It is difficult to make any firm conclusions about the lack of difference between the groups as the numbers in this study are small and there are no comparative studies. However, it is possible that the measures used were too general to pick up specific differences associated with bullying problems. It would be expected that most individuals referred to a clinic would be experiencing a degree of emotional distress and self-esteem difficulties. Perhaps assessing level of irritability; social functioning with peers and level of social anxiety would have revealed differences between the groups. It is also possible that the heterogeneity of symptomatology in the sample may have masked any difference. Future studies could control for type and severity of presenting problem. Finally, it would be expected that a significant proportion of clinic patients would be experiencing some form of life stress such as family problems even if they were not experiencing bullying but this was not accounted for in the current study.

The finding that bullied individuals scored lower on social acceptance is in keeping with other studies (Boulton and Smith, 1994; Callaghan and Joseph, 1995). The items for the subscale of social acceptance are: 'easy to make friends'; 'have a lot of friends'; 'easy to like'; 'do things

with a lot of children'; and 'popular with others'. It is possible that the experience of bullying reduces social confidence or that a pre-existing lack of confidence makes an individual more likely to experience bullying from their peers. Thirdly, it is possible that bullied children perceive themselves to be different in some way from their peers and this results both in rejection and lack of social confidence. There is evidence of an association between victimisation and rejection by peers (Perry et al., 1988; Boulton and Smith, 1994). Alternatively, it is possible that victimisation results in rejection by peers because other children fear that they may also be bullied if they associate with the victim. An important area of future study would be to determine the causal influence between bullying and lack of perceived social acceptance.

A differential analysis revealed that females scored significantly higher than males on the BDI and BHS in the bullied group and there was a similar trend for the control group. It is possible that there is a genuine difference in response to bullying between the sexes with bullying having a greater impact on females. However, the result may simply reflect a difference in self-reported depression and hopelessness between the sexes which is the result of socialisation. This difference merits further study.

The third aim of the study was to assess the effectiveness of a group intervention. There was an indication that the intervention was successful, however, there were practical difficulties in running the group within the clinic such as intermittent attendance and a high drop out rate. All of the patients attending the group were receiving individual treatment and it is possible that the group was given a lower priority as bullying was not the main presenting problem. Perhaps such an intervention could be offered to bullied patients who are waiting to be seen for individual treatment. This might improve attendance rates and also be cost efficient as it may result in

patients needing fewer individual sessions. Alternatively, it is possible that a clinic based intervention is not the best approach to tackle the problem of bullying. It is a known fact that bullying is a systemic problem within institutions and there is a case for being proactive and working within the institutional organisations of schools given that a lot is known about school based intervention and there is research evidence for the effectiveness of such work (Olweus, 1989; Smith and Sharp, 1994). Albee (1982) stated that no change in the incidence of a disease has been achieved by individual treatment. It has always occurred by public health methods. There is an obvious relation to this in tackling the problem of bullying by working within the organisational system of the school.

The responses given by bullied individuals about the effects of bullying were very similar to the findings of earlier non-clinical studies. Bullied individuals most commonly reported feeling angry (n=17) which is in keeping with the study by Sharp (1995). The second most common feeling reported was sadness (n=11) which adds support to the findings of Slee (1995) and Callaghan and Joseph (1995) who found an association between victimisation and depressed mood. Thirdly, the bullied group reported feeling worried or afraid (n=17) which is consistent with the findings of Slee (1994).

The majority of respondents (from both bullied and control groups) did not tell a member of staff when they saw someone being bullied. This is a worrying finding as the existence of effective interventions to tackle bullying will be redundant if there is an unawareness of the problem. It is clear that schools should be developing a culture within which telling is encouraged as right and proper and in which bullying is regarded as everyone's problem.

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5. SINGLE CASE RESEARCH STUDY-Reducing low self-esteem linked to negative childhood experiences

(Submitted in the format of Clinical Child Psychology and Psychiatry. See Appendix 5.1 for notes to contributors)

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Reducing low self-esteem linked to negative childhood experiences

ABSTRACT

This paper discusses and illustrates the use of cognitive therapy with adolescents. It highlights the importance of early intervention in preventing ongoing problem functioning into adulthood. It also demonstrates the possibility of working with young adults to target their core belief system. The case presented is of a young woman experiencing low and anxious mood due to current triggers and a difficult early childhood. Cognitive therapy was found to be effective in her treatment. In summary, many of the cognitive therapy techniques developed for adults can be applied with adolescents. However, adolescents have a variety of special problems which leads to unique differences associated with their treatment.

Key words: Low Self-Esteem; Physical Disability; Childhood

INTRODUCTION

Cognitive therapy is based on an underlying theoretical rationale that an individual's affect and behaviour are largely determined by the way in which she structures the world. Beck (1979) proposes that the deepest level of thinking is the structure of thought or schemata which underlies both negative automatic thoughts and thinking errors. Schemata are described as the basic beliefs and attitudes held by an individual. It is proposed that they develop during childhood as a result of certain negative experiences such as having an overcritical parent. They are activated by similar stressful circumstances.

Cognitive therapy (Beck, 1979) integrates cognitive, behavioural and affective strategies of change. It deals with the present and is problem-orientated. However, past traumas are worked through in the same way with the alternative perceptions or interpretations being discussed.

Children and adolescents are in the process of developing ways to view their world (Kendall, 1993). They must adjust and cope with certain developmental challenges. Central to a successful completion of childhood is the child's development of a confident sense of mastery; appropriate social behaviour; and an ability to engage in self-control. A key feature of adolescent depression is a negative view of self. The depressed adolescent tends to be acutely sensitive to her perceived deficiencies and to magnify the significance of any teasing or criticism (Emery, Bedrosian and Garber, 1983).

The cognitive analyses of the child considers her internal and external environment. A strength of the cognitive therapy approach is that patient and therapist work in a collaborative way which fosters independence within the young person. Cognitive treatment provides educational experiences and therapist coached the patient on a reconceptualisation of her problems to build a new 'coping' template.

This case illustrates the use of cognitive therapy with a young woman. It provides support for Beck's model. It also illustrates the importance of early intervention to prevent ongoing problem functioning into adulthood. In addition, it demonstrates the possibility of working with a young adult on their core beliefs.

PRESENTING PROBLEM

L (18) was referred to clinical psychology services by her GP because of low mood associated with certain childhood experiences and current stress at home.

On initial assessment L. was tearful and low in mood and reported having feelings of rejection and anger towards her mother associated with her current behaviour towards her and memories from the past linked to her mother's excessive drinking behaviour. She reported that she found it difficult to see her mother caring and attending to her young sister when she had been so neglected as a child.

L. also reported that her mother was overprotective of her, for example she did not allow L. to stay home alone if she and her husband went away and insisted that she stay with her grandparents. L.'s mother and step-father were recovering alcoholics and attended AA

regularly. They worried that L. would become an alcoholic and disapproved of her going out for a social drink. This led to rows at home. In fact, the precipitating event which led her to seek help was that her mother and step-father threatened to put her out of the family home after she went out drinking one night and came home very late.

L. did not seem to be experiencing any other depressive symptoms. Her sleep and appetite were normal.

Personal History and Background Information

L. had a very unhappy childhood. Her mother and father were both alcoholics and her parents separated when she was one year old. Her mother moved back home to her parents' house with L. and her younger brother and then moved into a council flat when L. was 5 years. She continued to drink and was often verbally abusive towards L. and unable to care for her and her brother properly. L. had to get herself and her younger brother up in the mornings and ready for school. A lot of the time L. and her brother were sent to stay at their maternal grandparents' house but L. was told not to say anything about her mother's drinking. Also, L.'s mother did not allow her to show any emotion and she was told to go to her room if she cried.

L. has cerebral palsy and a left hemiparesis. She had to have several operations as a child to correct her gait. She reported that her mother used to criticise her for being slow and keeping her back when they were walking together. In addition, L. was born with a squint in one eye and had to undergo surgery and attend the eye hospital for several months to correct this. Also, she had epilepsy until she was 8 years.

L.'s mother stopped drinking about 7 years ago. She met her new husband one year later at an AA meeting and he moved in to the family home soon after. L. reported that this had been a shock as her mother had not discussed this with her. The couple also had a child together. She was now 5 years old.

L. left school at 16 years and was an office worker on a Youth Training scheme.

MEASURES OF ASSESSMENT

L.'s level of depression was assessed using the Beck Depression Inventory (BDI: Beck et al. (1961) and her level of anxiety was assessed using the Beck Anxiety Inventory (BAI: Beck et al., 1974). She scored 10 on the BDI which is within the mild range and she scored 9 on the BAI which is also within the mild range. In order to gain an index of her beliefs the Dysfunctional Attitude Scale (DAS: Weissman and Beck, 1978) was administered. She scored 99 on the DAS. The scale was used to help identify particular core beliefs held by L. and to examine rigidity in her thinking.

FORMULATION

This young woman was experiencing low mood associated with current difficulties with her parents and her negative childhood experiences. There was also evidence of low self-esteem. It was apparent that she had difficulty being assertive both at work and with her mother. It was hypothesised that L.'s early experiences and her disability led to her forming a negative self-image. It was also hypothesised that she was not assertive with her mother because she feared that she would be rejected or verbally abused as in her childhood.

TREATMENT PROCEDURES

There were three main aims of treatment: 1) to help L. identify current triggers for her emotion and link these to the past; 2) to help L. explore her feelings associated with the past and the meaning she took from her experiences; and 3) to help L. re-define her relationship with her mother.

Following assessment, treatment consisted of 9 hour long sessions of Cognitive therapy according to Beck (1979). L. was introduced to the cognitive model by explanation. She was told that the way an individual thinks about a situation can lead to her feeling bad but by taking a step back and looking for alternative thoughts it is possible to change negative emotions. She was then asked to complete a thought diary. Initially this involved using the first three columns. She was asked to describe the situation leading to an unpleasant emotion; describe the feelings and rate them on scale of 1-100; and record what she thought at the time and rate her belief in the thought out of 100. Once she was proficient at this, she was asked to complete two further columns by forming a rational response to the original automatic thought and rating it out of 100; re-rating her belief in the automatic thought out of 100; and specifying and rating subsequent emotions.

The second aim of treatment was help L. explore her feeling associated with the past. A conceptualisation of her case was compiled together, as documented below in Figure 1 in order to elicit and link her negative beliefs about herself to her early experiences. It was then attempted to help L. to modify such beliefs using several techniques. L. was asked to keep a

positive log of any positive comments given which were not consistent with her core beliefs. She was able to list several compliments she received about her abilities at work and further evidence was provided by her being promoted at work. She was also encouraged to carry out behavioural experiments in order to test out the reality of the beliefs. In addition, the advantages and disadvantages of holding such beliefs were listed and discussed.

A session was spent discussing the issues surrounding L.s disability. This was particularly difficult for L. as she had never expressed her feelings about her disability before. She reported that she did not like it when colleagues or her mother were overprotective towards her because of her palsy. She also avoided applying for other jobs because of worries about people's reactions if she went for an interview or being employed as the token disabled employee because of a company's equal opportunities policy rather than because of her abilities. However, it was apparent that she had developed some coping strategies to deal with her negative thoughts about her disability. These were discussed and consolidated within treatment.

In order to help L. re-define her relationship with her mother a problem solving approach was used. This involved defining the specific problems, generating possible solutions and choosing the best solution. Role play was occasionally used to rehearse difficult problem situations that L. avoided.

OUTCOME OF TREATMENT

L. made good progress in treatment as evidenced by reductions on the Beck Depression Inventory (BDI) from 10 (mild) to 5 (not depressed) and the Beck Anxiety Inventory from 9

(mild) to 2 (minimal). Her self-esteem also improved. Specifically, L. endorsed the item 'I hate myself' on the BDI at baseline which scores a maximum of 3 but endorsed the item 'I don't feel disappointed in myself' which scores a minimum of 0 at Time 2. Her score on the DAS reduced from 99 to 70 and there was evidence of a reduction in the rigidity of her thinking as reflected in her DAS profile. Reductions on these formal assessments were further supported by clinical observation with improved mood and increased level of activity. There was also evidence of increased independence and taking more responsibility for her life. She applied and was successful in getting a promotion at work. She also started taking driving lessons and passed her driving test. There was a slight increase in assertiveness with her mother according to her self-report but this was still difficult for her. It was therefore decided that we schedule some more sessions to work on this specific issue.

DISCUSSION

This case demonstrates the effectiveness of using cognitive therapy with a young adult. One of the main aspects of treatment was to help L. explore her feelings associated with the past and the meaning she took from these experiences. It was hypothesised that her negative childhood experiences and her disability had led her to form a negative view of herself. Once L.'s beliefs were elicited she was helped to make links between her early experiences and her current feelings about herself. She was then helped to reinterpret her experiences from an adult point of view. Finally, she was helped to correct any distorted beliefs.

It was hypothesised that L. was not assertive with her mother because she feared that she would be rejected or verbally abused. It became apparent that L. was very concerned with seeking her mother's love and approval which often led to disappointment and fresh feelings

of rejection as her mother seemed unwilling or unable to provide this and was very critical of her. During treatment, she was helped to re-define her relationship with her mother and examine the possibility that she was able to live her life without her mother's approval. Other sources of love and approval within her life were identified such as grand-parents, friends and work colleagues. Some of her early coping strategies were also identified as being ineffective in adult life, for example avoiding conflict with her mother at all costs which may have been a good strategy for a young child was preventing her from having some of her own needs met. Role play was used to help her practice negotiating with her mother about certain problem areas.

A third aspect of treatment was to tackle L.'s belief that she was incapable possibly linked to her mother's overprotectiveness of her because of her disability, her reluctance to allow L. any independence as a young adult and her constant criticism. This belief was challenged by examining how well she coped with her difficulties as a child and by asking her to keep a positive log of any contradictory evidence to this belief.

Treatment resulted in reduced symptomatology and a more flexible belief system. It seemed that being given an opportunity to discuss unresolved issues from childhood and to explore and reattribute childhood experiences resulted in L. developing an improved self-image. Secondly, being able to challenge her belief that she needed her mother's love and approval allowed her to become more confident and more assertive with her mother and was able to negotiate for more of what she wanted. Finally, changing her belief about being incapable resulted in her increased independence and taking more responsibility for her life.

Figure 1 - Joint Formulation

EARLY EXPERIENCES

Mother drunk and abusive. Disability. Mum critical said L. was useless, lazy and too slow. Not allow to express angry emotions.

CORE BELIEF

'I am unimportant'

'I am incapable'

'I am useless'

CRITICAL INCIDENT

Came home after drinking with friends and parents threatened to put her out of the house.

BEHAVIOUR

Avoidance of confrontation

Does not make her own decisions as afraid of failure

AUTOMATIC THOUGHTS

'My Mum does not tell me things because she does not think I am important'

'My Mum does not let me do things independently because she thinks I am irresponsible'

EMOTIONS

Anger

Guilt

Anxious

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6. SINGLE CASE RESEARCH STUDY- Tackling dysfunctional thinking using a schema-focused approach

(Submitted in the format of Behavioural Psychotherapy. See Appendix 6.1 for notes to contributors)

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SUMMARY

This paper illustrates the schema-focused approach developed by Young (1989) which is suitable for patients who have difficulty accessing their negative thought content. It also illustrates the use of cognitive techniques as applied to spontaneous visual imagery.

INTRODUCTION

Beck (1979) proposes that there are three levels of dysfunctional thinking, namely, content, process and structure. The first level of negative thinking is described as automatic because the thoughts are so immediate that the individual is often unaware of them. According to Beck, negative thought content results from an underlying negative thinking style. Several logical errors have been described, for example, 'Arbitrary Inference' is the error of drawing a conclusion in the absence of supportive evidence or despite contrary evidence; and 'Overgeneralisation' is the error of making a general conclusion on the basis of a single incident (e.g. if an individual accidentally spills her drink, she concludes that she is a clumsy person). The third and deepest level of thinking is the structure of thought or schemata. This level underlies both the content and process of thought. Schemata are the basic beliefs and attitudes held by an individual. They are active in screening and categorising information about the world. They are thought to develop during childhood as a result of certain early experiences and are activated under similar stressful circumstances. There are two types of schemata: conditional (Beck, 1976), for example, 'Unless I do everything perfectly, I am worthless' and unconditional (Young, 1989), for example, 'I am worthless'.

Traditional cognitive therapy focuses at first on negative automatic thoughts then on specific thinking errors and finally on the level of negative schemata. However, it has been found that

some patients have difficulty working at the level of thought content and Young (1989) has developed a schema focused approach for such patients. The rationale is that helping a patient to understand how she has developed certain beliefs will enable her to modify her beliefs. In therapy, a joint conceptualisation of the patient's case is developed by patient and therapist.

Although Beck (1979) emphasises the use of verbal techniques in the methods of cognitive therapy, he points out that a patient's schemas can be represented visually and refers to the use of imagery techniques in the process of cognitive restructuring with anxiety problems (Beck and Emery, 1985). He emphasises the importance of eliciting information about a patient's spontaneous visual imagery in order to help her identify and restructure her distortions in a similar way as verbally expressed cognitions.

The case described below demonstrates the schema-focused approach (Young, 1989). It also illustrates the use of cognitive techniques as applied to spontaneous visual imagery.

PRESENTING PROBLEM

B. (33) was referred to clinical psychology services by her GP with symptoms of depression and anxiety associated with stress at work. She was a prison officer and had worked in the prison service for 13 years. On initial assessment, B. was tearful and low in mood, irritable and suffering disturbed sleep. Other symptoms suggestive of a depressive illness were loss of appetite, loss of energy and reduced interest in her personal appearance. She was also experiencing a number of symptoms of anxiety i.e. sweating, palpitations and shakiness. She reported worrying that something terrible might happen to her husband and young daughter.

Also, she found it difficult to leave her alone with anyone else including her husband even for a short time. She was experiencing nightmares three to four times a week, the main theme of which was life threatening danger to herself and responsibility to others.

B.'s difficulties started in April 1996 soon after a female prisoner under her care committed suicide by hanging. B. had been on duty at the time but had arranged to leave early as her husband had lost his house keys and had locked himself out. Soon after reaching home, she received a phone call informing her of the incident. She felt shocked and very guilty. Following this event, she experienced a sense of dread and anxiety on her return to work and started counting the prisoners regularly during her shift. This ritualistic counting also spread to her home with one aspect of this reflected by her checking the number of mugs on her mug rack. She eventually went off sick in June 1996 after another hanging occurred in the prison.

PERSONAL HISTORY AND BACKGROUND INFORMATION

B. was married and had two children, a boy (14) and a girl (10 months). Her husband was a policeman but he had retired on medical grounds 2 1/2 years before. This was B.'s second relationship. Her first partner left her when her son was 7 months old.

B. had a fairly unhappy childhood. Her mother and maternal grandmother, who lived in the family home, both abused alcohol and this caused rows between her parents. B.'s mother was often drunk when she came in from school and B. would tidy up and start tea before her father came home in order to avoid arguments. Her two sisters used to go to their friends' houses in order to avoid coming home. B.'s mother was both verbally and occasionally physically abusive towards her when under the influence of alcohol, for example, she called

B. a lesbian because she spent a lot of time with her girl friend.

B. met her first partner when she was 17 years while training to be a nurse. She dropped out of her course in order to go and live with him in London believing it was her chance to leave home. However, soon after moving to London her partner began to go out at nights and even stay out overnight without telling her where he had been. B suspected he was seeing other women but did not challenge him because she felt she did not have anywhere else to go. Also after a couple of months she discovered she was pregnant and believed that she should stay with her partner for the baby's sake. The couple stayed in London for 6-7 months and during that time B. worked as a shop sales assistant. However, they then moved up to Edinburgh where she had the baby. Her partner visited her on the day of the birth but did not return and she spent 6 days in the maternity hospital without receiving any visitors and worrying about her partner. She did not contact her family because she felt ashamed of the difficulties she was having with her partner. A few months later, B.'s partner accused her of seeing another man and started to lock her inside the flat with the baby for days on end only coming to bring her food and provisions for herself and the baby. He was also physically and sexually abusive towards her when he came home. After several months he told her the relationship was over. B moved back to her parents house but did not report what had happened to the police. Soon after she got a job as a prison officer in order to support herself.

MEASURES OF ASSESSMENT

B.'s level of depression was assessed using the Beck Depression Inventory (BDI: Beck et al., 1961) and her level of anxiety was assessed using the Beck Anxiety Inventory (BAI: Beck et al., 1974). She scored 35 on the BDI which is within the severe range and she obtained a

score of 34 on the BAI which is also within the severe range. In order to gain an index of her beliefs the Dysfunctional Attitude Scale (DAS: Weissman and Beck, 1978) was administered. She scored 136 on the DAS. B. displayed a number of ritualistic tendencies and in order to assess whether she exhibited any symptoms of obsessive compulsive disorder the Maudsley Obsessional-Compulsive Inventory (MOCI) was administered. She scored 1 out of 9 on the 'checking' subscale; 1 out of 11 on the 'washing' subscale; 1 out of 7 on the 'slowness-repetition' subscale; 3 out of 7 on the 'doubting-conscientious' scale; and obtained a total obsessional score of 6 out of 30 which was not clinically significant. This scale was only used at baseline as it was established that B. did not exhibit any such symptoms.

FORMULATION

This woman was suffering from a number of depressive and anxiety symptoms following the suicide of a prisoner in her unit. It was hypothesised that her symptoms were being maintained by her avoidance behaviour. It was also thought that her symptoms were associated with negative thinking specifically relating to an over strong sense of responsibility linked to a negative self-image due to her early experiences. This was supported by the fact that B. took responsibility for her mother when she was a child.

It was later re-formulated that B. had somehow subconsciously associated with the prisoner who had died due to her experiences of trauma within her first relationship i.e. being locked in the flat and physically and sexually assaulted. This was supported by the fact that B. had been a similar age to the prisoner when she had been locked up by her partner and had considered committing suicide. In addition, both women had a young baby.

TREATMENT PROCEDURES

There were three main aims of treatment: 1) to reduce B.'s depressed and anxious mood by helping her to identify current triggers for her emotions; 2) to help B. explore the meaning she took from her early experiences; and 3) to help her challenge her feelings of responsibility for the prisoner's death. Later in treatment it was decided to target B.'s anxiety about the prison itself.

Following assessment, treatment consisted of 21 hour long sessions of Cognitive therapy according to Beck (1979). The cognitive model was explained to B. and she was given information on negative automatic thoughts and thinking errors and their contribution to depressed and anxious mood. Beck et al. (1979) suggest that behavioural techniques are important early in therapy with depressed patients in order to disrupt the depressive cycle. B. was asked to keep a daily diary of her activities and it became apparent that she set herself unrealistic targets as regards household tasks that led her to experience failure which contributed to her low and anxious mood. This was targeted using a distancing technique. B. was asked to imagine how she would advise an individual presenting with a similar regime and was able to suggest some changes. She was also encouraged to schedule in more pleasurable activities.

B. was then asked to keep a daily diary of automatic thoughts. However, this proved very difficult for her partly due to avoidance and the fact that she sometimes experienced imagery. She later became proficient at this and was taught to challenge her thoughts using several techniques (i.e. examining the evidence for and against the thought; substituting alternative interpretations and behavioural experiments). B. continued to demonstrate resistance in

recording her negative thinking and it was therefore decided to use a schema focused approach (Young, 1989). The aim was to look in detail at B.'s life history and collaboratively compile a conceptualisation of her case. Considerable time was spent examining the meaning she took from her experiences and examining how the beliefs and coping strategies derived from them affected her present life. The joint formulation is contained in Figure One. Core beliefs were identified by using several techniques (i.e. eliciting general rules from specific examples ; looking for common themes; developing the logical implications of her automatic thoughts by the downward arrow technique; and examining her DAS profile).The dysfunctional attitudes were tackled in therapy by examining the cost benefit of these beliefs; evidence for and against; and reality testing which involves testing the consequences of disobeying the rule. B.'s strong sense of responsibility was challenged by drawing pie charts to illustrate the relative degree of responsibility attributed to her and other circumstances in different situations.

When thinking about the prison, B. experienced a number of images which she found very distressing, for example, a prisoner hanging with a black bag over her head. It was attempted to elicit the meaning of B.'s distressing imagery and dreams using distancing techniques. Also, B. was taught dream management techniques to manipulate such dreams in order to develop a sense of control.

Six further sessions were carried out to specifically target B.'s anxiety about the prison; her difficulties with the word 'suicide'; and continuing nightmares about the prison. B. agreed to these sessions with the condition that her unwillingness to return to work would not be discussed. B. had been unable to follow any media coverage about the suicides at the prison

without feeling panicky. Several techniques were used to counter B.'s avoidance (i.e. getting her to describe the prison as if she were a mile away or as if she was writing a novel; and reading through newspaper articles within sessions which were re-read for homework). As treatment progressed, new information came to light about B.'s traumatic experiences in her first relationship i.e. being locked in the flat and physically and sexually assaulted. This was linked in to the joint formulation. Work was then carried out to highlight information which was contradictory to B.'s core beliefs of weakness, for example the fact that she developed coping strategies to deal with being locked up alone and she did not attempt to commit suicide.

OUTCOME OF TREATMENT

After 15 sessions it was apparent that B.'s level of functioning had significantly improved. Her depression scores on the BDI decreased from 35 (severe) to 13 (mild) and her scores on the BAI decreased from 34 (severe) to 21 (moderate). Reduction on these formal assessments was further supported by clinical observation of improved mood, appetite, interest in personal appearance and social activities such as seeing friends, going out to the gym and going out with her family. She was able to share the responsibility for her daughter's care with her husband and allow him to do household tasks. However, she still experienced considerable anxiety when talking about the prison and continued to have nightmares.

After 21 sessions, B. scored 4 on the BDI which is classified as not depressed and 6 on the BAI which is classified as minimal anxiety. She was no longer experiencing nightmares. In addition, she returned to work at the prison. She reported that she had found it useful to examine her early childhood experiences and was able to see the relationship between her

past history and her beliefs and assumptions. There was evidence from her self-report that she had been able to change her beliefs in the light of her present knowledge. This was further supported by a decrease in her DAS score from 136 to 53 and a change in her DAS profile which suggested a reduction in the rigidity of her beliefs.

DISCUSSION

This case provides support for the efficacy of the schema focused approach with a patient who was unable or unwilling to access her negative thought content. The rationale of the approach is that helping a patient to identify her negative beliefs and to understand how she might have developed them will enable her to modify them. In treatment, after the initial difficulty in eliciting B.'s thought content, a lot of time was spent examining B.'s experiences as a child and in her early adulthood and forming links between her experiences and her dysfunctional beliefs. There were two main themes in B.'s thinking, namely, responsibility and threat.

The theme of responsibility was tackled first in treatment using a combination of behavioural and cognitive techniques. It was hypothesised that B.'s symptoms of depression and anxiety were linked to negative thinking relating to an over strong sense of responsibility which had possibly resulted from her early childhood experiences, for example, she held the conditional belief 'If I do not take responsibility for things I am nothing' It was thought that this had been triggered by the death of a prisoner under her care and had resulted in her feeling guilty and responsible for what had happened; and driven her to take sole responsibility for her young daughter and to be hypervigilant both at work and at home. Helping B. understand how her beliefs may have developed helped her to challenge them and develop a more flexible belief

system which took into account the uncontrollable nature of some aspects of life. This in turn resulted in her being able to share the responsibility for her daughter's care with her husband and allowed herself time for relaxation and recreation.

The theme of threat was also tackled in treatment but with limited success despite attempts to elicit B.'s automatic thoughts and the meaning of her dreams and images. It had been hypothesised that B.'s anxiety and hypervigilance was due to her beliefs of responsibility for the prisoners' well being and had resulted in her avoidance of work and in her unwillingness to talk about this in treatment. However, later in treatment, B. disclosed that she had been locked up and physically and sexually assaulted by her first partner and the case was reformulated. It was hypothesised that B. had subconsciously associated with the prisoner who died because of the similar nature of her experiences within her first relationship and her suicidal ideation at that time. It was apparent that B. was experiencing a number of symptoms suggestive of post-traumatic stress disorder, namely her intense fear reaction associated with the prison; her avoidance of going to the prison, thinking about it or following any media coverage about the suicides; her recurring nightmares and her symptoms of hyperarousal i.e. hypervigilance and sleep difficulties. Her symptoms were tackled using exposure; linking in her experiences and the meaning she took from them to her core beliefs and reattributing her experiences; examining similarities between the prisoner's situation and her own at that time and then highlighting differences such as the way she stopped herself from committing suicide because of her baby despite the difficult situation she was in and her coping abilities. These strategies resulted in a marked shift in the patient. She announced that she was returning to work after refusing to even discuss this in therapy. She also reported that she believed she was a strong person.

This multi-faceted treatment approach led to an improvement in B.'s functioning and to her reattributing her childhood experiences and those within her first relationship. It also resulted in her developing a more flexible belief system. She was able to distinguish differences between herself and the prisoner who died and to establish her strengths and coping abilities. It is impossible to test the hypothesis that B. had identified with the prisoner who died. Following treatment, B. herself denied ever seeing any similarities apart from those discussed within sessions. However, the marked shift in her behaviour and beliefs after exploring such similarities and differences suggests that this was an important therapeutic ingredient. It is possible that she had unconsciously made links for herself and her denial of any such similarities was an indication of her changed belief system.

Figure 1- Joint Formulation

EARLY EXPERIENCES

Alcoholic mother and grandmother. Verbally and physically abused.
Witnessed rows between parents

CORE BELIEF

'I am a failure'
'I am weak'
'I am a bad person'

CONDITIONAL BELIEF

'If I do not take responsibility for things I am nothing'

BEHAVIOUR

Cleaning excessively
and counting household
items

Worrying about family's
safety

Taking sole responsibility
for daughter's care

AUTOMATIC THOUGHTS

'I must be going off my head'

'Something could go wrong'

'People will think badly of me
if I do not take responsibility
for her'

EMOTIONS

depression

anxiety

irritable

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7. SINGLE CASE RESEARCH STUDY - The Victim

(Submitted in the format of Clinical Child Psychology and Psychiatry. See Appendix 7.1)

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The Victim

ABSTRACT

It is widely accepted that bullying is a stressful experience. This case study illustrates the painful effects of bullying as reported in the literature. It also provides support for the theory that the effects of bullying can be reduced by increasing self-esteem and coping skills to deal with it. A treatment procedure aimed at increasing such coping skills and its outcome are described and discussed. The case also highlights the problem of victimisation within clinical samples and the need for therapists to develop therapeutic strategies for patients experiencing this problem.

Key words: Victimisation; Depression; Family Characteristics

INTRODUCTION

Bullying has been defined as 'persistent aggressive behaviours designed and intended to cause distress and fear over a period of time' (Tattum and Herbert, 1990). In addition there is an imbalance of power between bully and victim which makes it a form of abuse. It is widely accepted that bullying is an important source of stress for young people (Sharp, 1995). Less is known about the specific effects of bullying. However, victimisation has been associated with various psychological symptoms including anxiety (Slee, 1994; Sharp, 1995); depression (Slee, 1995); and irritability (Sharp and Thomson, 1992; Sharp, 1995). It has also been associated with poor concentration (Sharp and Thomson, 1992; Sharp, 1995) and underachievement in school work (Hazler, Hoover and Oliver, 1992). In addition, there is some evidence to suggest that the effects of bullying can last through to adulthood (Olweus, 1993) and produce continued depressed mood and low self-esteem. It is worrying to think that a child may underachieve in school because of bullying problems which may not be apparent to teaching staff because it is not reported. In addition, the possible long-term consequences of victimisation suggested by Olweus (1993) highlight the importance of tackling bullying problems in schools in order to prevent current and future psychological difficulties; and helping vulnerable individuals to develop strategies to deal with such behaviour.

There is some indication that the parents of victimised children are more overprotective or overinvolved with their child (Bowers, Smith and Binney, 1992; Oliver, Oaks and Hoover, 1994). It is proposed that this may prevent the child from developing independence and social skills with peers. Olweus (1993) found that mother's overprotectiveness had the largest direct effect on degree of victimisation in a path analysis involving a sample of adolescent

boys. However, the causal relationship between the boy's temperament and mother's overprotectiveness is not clear from Olweus's study and it is possible that the mother's behaviour is in part a consequence of the boy's temperament. In addition, it is possible that overprotectiveness occurs as a reaction to the bullying itself.

The following case illustrates the painful nature of victimisation and its effects. It also illustrates some of the findings in the literature. It was speculated that a treatment procedure which increased coping skills to deal with bullying would result in reduced symptomatology.

PRESENTING PROBLEM

A. (16) was referred to clinical psychology services by his GP because of depressive symptoms associated with being bullied at school. He was in fifth year.

A. was being bullied on his way to and from school and within school by pupils in the year below him. He was mostly experiencing verbal bullying. However, he had also been physically attacked on one occasion by a group of boys. He reported feelings of uncontrollable anger when he was called names and being irritable at home. There was also evidence that his low and angry mood were maintained by rumination.

A. was experiencing a number of depressive symptoms, namely low and flat mood, suicidal ideation, irritability, loss of interest, loss of libido, early morning wakening and poor concentration. Also, he reported that he had no motivation to study for his Higher examinations. It was apparent from his school report that he was clearly underperforming at school in relation to his level of ability. He also said that he felt excluded by his classmates

and often sat on his own. In addition, he compared himself unfavourably with his brother in that he was doing well academically, had friends and was able to handle being called names. He said that he decided to seek help for his problems because of the way they were affecting his life.

During interview, A. presented as being rather anxious and withdrawn. He avoided eye contact with me and sat slumped down in his chair looking down at the floor.

PERSONAL HISTORY AND BACKGROUND INFORMATION

A lived with his mother and his identical twin brother. His parents had separated when he was four years old. A. enjoyed designing things and went to a school club for young engineers. Both A. and his brother were registered with MENSA.

Interview with A.'s mother

Mrs M. reported that A. had always been a rather quiet introverted individual. She said that he had experienced constant bullying ever since his last year of primary school. His brother, on the other hand, was more extroverted and did not experience bullying. He tried to support A. at school. However, A. felt that he should be able to handle his own problems. She said that A. was often very withdrawn and angry when he came home from school. However, he was a different boy during the school holidays. She said that she worried a lot about A. and was sometimes tearful. She reported that she had no friends to talk to about her worries.

MEASURES OF ASSESSMENT

A.'s level of depressed mood was assessed using the Beck Depression Inventory (BDI: Beck et al., 1961). He scored 24 on the BDI which is classified as moderately depressed. His level of activity was also assessed by asking him to keep a daily diary of his activities.

FORMULATION

It seems that this young man was experiencing depressive symptoms and low self-esteem as a result of ongoing bullying. It was hypothesised that the bullying was being maintained because of A.'s reactions when negative comments were made towards him. It was also hypothesised that his low mood was being maintained by rumination about the bullying incidents; lack of pleasurable activity and lack of social contact with his peers out of school. Thirdly, it was hypothesised that that A.'s mother was very anxious and over-involved with her son which was contributing to his problems. She had very few social contacts and rarely left the house.

TREATMENT PROCEDURES

There were three main aims of treatment: 1) to target A.'s depressive symptoms; 2) to help him develop strategies to deal with bullying; and 3) to provide detailed advice to Mrs M. about his management at home.

Treatment was conducted over 10 hour-long weekly sessions using a cognitive- behavioural approach. Treatment can be conceptualised under 4 headings: 1) Cognitive therapy; 2) A behavioural approach; 3) Strategies to cope with bullying; and 4) Advising Mrs M. regarding A.'s management at home.

1) Cognitive Therapy -The cognitive component of treatment was carried out in accordance with Fennell (1994). It became apparent from A.'s daily diaries of his activities that he spent most of his time reading physics books at home or in the library. He was not studying physics at school but reported that he was more interested in it than his school subjects, and he was not studying for his examinations. His only social experience was attending the engineering club at school during lunch times. A. reported that he was often excluded by his classmates. However, it became apparent that he avoided social contact because he felt uncomfortable with other people and because he was anxious about being ridiculed or left out. He was encouraged to do more activity and to socialise more with people at school. However, he failed to carry out a number of agreed behavioural experiments such as attempting to go to a karate class with his brother who was a member of a club.

A. was given information about negative automatic thoughts and types of thinking error and their contribution to depressed mood. He was also taught to examine the evidence for and against certain thoughts. He was asked to keep a daily diary of his negative automatic thoughts and to challenge such thoughts. However, in practice, A. found this difficult to do and failed to fill in his diary of negative automatic thoughts on a number of occasions and also to carry out a number of homework tasks. It was therefore decided to discontinue this approach.

2) Behavioural Approach - A. was helped to develop a more confident body posture by putting his head up, walking tall and using eye contact. At first, he found it difficult to maintain eye contact and felt as if he would fall over if he did not look at the ground when he walked, but he became more confident over time. He was encouraged to look me in the eye

during treatment sessions and prompted to change his body posture during sessions. He also practised this at home with his family. Secondly, A. was taught to use relaxation in order to deal with tension and anxiety and distraction to deal with anxious thoughts. Thirdly, he was taught to develop study techniques in order to organise his work for his Higher examinations and to counter his lack of motivation. He seemed to find this approach much more helpful and complied more with homework tasks.

3) Strategies to cope with bullying

A. was provided with some literature on how to cope with bullying written by Childline. Modelling and role play were used in order to help him develop a more confident body posture. He was taught to use a number of strategies to cope with bullying, namely fogging and teaseproofing. Fogging involves imagining that there is a thick fog around you and you cannot be affected by what other people say to you. Teaseproofing involves practising verbal responses to use when replying to negative/derogatory comments..

A. was also invited to attend a 6 week intervention group for victims of bullying in order to practice his skills within a more supportive environment. The content of the group involved talking about bullying behaviour and its different forms. The ‘Sticks and Stones’ video by Central Television (1990) which contains interviews and drama sketches of bullying incidents was shown and discussed within the group. Also, coping strategies to deal with bullying were both elicited from group members and taught and practised within the group itself. Role play and teaseproofing were carried out with other group members. Also group members were given feedback on their non-verbal communication and opportunity to practice this within the group.

4) Providing support and advice to Mrs M.

It was suggested to Mrs M. that she try not to convey her anxiety to A. when he had been bullied and that after sympathising with A. she move the conversation on to other things. She was also encouraged to be firm with him about doing his homework. In addition, it was suggested that she tried to socialise more herself. A problem solving approach was used to identify possible ways to meet other people as it seemed that she was fairly isolated and received little social support.

OUTCOME OF TREATMENT

A made good progress in treatment. His score on the BDI went from 24 at the start of treatment which is classified as moderately depressed to a score of 5 which is classified as not depressed. Reductions on these formal assessment were further supported by clinical observation of improved mood and interest and improved concentration. He reported that he felt more confident in dealing with incidents of bullying and the number of incidents had reduced due to him appearing more confident. In addition, he found the intervention group very helpful especially finding out that others had similar experiences to himself. He was also using the study skills he had learned and had drawn up a plan of what he needed to cover for each of his subjects. In fact, he decided to stay on at school in order to improve his qualifications and he planned to study physics in his 6th year. He was still fairly isolated socially and had resisted any suggestions to improve this. However, he became friendly with another boy in the bullying group and was planning to ask a friend from his engineering club back to his home. A. said that he wanted to try and manage on his own using the strategies he had learned and he was discharged. Finally, Mrs M. was slightly more active outwith the

home and felt happier about A. and more able to deal with his mood swings at home. She was also encouraging A. to see friends whereas before she had been afraid that he might be bullied if he went out.

DISCUSSION

This case illustrates the association between victimisation and depression. It demonstrates that it is possible to relieve symptomatology by increasing coping skills to deal with bullying. It also highlights the need for sensitivity in the therapist to tailor the treatment approach to suit the patient.

It was hypothesised that A.'s experience of bullying throughout much of his school life had resulted in reduced self-esteem and depressed mood. There seemed to be several vulnerability factors linked to him being bullied currently such as his quiet temperament, his fragile self-esteem due to repeated episodes of bullying and his lack of social contact with peers.

A cognitive approach was used in order to help A. identify negative thinking which may have been triggering his low mood. However, A. had difficulty with this and the approach was discontinued.

It became apparent that A. did little pleasurable activity and it was hypothesised that this would contribute to his low mood. Activity scheduling was used to encourage A. to increase his level of pleasurable activity. He was also encouraged to socialise more with his peers but resisted this. In fact at the end of treatment he was still fairly isolated socially. Arora (1991)

maintains that victims of bullying do not have the sufficient skills to integrate with peers and this makes them vulnerable to ongoing bullying. A was invited to participate in a group intervention for victims of bullying which provided him with a positive experience with his peers. He found the group very helpful and especially meeting others who were experiencing bullying like himself. Perhaps this normalised his experience.

A. reported that he had no motivation to study for his exams and he was clearly underachieving at school in relation to his level of ability. Activity scheduling was used in order to help him structure his study time better. This seemed to be beneficial.

It was hypothesised that A.'s occasional angry reactions to being bullied were maintaining the bullying behaviour. Smith and Sharp (1994) proposed that training individuals to maintain neutrality can de-escalate bullying situations rather than exacerbating them. A. learned several coping strategies to deal with bullying situations, namely, distraction, confident body posture; relaxation; fogging and teaseproofing. These reduced his anxiety and increased his confidence. It was also noted that the number of bullying incidents appeared to reduce.

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8. RESEARCH PORTFOLIO APPENDIX

APPENDIX 1.1

1. Notes for contributors to Clinical Psychology Forum

APPENDIX 2.1

Notes for contributors to the *Journal of Child Psychology and Psychiatry*

APPENDIX 3.1

Record form for team members to complete following first interview

**PLEASE STICK NAME & ADDRESS LABEL FROM
CASENOTES OR WRITE IN PATIENT DETAILS:**

DOES THIS PATIENT HAVE PROBLEMS WITH BULLYING?

YES*

NO

* If Yes, please ask Val for questionnaire pack and return to Angela.

Please return this form immediately to Angela's pigeon-hole.

Thank you.

APPENDIX 4.1.

Notes for contributors to Child Psychology and Psychiatry Review

APPENDIX 4.2

Consent Form

CONSENT FORM

We are interested in how young people coming to see us feel about themselves and in whether or not they have been bullied. We hope that this information you can give us can help us to provide a better service. If you are willing to take part in this study your answers will be confidential. However, if you do not wish to take part, this will not affect your treatment in any way.

The study has been fully explained and I am willing to take part.

Signature

Date

Parent/Guardian's Signature

Date

APPENDIX 4.3

Bullying Questionnaire

BULLYING QUESTIONNAIRE

1. Have you been bullied? Yes () No ()

If YES please continue

If NO please go to question 18

2. How often is this bullying happening?

Less than once a month ()

Once a month ()

Once a week ()

Once a day ()

Several times a day ()

Other:

3. Was the bully Alone () In a group () Some of each ()

4. Was the bully(bullies)

A girl ()

A Boy ()

Both ()

A teacher/member of staff ()

5. What type of bullying was it? (Tick any that apply)

Punching, Kicking, Pushing ()

Property taken or damaged ()

Being called names ()

Being threatened ()

Being excluded or ignored ()

Other type () PLEASE EXPLAIN:

6. Where were you bullied (Tick any that apply)

- On way to or from school ()
- In corridors ()
- In playground ()
- In toilet block ()
- In classes ()
- Other () PLEASE EXPLAIN:

7. When does the bullying happen?

- Morning ()
- Lunchtime ()
- Afternoon ()
- After school ()
- Other () PLEASE EXPLAIN:

8. Did you report the bullying? Yes() No()

If not, why not?

- Afraid to ()
- Did not think it would be taken seriously ()
- Thought it would stop ()
- Thought it would make things worse ()
- Other reason ()

PLEASE EXPLAIN:

9. Who did you tell?

Teacher/member of staff ()
Parent ()
Other family member(s) ()
Friend(s) ()
Other

PLEASE EXPLAIN:

10. How much support did you get from members of staff?

1 2 3 4 5
very little very much

11. How much support do you get from your parent?

1 2 3 4 5
very little very much

12. How much support did you get from other family member(s)?

1 2 3 4 5
very little very much

13. How much support do you get from your friend(s)?

1 2 3 4 5
very little very much

14. How much support did you get from other?

1 2 3 4 5
very little very much

15. How did the bullying make you feel?

- worried ()
- frightened ()
- Sad ()
- Angry ()
- No feelings ()
- Other ()

PLEASE EXPLAIN:

16. What effect does the bullying have? PLEASE EXPLAIN:

17. Why do you think you were bullied?

18. Do you think the person/people that bullied you has/
have bullied others? Yes () No () Don't Know ()

19. Have you ever bullied anyone? Yes () No ()

If YES, why?

20. Are you bullying someone in school now? Yes() No()

21. Have you ever seen any bullying at school? Yes() No()
If YES what type of bullying? *Describe below

22. Did you report it? Yes() No()

If YES, did reporting the bullying stop it?

Yes() No()

If it did not stop, why not

PLEASE EXPLAIN:

23. If you did not report it, why not? Describe below:

24. What should be done about the problem of bullying?

APPENDIX 4.4

Results for the Bullying Questionnaire for bullied individuals

Q5. What type of bullying was it?

			%	
Physical	Yes	6	27.3	
	No	16	72.7	
Theft	Yes	2	9.1	
	No	20	90.9	
Verbal	Yes	20	90.9	
	No	2	9.1	
Threat	Yes	9	40.9	
	No	13	59.1	
Ignore	Yes	11	50.0	
	No	11	50.0	
Other	Yes	1*	4.5	*chased
	No	21	95.5	

Q 6. Where were you bullied?

			%	
On the way to school	Yes	9	40.9	
	No	13	59.1	
In corridors	Yes	13	59.1	
	No	9	40.9	
In the playground	Yes	12	54.5	
	No	10	45.5	
In the toilet block	Yes	3	13.6	
	No	19	86.4	
In class	Yes	14	63.6	
	No	8	36.4	
Other	Yes	1*	4.5	* outside the school round at the shops
	No	21	95.5	

Q7. When does the bullying happen?

			%
Morning	Yes	18	81.8
	No	4	18.2
Lunch	Yes	14	63.6
	No	8	36.4
Afternoon	Yes	13	59.1
	No	9	40.9
After school	Yes	9	40.9
	No	13	59.1
Other	Yes	4*	18.2
	No	18	81.8

* In the evening; between classes; when he sees me; and any time

Q9. Who did you tell?

			%
Teacher/ Member of staff	Yes	8	36.4
	No	10	45.5
Parent	Yes	13	59.1
	No	5	22.7
Other family member	Yes	2	9.1
	No	16	72.7
Friend(s)	Yes	5	22.7
	No	13	59.1
Other*		no responses.	

Q10. How much support did you get from members of staff?

	Frequency	%
Very little	1	12.5
Some		
Medium	1	12.5
Moderate	6	75.0
Very much		

Q11. How much support did you get from parents?

	Frequency	%
Very little		
Some	1	7.7
Medium		
Moderate	1	7.7
Very much	11	84.6

Q12. How much support did you get from other family?

	Frequency	%
Very little		
Some		
Medium	2	100
Moderate		
Very much		

Q13. How much support did you get from friends?

	Frequency	%
Very little	1	20.0
Some		
Medium		
Moderate		
Very much	4	80.0

Q14. How much support did you get from others?

	Frequency	%
Very little		
Some		
Medium		
Moderate		
Very much		

* no responses

Q15. How did the bully make you feel?

			%
Worried	Yes	10	45.5
	No	12	54.5
Afraid	Yes	7	31.8
	No	15	68.2
Sad	Yes	11	50.0
	No	11	50.0
Angry	Yes	17	77.3
	No	5	22.7
No feelings	Yes	2	9.1
	No	20	90.9
Other*	No responses		

APPENDIX 4.5

Mean pre- and post BAI, BDI, BHS and Self Perception Profile Scores for subjects in the bullying group

	n	<u>Before</u>		n	<u>After</u>	
		mean	(SD)		mean	(SD)
BAI	3	17.0	(5.3)	3	6.0	(4.0)
BDI	3	15.0	(7.2)	3	3.3	(4.0)
BHS	3	4.0	(2.7)	3	2.5	(2.1)
Self-Esteem						
Scholastic Competence	3	19.0	(1.0)	3	18.0	(2.0)
Social Acceptance	3	16.0	(1.7)	3	13.0	(1.0)
Athletic Competence	3	17.3	(1.2)	3	14.7	(4.0)
Physical Appearance	3	14.3	(1.2)	3	15.7	(1.2)
Behavioural Conduct	3	20.3	(2.9)	3	20.7	(2.3)
Global Score	3	90.0	(3.0)	3	86.7	(5.1)

APPENDIX 5.1

1. Notes for contributors to Clinical Child Psychology and Psychiatry

APPENDIX 6.1

1. Notes for contributors to Behavioural Psychotherapy

Editorial Statement

Behavioural Psychotherapy is an international multidisciplinary journal for the publication of original research, of an experimental or clinical nature, that contributes to the theory, practice and evaluation of behaviour therapy. As such, the scope of the journal is very broad and articles relevant to most areas of human behaviour and human experience, which would be of interest to members of the helping and teaching professions, will be considered for publication.

As an applied science, the concepts, methodology and techniques of behavioural psychotherapy continue to change. The journal seeks both to reflect and to influence those changes.

While the emphasis is placed on empirical research, articles concerned with important theoretical and methodological issues as well as evaluative reviews of the behavioural literature are also published. In addition, given the emphasis of behaviour therapy on the experimental investigation of the single case, the Clinical Section of the journal publishes case studies using single case experimental designs. For the majority of designs this should include a baseline period with repeated measures; in all instances the nature of the quantitative data and the intervention must be clearly specified. Exceptionally, the journal will consider case studies where, although the interventions have not been experimentally evaluated, the treatment approach and/or problem dealt with is considered to be of particular importance *and* clear indicators of change are provided.

The following types of articles are suitable for *Behavioural Psychotherapy*:

- ★ Reports of original research employing experimental or correlational methods and using within or between subject designs.
- ★ Review or discussion articles which are based on empirical data and which have important new theoretical, conceptual or applied implications.
- ★ Brief reports and systematic investigations in single cases employing innovative techniques and/or approaches.

Articles should concern original material which is neither published nor under consideration for publication elsewhere.

APPENDIX 7.1

1. Notes for contributors to Clinical Child Psychology and Psychiatry