

Conclusion

“The first principle of non-violent action is that of non-cooperation with everything humiliating.”

Mahatma Gandhi

Though childhood sobriquets or so-called teasing may seem harmless, being a victim, a witness, a bully, or all of these can result in several detrimental outcomes for adults. Bullying feels like rejection to children and adolescents and has been described as “a psychological malignancy” (Rohner, 1975, 1986). Throughout the book, we have seen numerous examples that led to this kind of outcome. Disturbing memories of being involved with bullying and harassment came immediately to mind for participants as they described issues they contend with still. Their emotional and mental well-being is compromised as they struggle with various forms of anxiety and depression. Children who were bullied have grown up with a diminished sense of self. Their self-image and self-esteem are tarnished. As adults they have to work to try to achieve an accurate sense of self-worth.

It is important to be aware of the continued damage people take with them from childhood pain into many aspects of adult life and relationships. There are several areas in which damage can result. The decisions that are made in adult life after childhood bullying reflect the problems associated with self-esteem. Through the voices of those in the book, we heard about choices to misuse and abuse substances, to participate in violent activities, to cling to others or refrain from relationships altogether. The decision-making process of those involved in bullying is altered by their experiences of mistreatment. Interestingly, some decisions indicated

growth in moral development. For example, people purposefully decided to treat others with respect. Decisions were made signifying the importance of being helpful to others. These decisions sometimes led to service-oriented careers.

Relationships with friends and intimate partners seem to bear the brunt of the impact of childhood bullying for those most affected. Trust in others is severely affected. Adults expect to be betrayed and, indeed, find themselves in relationships where that is exactly what happens. From a developmental and a systems perspective we would say that these adults are repeating patterns they know, they are repeating configurations they are “comfortable” with merely because they are the familiar.

BULLYING INCIDENCE

There are numerous studies on the incidence of bullying, however the data are competing. This is complicated by differing definitions used by researchers (Carbone-Lopez, Esbensen, & Brick, 2010) and by the fact that children may use a definition for bullying not adhered to by adults (Cheng, Chen, Ho, & Cheng, 2011; Cuadrado-Gordillo, 2011; deLara, 2008, 2012; Garbarino & deLara, 2002). This was elucidated in the first chapter. Calculating incidence trends is further compromised by children not reporting bullying when they are asked either in person or via survey (deLara, 2012; Mishna, 2005). In my research, 38.7% of the over 800 participants were bullied in elementary school, 39.8% were bullied in middle or junior high schools, and 22% were bullied in high school. A quarter of the participants said they were bullied at home. About 20% admitted to being a bully at some point in their school years. Also, 24% to 30% of the people in my study admitted to being *both* a bully and a victim, confirming the bully-victim-bully cycle and further confounding the definition debate.

BEING DIFFERENT

Being different in any way is the main reason that a child is selected for mistreatment (Annerback, Sahlqvist, & Wingren, 2014; Swearer, Turner, Givens, & Pollack, 2008). For example, adolescents prize conformity and therefore will bully someone who looks or behaves outside the norm (deLara, 2002; Garbarino & deLara, 2002). Even at the adult level, most organizations find orthodoxy important and will promote it (Scott, 1995).

Viewed from a systems theory perspective, conformity is useful for any organization or system because it enhances predictability of behavior. It is a component of the homeostasis or balance of the system (deLara, 2002; Von Bertalanffy, 1973).

The participants in the study spoke eloquently of their experiences with bullying as a result of some sort of difference from others—or perceived difference—and also discussed the lifelong impacts. The differences may seem minute or unworthy of consideration to most adults, but being discriminated against as a child is a very powerful experience. Childhood bullying can be as a result of being too tall, too short, too fat, too thin, too white, too black. A child may cry easily. And these bullying incidents can be perpetrated by adults on children, not just by one peer on another. Those subjected to bullying by people with authority over them, such as parents or teachers, may suffer with issues of authority for their entire lives. They may find it difficult to trust bosses or others holding power (see Johnson, 2011).

BULLYING IMPACT IN ADULTHOOD

Of those bullied as children, 63% said they noticed an impact in their adult lives. The consequences were in various areas but included their personal sense of well-being, their relationships to others, and their decisions. This finding is similar to that of Schafer et al. (2004), who found that self-esteem and relationship quality in adult life suffered as a result of childhood bullying victimization. Interestingly, among those in my study who were *not* bullied as children, fully 42% of those who witnessed bullying in elementary and middle school and 53% of those who did in high school claimed an impact in their lives now just as a result of observing acts of violence and torment against other children. My research indicates those consequences seem to be in the area of moral development and decisions about how to treat other people.

GENDER TRENDS

As Children

Over the last several years, research trends have held steady regarding bullying and gender. Boys tend to be involved in physical bullying more often than girls, and girls tend to be indicated in relational bullying more often than boys (Carbone-Lopez, Esbensen, & Brick, 2010). However, although

these trends and tendencies exist, both boys and girls participate in all forms of bullying. Consequently, the impacts from all forms show up in adulthood for both men and women (Sourander et al., 2007; Sourander et al., 2009). I have seen this trend in my research as well, particularly the fact that boys will engage in relational aggression and girls will participate in physical bullying. However, all types of bullying were recounted by both men and women. Without identifying a specific type of bullying, the following statistics represent the experiences of those in my study:

Were You Bullied in Elementary School?

40.8% of boys and 38% of girls

Were You Bullied in Middle or Junior High School?

48.2% of boys and 37.5% of girls

Were You Bullied in High School?

21.1% of boys and 22.1% of girls

Were You Bullied at Home?

24% of boys and 25.3% of girls

As Adults

On the question of general impact from childhood bullying, male respondents claimed they experienced impact in their adult lives about as frequently as females. There was no statistically significant difference between them on this score. In survey information and in discussions, men and women appeared to face the same issues in relationships, decision-making, and basic self-concept. On the question of the impact on decisions, there was no statistically significant difference between men and women. Similarly, on the question of positive consequences as a result of bullying, there was no statistically significant difference seen. A significant difference did show up in response to the question, "Do you see an impact on your relationships?" Male respondents were much less likely to experience this or to see an impact, compared with females in the study (30% v. 40%).

HEALTH AND MENTAL HEALTH

There were consequences in terms of health and mental health for those who were victimized as children. Among them were eating disorders, anxiety disorders, and depression. There were those whose lives were changed

forever due to acting-out and violence. For some, substance use was an outcome that carried over to abuse in adult life. Other research finds long-term impacts on health and mental health for those bullied as children (Biebl, DiLalla, Davis, Lynch, & Shinn, 2011; Copeland, Wolke, Lereya, Shanahan, Worthman, & Costello, 2014; Monsvold, Bendixen, Hagen, & Helvik, 2011; Teicher, Samson, Sheu, Polcari, & McGreenery, 2010). There are a number of studies indicating a correlation between bullying victimization and anxiety in adults (Gladstone, Parker, & Malhi, 2006; Schafer et al., 2004; Sourander et al., 2007). There is also a significant correlation between bullying, depression, violence, and substance use (Copeland, Wolke, Angold, & Costello, 2013; Kim, Catalano, Haggerty, & Abbott, 2011; Renda, Vassallo, & Edwards, 2011). As we have seen, bullying and harassment are psychological malignancies in a variety of ways. Survivors in my study experience anxiety and depression, substance misuse problems, and self-image issues that haunt them from the time they were first subjected to bullying into adulthood.

CONSEQUENCES IN RELATIONSHIPS

Adults were divided in terms of consequences in relationships per se. Of the respondents, 35.6% claimed no consequences in their relationships, while 37.6% responded saying there were definite effects. The other participants did not choose to answer the question. Interesting trends were present. On the survey data, women did indicate a greater impact on their relationships than men, however in focus groups and individual interviews no significant difference was seen. This may be due to the fact that once engaged in a verbal interview, people have the chance to think through an issue in greater depth. Those affected by bullying described difficulty in friendship and intimate partner relationships. They cited problems trusting others, expecting betrayal, wanting to be accepted, and becoming “people-pleasers” to have or keep someone in relationship with them. This resulted in what they deemed a lack of genuineness in relating. Other research does find consequences in adult relationships similar to my own findings. These include problems with trust, problems with attachment, and issues of insecurity in friendships and intimate relationships (Schafer et al., 2004). Other studies also find bullying leads to social and emotional problems in adult relationships (Almquist & Brännström, 2014; Boulton, 2013; Jantzer, Hoover, & Narloch, 2006). So far, we have seen that there are consequences in adult relationships for those involved with bullying as children. Still further research is indicated in this important area.

[200] Conclusion

SEXUAL HARASSMENT

The 2011 study by the American Association of University Women reported an incidence of about 50% of both boys and girls involved with sexual harassment by peers (Hill & Kearl, 2011). During my focus groups and individual interviews, almost half of all participants reported encountering sexual harassment in childhood or adolescence as victims or bystanders. Those who did described significant impacts on their self-esteem and development. It is important to note some studies find more adverse health outcomes from sexual harassment than from any other form of bullying (Gruber & Fineran, 2008; Keeshin, Cronholm, & Strawn, 2012). In the focus groups and individual interviews, more women than men admitted to being sexually harassed. Typically, sexual harassment is a cultural construct that we most often apply to the lives of women and girls. One important question might be asked: How many men consider any or all of the sexual encounters they endure, such as games of “sac-tap-ping,” to be sexual harassment?

EFFECT ON DECISIONS

When asked about adult decision-making, 41.6% said being bullied affected their decisions now, while 31.7% saw no effect on their decisions as adults. The other participants did not respond to this question. As stated earlier, I found no statistically significant difference between men and women on this score. An example of an effect on decision-making can be seen in the ongoing struggle with low self-esteem and confidence that promotes decisions to stay in unhealthy relationships. People conclude, “Who else will want me?” Other consequences on decision-making are in the realm of jobs or professions to pursue and extending trust in friendships. The impact or consequences on adult decision-making as a result of childhood bullying is an area in need of further research.

IMPACT ON FAMILIES

A quarter of those in the study said they were targets of bullying in their own homes. All types of bullying were mentioned, including verbal abuse, sexual harassment, and physical abuse. There can be a considerable impact for families when children are bullied at home or at school. In earlier chapters, we read about those who were bullied at school who then brought

their rage home to visit upon family members. We have read accounts of children who were bullied at home and also bullied at school. Perhaps children accept peer mistreatment because they come to expect being treated disrespectfully in all environments. The impact can even extend intergenerationally as adults come to terms with what has happened to them or as they attempt to protect their own children from peer mistreatment. Some parents become overly zealous and cautious in their parenting approach. Parents who have witnessed or participated in bullying in any way feel an intense need to shelter their children from any similar harm.

Being bullied by a sibling leaves its own brand of injuries. While sometimes a sibling can be supportive, other times siblings torment one another, saying and doing the worst they can think of at the time. This kind of behavior flourishes in families where parents don't expect anything different and don't intervene to stop it. In most systems, adults believe kids will be kids and this means treating each other badly at times. The end result in this family is that children, even when they are grown, believe that sibling bullying is just the way it is—an acceptable form of interaction. Of course this sets the stage for later interpersonal adult relationships and behavior. People learn as children how to act, either with respect toward everyone or not. Some families cultivate respectful behaviors by example, by family rules, and by interrupting poor behavior. Other families do not see this as a priority; they do not know the consequences for the future of their children's relationships with one another or of their children's sense of themselves in the world as adults.

Sibling bullying is a form of peer bullying and should be considered as such. Long-lasting effects from sibling bullying include mistrust in significant relationships in adulthood and a permanent disruption in the sibling relationship. Further, when siblings bully one another this becomes an acceptable, learned behavior that is then carried over to adult interactions with same-age intimates. Bullying has been learned as the means to negotiate interpersonal interactions.

For many, the passage of time seems to take care of the effects of bullying in the family. However, for others, the bullying and/or harassment were too severe or too chronic and have left too many unresolved remnants. Relating as an adult is strained, at best, or even impossible. If family members want to come to a resolution so they can move forward, family therapy is recommended. In this case, it is imperative to find a mental health practitioner who is trained as a family systems therapist. That person will have a true understanding of how family systems work and the dynamics that helped to support the bullying that took place. Without a systems-trained person, there is a danger that one member of the family

will be blamed for all of the bullying that took place. He or she will be scapegoated and will be victimized again. That would not be a therapeutic outcome.

UNEXPECTED OR POSITIVE OUTCOMES

In my research, 47.2% of all adults reported what they described as a positive impact resulting from childhood bullying, while 17.5% said there were no positive effects. The rest were unsure or did not answer the question. This means that though struggling to deal with the aftermath, almost half were able to not only overcome some of the poor influences of bullying but also find something positive. This finding contrasts sharply with research on children and bullying. When children and teens are asked, "Is there anything positive about bullying?", they universally reply, "No." However, the adult responses from my study are in line with research findings on post-traumatic growth (Calhoun & Tedeschi, 2014; Tedeschi & Calhoun, 2004).

ADULT POST-BULLYING SYNDROME

At this point in our history, no one contends that post-traumatic stress exists. Much is known about its etiology, its symptoms, and its poor outcomes. However, for hundreds of years those suffering with PTSD faced ridicule. They were considered mentally weak or cowardly for what were normal reactions and behavior after experiencing trauma. The trauma of war is the best-known example.

The noted developmental psychologist Bessel Van der Kolk (2005) has written about post-traumatic stress disorder:

The PTSD diagnosis does not capture the developmental effects of childhood trauma: the complex disruptions of affect regulation; the disturbed attachment patterns; the rapid behavioral regressions and shifts in emotional states; the loss of autonomous strivings; the aggressive behavior against self and others; the failure to achieve developmental competencies; the loss of bodily regulation in the areas of sleep, food, and self-care; the altered schemas of the world; the anticipatory behavior and traumatic expectations; the multiple somatic problems, from gastrointestinal distress to headaches; the apparent lack of awareness of danger and resulting self-endangering behaviors; the self-hatred and self-blame; and the chronic feelings of ineffectiveness. (p. 406)

This diagnosis may not capture the effects on development of trauma in childhood, but Van der Kolk's assessment does describe many of the elements and impacts on development that are common for those suffering from adult post-bullying syndrome (APBS) brought on by the traumas they experienced in childhood. It is evident from their stories that people live with and experience APBS. They demonstrate the indicators of this syndrome as outlined in the chapter describing it. While APBS does not tend to be associated with threats of death or serious harm as PTSD does, there are some instances in which a person does experience death threats and serious harm as a component of the bullying they endure. Researchers are beginning to uncover the extent of the impact of bullying into adulthood. Its trauma cannot and should not be written off as weakness as we once did with PTSD. It needs to be fully recognized for what it is: Adult Post-Bullying Syndrome. Some people who encounter childhood bullying will end up with this syndrome. They need understanding, not scorn. The consequences need consideration, not disregard. In some cases, people with APBS will need to and want to seek professional help to overcome traumatic memories and their effects. We have seen all too clearly how these memories can cripple. It is essential for mental health practitioners to increase their awareness of the aftereffects of bullying in people's lives and to become aware that there are ongoing consequences. The first place to start is by asking clients about any bullying they experienced as children. This question is not commonly asked by health or mental health providers at this time. It needs to be. We don't tend to ask children and we don't ask adults. From their responses, practitioners can formulate a treatment plan that will address the issues raised by a client or a family. As adults report depression and anxiety stemming from childhood bullying, medication may be indicated in some cases. Typically for anxiety and depression that impair, research demonstrates that the most effective treatment is a combination of some form of psychotherapy along with appropriate medications (Young, Klap, Sherbourne, & Wells, 2001).

WHAT CAN BE DONE?

Adults in the study commented that passive kids are targeted for bullying. I often heard the suggestion that children should be taught to be assertive, not aggressive, and that martial arts programs could be beneficial for children who lack confidence and do not know how to stand up for themselves. While some schools do offer martial arts classes (see Twemlow et al., 2008), there are recognized intervention strategies that

can be employed in the school setting. Where bullying has become established in a school, a systemic approach to interrupt or decrease incidents is required.

Programs Meeting with Some Success and Using a Systemic Approach

The Olweus Bullying Prevention Program is a whole-school approach for children grades K-12 and has the greatest research base of all programs currently in use. It has been found to reduce bullying among children, improve the social climate of classrooms, and reduce antisocial behaviors (Olweus & Limber, 2010). For more information on how this program is implemented in the schools and possible difficulties, please consult Espelage, (2013), Olweus (2007).

Steps to Respect provides training about bullying to the full staff of the school including bus drivers, teachers, and cafeteria workers. It is aimed at grades K-8. Its results demonstrate a decrease in bullying behaviors, an increase in bystander interventions, and an overall increase in positive school climate (Brown, Low, Smith, & Haggerty, 2011; Committee for Children, 2015).

PeaceBuilders is a K-12 program that includes students, staff, and parents. The values of the program include praising others, giving up the use of put-downs, encouragement to seek wise people when you are faced with an interpersonal dilemma, noticing if someone is hurt, righting wrongs, and helping others. Results have shown decreased aggression and increased social competence (Vazsonyi, Belliston, & Flannery, 2004).

The Resolving Conflicts Creatively Program is research-based and intended for K-12 students. It is focused on social-emotional learning and is one of the longest-running programs in the United States on conflict resolution. It attempts to create caring environments, and the program's strategies are continuous over several years (De Jong, 1993; Selfridge, 2004).

KiVa is an evidence-based program originating in Finland and now being used globally. It is demonstrating good results in curbing bullying in school settings. *KiVa* is effective because it takes a systemic perspective involving the students, counselors, teachers, and parents. Along with intensive training of adults as well as students, the program accounts for the need for reconciliation between those who have been involved in a disrespectful encounter.

Restorative Justice programs are based on the premise that bullies and victims need to enter into reconciliation to prevent future bullying and

to enhance a safe school environment. It focuses on the impact of interpersonal actions and the associated shame (Ahmed & Braithwaite, 2012). Restorative justice supports the idea of engaging multiple stakeholders in the school over the long term to build a positive community atmosphere (Wong, Cheng, Ngan, & Ma, 2011).

In general, readers are encouraged to review the work of Maria Ttofi and David P. Farrington on bullying prevention programs and their impact on reduction, shame, and later criminal offending. Further, Peter K. Smith's book *Understanding School Bullying: Its Nature and Prevention Strategies* (2014) provides some invaluable information.

Programs Showing Promise

Roots of Empathy is a program that helps very young elementary school children build empathy for others and social-emotional competence by using a developmental approach. Children become acquainted with an infant who visits their classroom on a regular basis over a substantial period of time. The children begin to understand the baby's growing strengths and limitations. In this way, they start to develop a sense of empathy and compassion for another person (Schonert-Reichl, Smith, Zaidman-Zait, & Hertzman, 2012). Growing empathy for others is thought to be an important aspect of moral development and a stepping-stone in bullying reduction.

The goal of CASEL (*Collaborative for Academic, Social, and Emotional Learning*) is to make social-emotional learning a critical part of education for children from preschool through high school. As mentioned earlier, promoting social-emotional intelligence is one way that schools and organizations can address respectful behavior among children. Emotional intelligence was a concept first developed by psychologists John Mayer and Peter Salovey. The idea was elucidated by psychologist Daniel Goleman (1996, 2006). He wrote, further, on social intelligence. Social-emotional intelligence then is the combination of these ideas. It describes how we deal with our impulses and our abilities to succeed in interpersonal relationships. Social intelligence and emotional intelligence are concepts beyond what we think of as a person's IQ. Children with high social-emotional IQs seem to have a built-in barrier against the ravages of bullying. They exercise certain cognitive-behavioral strategies that assist them when they are bullied by their peers (deLara, 2008). They say such things to themselves as, "They don't know who I am." "He's [the bully] going nowhere." "I'm going to make something of my life. For them, high school is all

they have.” These cognitions or inner speech serve to keep a child’s dignity and a sense of self intact. Fortunately, social-emotional intelligence and cognitive-behavioral strategies can be taught. At this point, some schools have classes that focus on building a child’s social-emotional IQ. To learn more about this, visit the Collaborative for Academic, Social and Emotional Learning at <http://www.casel.org/>. The website states, “Social and emotional learning (SEL) is the process through which children and adults acquire and effectively apply the knowledge, attitudes and skills necessary to understand and manage emotions, set and achieve positive goals, feel and show empathy for others, establish and maintain positive relationships, and make responsible decisions” (CASEL).

Programs that are helpful specifically for lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ) students are the *Gay-Straight Alliance*, a program bringing gay and heterosexual students together in schools to support one another, and *GLSEN*, the Gay, Lesbian, Straight Education Network. Another organization specifically for the support, education, and advocacy of gay children and adults is *PFLAG*, the largest of its kind in the country uniting parents, families, friends, and allies of lesbian, gay, bisexual, queer, and transgender people.

TREATMENT: ADULTS COPING WITH THE AFTERMATH OF CHILDHOOD BULLYING

What we have seen from the stories presented is that many of those affected by bullying have to build or rebuild a basic sense of self. Their self-esteem and self-worth have been severely diminished. Much effort, as an adult, goes into claiming an individual sense of dignity. Further, childhood maltreatment, including bullying, changes the brain (Edmiston et al., 2011). It impacts development and influences all aspects of a person’s behavior in relationships. Schor reminds us that “the concept of trauma . . . is by definition psychobiological” and is “a bridge between the domains of both mind and body” (2003, p. 109). Schor indicates further that when children are exposed to stress early in life, this produces neurobiological changes that continue through adulthood. These changes can manifest as a dysregulation in the brain’s “fight or flight” centers—one being intense rage, one expressing as intense terror. Anyone, child or adult, struggling to get past the damage done by others can seek help from mental health professionals trained in cognitive therapy or cognitive-behavioral therapy (CBT). Both are effective in terms of establishing a new, more helpful, and more appropriate way of thinking about themselves and past events

(Beck, 1979; Beck, Rush, Shaw, & Emery, 1979). Without treatment or at least some insight into residual pain, adults and children may lash out against others or turn the pain inward in the form of poor treatment toward themselves. A practitioner trained in trauma treatment is essential. There are several ways to approach the treatment of the anxiety, depression, or trauma associated with bullying. It is important to look for interventions that are evidence-based in terms of their effectiveness. The cognitive-behavioral therapies have proven efficacy (Courtois & Ford, 2009; Silverman et al., 2008). This holds true for a wide range of ages and with different populations of people. Cognitive-behavioral therapy is beneficial because it addresses the thoughts or cognitions that a person is telling him or herself. It exposes the essential elements that are continuing to support a negative self-image and works to change that. A very specific form of CBT for anxiety, depression, and trauma is trauma-focused cognitive-behavioral therapy (TF-CBT) (Foa, Keane, Friedman, & Cohen, 2008; Silverman et al., 2008). A hybrid model for treating trauma, TF-CBT integrates cognitive-behavior principles, family therapy, empowerment therapy, attachment therapy, humanistic therapy, trauma sensitive interventions, and knowledge of developmental neurobiology. Consequently it addresses cognitive problems, relationships problems, family problems, difficulty with affect, somatic concerns, and behavior problems stemming from trauma (Mannarino, Cohen, & Deblinger, 2014). Another form of CBT to address these concerns is mindfulness-based CBT. Popularized by Jon Kabat-Zinn for stress reduction and positive well-being, it is based on conscious mindful awareness (Davidson et al., 2003; Evans et al., 2008; Kabat-Zinn & Hahn, 2009; Segal, Williams, & Teasdale, 2012). Victims with severe trauma alter their awareness and consciousness to make trauma more tolerable. Consequently, to minimize the possibility of retraumatization, a phase-oriented approach is suggested in clinical practice for addressing the effects of trauma, including when PTSD has been diagnosed (Cloitre et al., 2011; Leenarts, Diehle, Doreleijers, Jansma, & Lindauer, 2013; Resick, Suvak, Johnides, Mitchell, & Iverson, 2012). For clinicians looking to determine whether a client is, indeed, experiencing PTSD, the PTSD Checklist—Civilian Version (PCL-C) is an effective tool. It can be completed by a client prior to any session and should take no more than 10 minutes (Weathers, Litz, Herman, Huska, & Keane, 1991). The interpretation of the checklist is completed by the clinician, but it provides a vehicle for discussion with the client once this has been done (Weathers et al., 1991).

Developed by Francine Shapiro (1998, 2013), eye movement desensitization and reprocessing (EMDR) therapy uses proven methods to reduce

the emotions surrounding traumatic memories. As a result, this is a very effective therapy to consider for those enduring the pain of past events including bullying (Forbes et al., 2007). It is critical, however, to find a practitioner who has had this specialized training.

There are other evidence-based treatments for those who have been exposed to trauma and violence including multidimensional family therapy and multisystemic family therapy. Multidimensional family therapy is a developmentally focused therapy targeting violence and delinquency with the goal of promoting successful adolescent and family growth. This family therapy is successful with children and adults from diverse ethnic, racial, and socioeconomic groups (Liddle, 2010; Rowe & Liddle, 2008). Multisystemic family therapy is a blend of cognitive-behavioral therapy, behavior management training, family therapies, and community psychology. Its strength is that it acknowledges that families, communities, friends, and schools all impact a child. From that perspective, practitioners of multisystemic family therapy aid children and families with the traumas they have experienced (Carr, 2000, 2009; Stratton, 2011).

The collaborative change model (CCM) (Barrett & Stone Fish, 2014) is a clinically evaluated model that helps individuals and families move from traumatic mind-states to a hopeful and meaningful vision of the future. The model has three stages that eventuate in individuals acting from engaged states of mind to regulate their affect, cognitions, behaviors, and relationships. Clients in this model are active members of their treatment as their strengths and resources are integrated into the creation of the interventions that will help them recover. The model was developed from many years of working with individuals and families who experienced complex trauma. In this case, complex trauma is defined as “a pervasive mindset that often develops from historical and ongoing relationships of abuse, neglect, and violation.” Aspects of trauma resilience and mindfulness are incorporated into this effective intervention.

POST-TRAUMATIC GROWTH AND RESILIENCY

Researchers have been writing about the possibilities of individual growth after trauma for over 20 years (Calhoun & Tedeschi, 1998; Tedeschi & Calhoun, 1995). It is evident that there can be growth for some individuals after a traumatic event. Bonanno, Galea, Bucciarelli, and Vlahov (2007) found that for a portion of those exposed to trauma, the after-effects included post-traumatic growth. Their growth was measured to exceed their prior functioning. Others recovered to their previous

baseline of functioning, while still others were categorized as being in the merely surviving group. They did not return to normal functioning after the traumatic event. Certainly people who have experienced trauma and loss can be encouraged through various community-based interventions and through therapy to find a portion of resiliency (Boss, 2006). Resilience is a construct attributed to the “positive psychology” field. Resilience “focuses on identifying strengths ... rather than weaknesses ... and is generally considered a multidimensional construct consisting of behaviors, thoughts, and actions, which can be learned overtime” (White, Driver, & Warren, 2008, p. 9). Further, there is some research that depicts neural changes in the brain reflecting resilience to trauma (Feder, Nestler, & Charney, 2009). Consequently, one means of growing after trauma is to increase resiliency, which can be accomplished with the help of practitioners who are trained to identify strengths and positives in individuals and families. Clinicians should review Calhoun and Tedeschi’s book (2014) for numerous chapters on clinical applications in this area.

ALTERNATIVE TREATMENTS

As we have seen, bullying and other forms of maltreatment of children have been linked to the development of poor health and mental health outcomes including psychosis in adult life (Allison, Roeger, & Reinfeld-Kirkman, 2009; Bebbington, 2011; Cohen, 2011; Wolke, Copeland, Angold, & Costello, 2013). The fear response in the brain of a maltreated child is under constant stimulation. This means that other regions of the brain, such as those for complex thought, are less activated. The brain becomes focused on survival at the expense of other aspects of healthy development. Additionally, there is a permanent alteration in the brain’s use of serotonin, a chemical needed to promote a sense of well-being (Healy, 2004; Perry, 2009). Other research demonstrates changes in the brain’s hypothalamic-pituitary-adrenal (HPA) axis that result from bullying (see Cicchetti & Rogosch; Vaillancourt et al., 2008). Chronic stress or repeated traumas can result in a number of biological reactions, including a persistent fear state (Perry, 2009). In other words, the brain learns to be on the lookout and fearful. Consequently because the brain sustains substantial changes, employing alternative therapies such as yoga, mindfulness, acupuncture, and massage can be effective in quieting the autonomic nervous system (Agelink et al., 2003; Diego & Field, 2009; Streeter, Gerbarg, Saper, Ciraulo, & Brown, 2012). Trauma is jarring to the nervous system. Trauma throws us off, out of balance. After experiencing trauma, people

need to do a variety of things to reset their nervous systems to try to feel okay. Some people seem to have instinctual abilities along these lines. They “shake it off” figuratively or literally, as singer Taylor Swift enjoins. However, when the nervous system is overwhelmed or overloaded from trauma, a somatic experiencing (SE) practitioner can help restore equilibrium. According to the theory behind SE, trauma can result from a wide variety of stressors and its symptoms are a result of dysregulation of the autonomic nervous system. However, an event does not cause trauma per se. The theory behind SE postulates trauma is the outgrowth of an inability of the body, the mind, and the nervous system to deal with adverse occurrences (Levine, 2010).

An interesting new study finds that painful memories may be dissipated or changed during sleep. In an experiment conducted at Northwestern University, volunteers were shown a face connected with an unpleasant odor then paired with a shock. The volunteers learned to anticipate the shock when they encountered the face and odor again. Then during a nap, the volunteers experienced the odor again but without the shock. After they woke up, they no longer associated the face–odor combination with anticipating a shock. It appears that as a result of the aromatherapy, neural changes had occurred in the hippocampus and the amygdala. They had overridden the bad memory. Brain scans revealed these changes had indeed occurred (Hauner, Howard, Zelano, & Gottfried, 2013). While this is similar to exposure therapy, it has the advantage of being easier for the participant who is not confronted with painful memories or images while awake. It has promise for those who suffer with various forms of PTSD and for those whose distressing memories were formed during childhood bullying. People with adult post-bullying syndrome may benefit from this intervention. It is important to point out that, at this time, neither SE or aromatherapy have substantive evidence-based research backing. Consequently, they should be thought of as alternatives to consider in the healing process.

IN SUMMARY

Bullying, harassment, and hazing by peers or by adults can have serious and lifelong implications. Much of the time, adults want to deny that this is a possibility and cloak any discomfort about it under euphemisms. As research piles up on the adverse effects of this phenomenon, we cannot allow ourselves to be in denial. We cannot rely on the belief that anything untoward that occurred during school years is left behind at graduation.

Despite the efforts of adults, bullying, harassment, and hazing continue to be widespread problems in our nation's schools. Virtually all students are involved as victims, bullies, bully/victims, or witnesses. With severe impacts on lifelong development and mental health, finding a way to prevent bullying is a major public health concern. Far more prevalent than we once believed, bullying occurs in our schools and via cyberspace on an around-the-clock basis. There are long-term costs that haunt those involved, and these consequences are not solely carried by the victims. Bullies are more likely than the general population to become workplace bullies (Matthiesen & Einarsen, 2007; Zapf & Einarsen, 2011) or to end up involved with the criminal justice system (Apel & Burrow, 2011; Carter, 2012). As noted earlier, research establishes that both bullies and victims can experience lifelong depression, anxiety, difficulties in relationships, and an inability to trust others. Because bullying is traumatic, it can result in post-traumatic stress disorder.

Schools and grassroots movements attempt to curtail bullying by involving children who witness peer-on-peer violence. While it is commendable to engage students to stop bullying, it is simply not enough. Bullying and hazing flourish in organizations where they are inadvertently enabled, tacitly permitted, or worse, openly sanctioned by the behavior of adults. Parents know that children are great imitators. Children watch their parents, and their moral development is based on what they see within the family. Children watch their teachers and other school personnel, and this contributes to their growing moral compass. Yet research informs us that 45% of teachers have admitted to bullying children (Twemlow et al., 2006). When this happens, bullying is a systemic problem and becomes almost intractable as part of the school or organizational culture. While adults admonish children to stop bullying each other, there is an adult moral code witnessed in their behavior that allows for—and promotes—bullying and revenge. Consequently, we have to realize that children do not have enough power to change it and it is not their responsibility. Prevention of this pervasive phenomenon is the direct responsibility of adults. Adults at school and in the community need to make the commitment to examine and change their own behavior if they hope to diminish bullying among children.

Parents, educators, and policy makers must see the serious long-term consequences of bullying. Only in this way will there be a concerted and ongoing effort to interrupt bullying at first signs in childhood. We can no longer afford the attitude that says, "Bullying is just a rite of passage" or "Bullying happens; you get over it." Clearly this is not the case. The adults in this study and in other research prove otherwise. Health and mental

health practitioners need a comprehensive vision of the effects of bullying on both children and adults. With the understanding that bullying and harassment may lead to a lifetime of poor decisions, of relationship problems, and of mental health issues, practitioners can begin to regularly ask about current or past bullying episodes. Doing so will provide a key to unlocking the history behind problems clients are experiencing and will offer a direction for treatment. This is a call to parents, educators, all health practitioners, and policy makers to stand up and make a difference so that a childhood of bullying does not turn into an adult life full of its aftermath. Bullying scars.

