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Australas Psychiatry 2014 22: 149 originally published online 10 February 2014

DOI: 10.1177/1039856214520791

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Australasian Psychiatry
2014, Vol 22(2) 149–153
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DOI: 10.1177/1039856214520791
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Abstract

Objective: The purpose of this study was to determine whether a parent's past history of peer victimisation predicted their children's risk of being bullied at school.

Method: In face-to-face interviews, a representative community sample of 1895 mothers and fathers were asked about exposure to traumatic bullying during their schooling. Parents completed the Medical Outcomes Study Short-Form Health Survey (SF-36) to measure possible links with health-related quality of life. The interviews also inquired whether their children were victims of traumatic bullying at school.

Results: Parental victimisation was associated with an increased risk for their children being bullied (55% with a positive parental history compared with 25% with no parental history: relative risk=2.17). In a multivariate logistic model controlling for the parents' age, gender, socioeconomic status and health-related quality of life (physical and emotional components), parental victimisation remained a strong predictor for the children's victimisation at school (relative risk=2.00). In 9.3% of the sample, both parent and child experienced bullying during their schooling.

Conclusions: Parent and child dyads can be exposed sequentially to school bullying. In some instances, they may share familial characteristics that are exploited by bullies. These experiences can be explored in parent-child psychotherapy.

Keywords: school bullying, family history, parent-child psychotherapy

School bullying is highly distressing and victims have increased risks of depression, psychotic symptoms, and suicidal behavior.^{1–6} Prolonged victimisation has enduring effects with social and emotional consequences lasting into adult life.^{4,7–9} Unfortunately, school bullying has remained a common occurrence across recent generations. Hence, today's parents could have experienced traumatic victimisation during their school years. Despite recognition of the possible long-term effects, there are few studies of parents' exposure to peer victimisation. However, a parent's exposure to social victimisation may have had a significant formative influence on their awareness of bullying as a potential problem for their children and their responses should it occur.

Fortunately, there is one pioneering longitudinal study into parental exposure to school bullying. The Cambridge Study into Delinquent Development identified victims

of school bullying while they were aged 8–14 years.¹⁰ These children were followed into adulthood, and nearly one-half (45%) of the adolescent victims who later became parents identified that their children were also victimised. In comparison, only 18% of the non-victim parent group reported that their children were victimised. This represented a doubling of risk for children whose parents were victimised during adolescence.

In clinical settings, parents' past exposure to school bullying can be fully explored so it is possible to investigate whether parents and children have experienced school bullying across two generations. Our group has encountered many instances among school referrals to a Child

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and Adolescent Mental Health Service (CAMHS)¹¹ where a parent and child report remarkably similar experiences with school bullying. In formulating these cases of inter-generational peer victimisation, we include familial risk factors such as shared temperament, physical characteristics, mental health problems (internalising and externalising), and intergenerational patterns of neglectful parenting and maltreatment.

With knowledge of the immediate family history, parent-child psychotherapy can focus on these risk factors and common experiences around school bullying. A narrative exploration of school bullying can improve mentalisation – the ability to understand the mental states behind overt behavior. Mentalisation has a key role in psychiatric interventions to reduce aggressive school bullying¹² and it is also important in improving outcomes for victims.¹³ It underlies the warm and empathic responses known to promote resilience in the face of school bullying.¹⁴ Bullied children feel isolated, fearful and humiliated; and parent-child psychotherapy can increase attachment security and buffer children from the emotional impact of victimisation.

While case studies have a valuable role in informing psychotherapeutic approaches, it was unclear whether these are isolated instances or part of a more general pattern of familial risk. In the current study, we sought to broaden our investigation from the clinical setting to a representative sample drawn from the wider community. In face-to-face interviews with a large sample of parents, we inquired about their past histories of traumatic bullying and their health-related quality of life because of the potential long-term effects of bullying on health and wellbeing.^{4,7–9} In addition, we asked about their child's experiences of traumatic bullying at school.

Method

Participants

Data were obtained from the South Australian Health Omnibus Survey (HOS). The HOS is a population-based face-to-face survey conducted in the autumn of each year. Ethical approval for the questions included in the survey and used in the present study was obtained from the South Australian Department of Health Human Research Ethics Committee. Written informed consent was obtained for each respondent prior to the conduct of the survey. The methods used in the HOS are described in detail elsewhere.¹⁵

Survey instruments and measures

Health-related quality of life was evaluated by the Medical Outcomes Study Short-Form Health Survey (SF-36) version 2. The SF-36 is composed of 36 items, which can be combined into two summary measures providing an overall estimate of physical health (physical health component scores) and mental health (mental health component scores). In

the present study norm-based (based on Australian weights) T-scores (Mean=50, standard deviation (SD)=10) were used for the summary measures of physical and mental health. Studies have indicated that the reliability estimates for the summary scores for physical and mental health tend to exceed 0.90.¹⁶ The use of the SF-36 across a variety of contexts has confirmed the validity of this measure.¹⁶

Self-reported history of peer victimisation was assessed in respondents using the following question: 'When you were at school did you experience traumatic bullying by peers that was particularly severe, for example, being frequently targeted or routinely harassed in any way by 'bullies'?'.¹⁶ Respondents were classified as experiencing peer victimisation or not experiencing peer victimisation at school with responses coded as zero, 'No' and one, 'Yes'. Respondents also reported whether their children had been victimised, by answering the following question: 'If you have children, have they experienced traumatic bullying by peers at school?' Responses available were 'No children', 'Children not at school yet', 'No', 'Yes' and Missing ('Don't know', 'Refused', 'Not stated').

Statistical analyses

Statistical analyses were conducted with Stata version 11 (StataCorp, College Station, Texas, USA). Survey estimators were used to account for the clustered multi-stage design of the HOS. Strata were defined by area (metropolitan/rural), the primary sampling unit as Collector Districts, and a non-integer weighting variable (pweight) based on benchmarks derived from the Australian Bureau of Statistics was used to provide estimates representative of the South Australia population in terms of age and sex. Generalised linear models (logistic regression) based on a modified Poisson method were used to estimate risk ratios (RRs). RRs were preferred over odds ratios because they are more accurate when outcomes are relatively common (prevalence>10%).

Results

Sample characteristics

Of the 5000 private dwellings selected, there was a participation rate of 73% of those in scope. The parent sample used in the analyses comprised adults (18 years of age and above) with children that were old enough to have attended school ($n=2048$). Respondents who did not answer either the questions regarding bullying or the SF-36 questions were excluded ($n=153$). The final unweighted sample was 1895 respondents which when corrected for the complex survey design produced an effective weighted sample of 1782. The weighted sample comprised 804 males (45%) and 978 females (55%). Around one-half (53%) of the sample were 54 years old or less.

Analyses

Table 1 shows that 17% of the parents reported that they had been bullied and just under one-third (30%) of

Table 1. Rates of parent and child victimisation

	<i>Child was victimised</i>		<i>Total</i>
	<i>No</i>	<i>Yes</i>	
	<i>n (%)</i>	<i>n (%)</i>	
Parent was victimised			
No	1107 (75)	373 (25)	1481 (83)
Yes	137 (45)	165 (55)	301 (17)
Total	1244 (70)	538 (30)	1782 (100)

Table 2. Logistic models of the relative risk for child victimisation

	<i>Relative risk</i>	<i>t</i>	<i>p</i>	<i>95% CI</i>
Univariate model				
Parent victimised (no/yes)	2.17	11.56	<0.01	1.90–2.47
Multivariate model				
Parent victimised (no/yes)	2.00	10.23	<0.01	1.75–2.28
Gender (father/mother)	1.32	3.64	<0.01	1.14–1.54
Age group (18–54 years/55+ years)	0.73	–4.25	<0.01	0.63–0.84
Socio economic status (lower/higher)	0.93	–1.95	0.05	0.87–1.00
SF-36 physical health component score	0.99	–2.87	<0.01	0.99–1.00
SF-36 mental health component score	1.00	–1.78	0.08	0.99–1.00

CI: confidence interval; SF-36: Short-Form Health Survey.

parents reported that their child had been bullied. Over one-half (55%) of parents who had experienced peer victimisation reported that a child had also experienced victimisation. In contrast only one-quarter (25%) of parents who had not been peer victimised reported that a child was victimised. Both a parent and their child were bullied in 9.3% of the reports.

Unadjusted for any other variables, the RR of parents reporting that their child had experienced peer victimisation was approximately double (RR=2.17, 95% confidence interval (CI): 1.90–2.47) for parents who reported that they themselves had been peer victimised compared with parents who had not experienced peer victimisation (Table 2).

Parent factors associated with likelihood of reporting that a child had been victimised are shown in Table 2. Controlling for whether parents reported being peer-victimised, higher reporting rates were evident for younger (<55 years of age) parents compared with older parents; mothers compared with fathers; and parents with poorer levels of physical health-related quality of life compared with parents with better levels of physical health-related

quality of life. Importantly, the increased risk found in the univariate model remained basically unchanged when these reporter effects were taken into account in the multivariate logistic model (RR=2.00, 95% CI: 1.75–2.28).

Discussion

In the present study, parent and child dyads were reported as being bullied in 9.3% of the large community sample. A positive parental history was significantly associated with an increased risk of their children's victimisation (55% with a parental history compared with 25% with no parental history: Relative risk=2.17). This doubling of risk is similar to the findings of the Cambridge Study into Delinquent Development.¹⁰ Using a different methodology, the current study provides around the same risk estimate. These two studies suggest that parental history may be a useful predictor of children's peer victimisation. However, further studies are required to elucidate the mechanisms of familial transmission.

Both genetics and the environment factors could contribute to the intergenerational transmission of risk

factors for peer victimisation. It is reasonably well established that both genes and the environment can influence the general quality of peer relationships.¹⁷ Furthermore, evolutionary psychology theory suggests that peer bullying may be 'an evolutionary adaptation', which increases competitive fitness through better access to material resources and reproductive success.¹⁸ Bullies gain rewards from their behavior and this may partly explain the limited success of school-based interventions. Even in modern societies, bullies tend to be larger, socially dominant and more sexually active in adolescence.¹⁸

However, the Environmental Risk (E-Risk) Longitudinal Twin Study was the first to report strong genetic and shared family environmental influences among victims.¹⁹ Genetic factors accounted for 73% of the variation in peer victimisation among E-Risk school-aged twins. In a follow-up study, the E-Risk Twin Study reported that heritable factors influenced the persistence of peer victimisation from primary school into high school.²⁰ The research group highlighted the psychotherapeutic importance of 'helping children manage heritable characteristics that may predispose them to victimisation.'²⁰ Importantly, persistent victimisation was also associated with shared family environmental characteristics such as socioeconomic disadvantage, low maternal warmth, and child maltreatment.²⁰

The current study has a number of methodological limitations. Firstly, information about child and parent victimisation was based on reports from a single informant (the parent). Multiple informants are preferred but in the absence of child self-reports, parents are an accepted alternative for identifying child victimisation at school.²¹ In addition, controlling for parental variables did not have a major effect on the strength of the main association. Quite surprisingly, entering the parents' age, gender, socioeconomic status and health-related quality of life (physical and emotional components) into a multivariate logistic model made little difference to the predictive power of family history when compared with the univariate model (RR=2.00 vs 2.17). Secondly, the survey relied on retrospective reports. Although prospective studies are preferred, the accuracy of retrospective recall has been examined and there is support for the validity of adults' recall. Following a review of both experimental and naturalistic studies it was concluded that recall of significant past events is not greatly affected by mood state.²² In addition, a longitudinal study²³ found that retrospective recall of bullying victimisation was stable over time.

In conclusion, peer victimisation presents young people with an impossible social predicament¹ and they may need adult assistance to escape. This assistance requires a united response with parents, teachers and mental health services acting together to resolve the bullying and ensure the child's safety and wellbeing. Parents have a central role as their child's natural advocates in the school system. This role can be compromised if a parent

has a traumatic narrative from his or her bullying experiences at school. Specific events related to their child's victimisation can re-activate traumatic memories for some parents. The present study indicates that parental exposure to school bullying is a reasonably common occurrence. Hence, child psychiatrists may find it useful to inquire about parental histories of school bullying and offer specific support to parent-child dyads where both a parent and child have been victimised. This psychotherapeutic support may help parents while they navigate the school system in order to extricate their children from the harmful dynamic of school bullying.

Acknowledgements

The authors wish to thank Robert Goldney for his helpful insights and allowing use of the SF-36.

Disclosure

The authors report no conflict of interest. The authors alone are responsible for the content and writing of the paper.

References

1. Pridmore S and Ahmadi J. Two cases of 'Type 3' suicide. *Aust Psych* 2010; 18: 426–430.
2. Kaltiala-Heino R, Rimpela M, Marttunen M, et al. Bullying, depression and suicidal ideation in Finnish adolescents: School survey. *Brit Med J* 1999; 319: 348–351.
3. Arseneault L, Bowes L and Shakoor S. Bullying victimization in youths and mental health problems: 'Much ado about nothing'? *Psychol Med* 2010; 40: 717–729.
4. Sourander A, Jensen P, Ronning J, et al. What is the early adulthood outcome of boys who bully or are bullied in childhood? The Finnish 'from a boy to a man' study. *Pediatrics* 2007; 120: 397–404.
5. Strassen Berger K. Update on bullying at school: Science forgotten? *Dev Rev* 2007; 27: 90–126.
6. Schreier A, Wolke D, Thomas K, et al. Prospective study of peer victimization in childhood and psychotic symptoms in a nonclinical population at age 12 years. *Arch Gen Psychiatry* 2009; 66: 527–536.
7. Lund R, Nielsen K and Hansen D. Exposure to bullying at school and depression in adulthood: A study of Danish men born in 1953. *Eur J Public Health* 2009; 19: 111–116.
8. Cohen P. Editorial: Abuse in childhood and the risk for psychotic symptoms in later life. *Am J Psychiatry* 2011; 168: 7–8.
9. Gladstone G, Parker G and Malhi G. Do bullied children become anxious and depressed adults? A cross-sectional investigation of the correlates of bullying and anxious depression. *J Nerv Ment Dis* 2006; 194: 201–208.
10. Farrington D. Understanding and preventing bullying. *J Crim Just* 1993; 17: 381–458.
11. Allison S, Roeger L and Abbot D. Overcoming barriers to referral from schools to mental health services. *Australas Psychiatry* 2008; 16: 44–47.
12. Fonagy P, Twemlow S, Vernberg E, et al. A cluster randomized controlled trial of child focused psychiatric consultation and a school systems-focused intervention to reduce aggression. *J Child Psychol Psych* 2009; 50: 607–616.
13. Chambers H, Amos J, Allison S, et al. Parent and child therapy: An attachment-based intervention for children with challenging problems. *Aust New Zeal J Fam Ther* 2006; 27: 68–74.
14. Bowes L, Maughan B, Caspi A, et al. Families promote emotional and behavioural resilience to bullying: Evidence of an environmental effect. *J Child Psychol Psych* 2010; 51: 809–817.
15. Wilson D, Wakefield M and Taylor A. The South Australian Health Omnibus Survey. *Health Promot J Aust* 1992; 2: 47–49.
16. Ware J. SF-36 Health Survey update. *SPINE* 2000; 25: 3130–3139.
17. Boivin M, Brendgen M, Vitaro F, et al. Strong genetic contribution to peer relationship difficulties at school entry: Findings from a longitudinal twin study. *Child Dev* 2013; 84: 1098–1114.

18. Volk A, Camilleri J, Dane A, et al. Is adolescent bullying an evolutionary adaptation? *Aggressive Behav* 2012; 38: 222–238.
19. Ball H, Arseneault L, Taylor A, et al. Genetic and environmental influences on victims, bullies and bully-victims in childhood. *J Child Psychol Psych* 2008; 49: 104–112.
20. Bowes L, Maughan B, Ball H, et al. Chronic bullying victimization across school transitions: The role of genetic and environmental influences. *Dev Psychopathol* 2013; 25: 333–346.
21. Shakoor S, Jaffee S, Andreou P, et al. Mothers and children as informants of bullying victimization: Results from an epidemiological cohort of children. *J Abnorm Child Psych* 2011; 39: 379–387.
22. Brewin C, Andrews B and Gotlib I. Psychopathology and early experience: A reappraisal of retrospective reports. *Psych Bull* 1993; 113: 82–98.
23. Rivers I. Retrospective reports of school bullying: Stability of recall and its implications for research. *Brit J Dev Psychol* 2001; 19: 129–142.