

The Association Between Bullying Involvement and Mental Health Indicators, Parenting Challenges, and Individual Strengths

Briana J. Goldberg

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Faculty of Education
University of Ottawa

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Abstract

Bullying is well known to have harmful effects on child development and mental health, so understanding the underlying factors involved in bullying behaviour is critical (World Health Organization, 2008). In the present study, mental health, parenting challenges, and children's individual strengths were explored across different types of bullying involvement. In this cross-sectional study involving 91 children between the ages of four to 11 receiving services at a mental health agency, the results indicated significant differences on dependent variables across the four different bullying involvement groups: bully, victim, bully-victim, and non-involved. Children in the bully group were more likely to be experiencing externalizing behaviours and have fewer individual strengths whereas children in the victim group were more likely to be experiencing difficulties with internalizing behaviours and have fewer individual strengths. Children in the bully-victim group were more likely to be displaying externalizing behaviours, come from homes experiencing parenting difficulties, and have fewer individual strengths. In contrast, children who were non-involved in bullying were more likely to have greater individual strengths including stronger peer relations, greater self-expression, able to successfully adapt to change, and have stronger family units. The results of this study highlight the different behaviour patterns across the types of bullying involvement as well as shed light onto the needs and strengths of children accessing mental health services from a community agency.

Keywords: Bullying; parenting challenges; mental health; individual strengths, protective processes

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The Impact of Bullying Involvement on Mental Health Indicators, Parenting Challenges, and Individual Strengths

Introduction

With Canada ranking within the top 10 for bullying rates around the world, it is essential that researchers gain greater insight into the contributing factors of bullying (World Health Organization, 2008). Doing so would advance bullying prevention to help to reduce Canada's troubling bullying rates (Freeman, King, & Pickett, 2016). Since bullying is a dynamic process that is influenced by numerous factors including the social environment, parenting, and individual characteristics, reducing bullying requires a holistic approach (Gómez- Ortiz, Romera, & Ortega-Ruiz, 2016; Smith, 2008; Wölfer & Scheithauer, 2014). To date, much of the research on bullying has focused on the school environment to create efficacious school-based interventions. It has been recommended that future studies extend the focus beyond the school environment (Ttofi & Farrington, 2011). More specifically, researchers have pointed to the role that mental health, families, and individual strengths play in the type of bullying that children engage in (Gómez- Ortiz et al., 2016; Pepler, Jiang, Craig, & Connolly, 2008; Donnon & Hammond, 2007; Smokowski & Kopasz, 2005). By taking a holistic lens on bullying involvement, this study sheds light into the needs and strengths of children who are displaying specific patterns of bullying involvement and are receiving mental health services. This study has the potential to inform the anti-bullying efforts of clinicians and educators.

Bullying involvement is typically categorized into four groups: non-involved, bully, victim, and bully-victim. Categorizing children into the four groups of bullying involvement allows researchers to best capture the behaviour differences amongst children within the different groups (Smokowski & Kopasz, 2005). For example, on mental health indicators, certain bullying involvement groups are more likely to be experiencing internalizing behaviours whereas others

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are more likely to be displaying externalizing behaviours (Smokowski & Kopasz, 2005). Internalizing behaviours are behaviours that turn inwards and influence one's psychological and emotional state and can include the presence of anxiety, depression, somatic complaints, and suicide ideation (Liu, Chen, & Lewis, 2011). In contrast, externalizing behaviours are behaviours that turn outwards and can include anger, impulsivity, and weak behavioural and cognitive regulation (Eisenberg et al., 2001). Previous research has suggested different patterns amongst parenting characteristics across the bullying involvement groups, with parenting challenges being linked to bullying and victimization (Espelage, Bosworth, & Simon, 2000; Flouri & Buchanan, 2003). As well, research has suggested that the individual strengths of the child play a role in the likelihood of being involved in bullying (Donnon & Hammond, 2007; van Hoof, Raaijmakers, van Beek, Hale, & Aleva, 2008).

The purpose of this study was to gain greater insight into children who were receiving mental health services and were displaying specific patterns of bullying involvement. More specifically, this study explored the different patterns of mental health indicators, parenting challenges, and individual strengths. Within a cross-sectional research design, a MANOVA analysis was used to compare the differences among these variables across the four types of bullying involvement. It was hypothesised that significant differences across internalizing behaviours, externalizing behaviours, parenting challenges, and individual strengths would be found amongst children displaying differing patterns of bullying involvement who were accessing services at a children's mental health agency.

Literature Review

What is Bullying?

Bullying is a widespread social phenomenon that has the potential to negatively impact a child's development (World Health Organization, 2008). Bullying involvement includes bullying, victimization, and combined bully-victim roles. Bullying is characterized by repeated aggressive behaviour towards another person within the context of a power imbalance (Farrington, 1993; Olweus, 1997; Smith & Sharp, 1994; Smokowski & Kopasz, 2005).

Victimization is being the recipient of repeated aggressive behaviour. While there is an overlap between bullying behaviour and aggression, Carrera, DePalma, and Lameiras (2011) critique the existing literature, stating that much of the research lacks a clear definition of bullying and aggression. As such, these terms often are used interchangeably (Cornell & Bandyopadhyay, 2010). Aggression is defined as "any form of behaviour directed towards the goal of harming another living being who is motivated to avoid such treatment" (Baron & Richardson, 1994, p. 5). Since bullying behaviour is considered a subset of aggression, these terms should not be used interchangeably (Sanders & Phye, 2004).

One of the characteristics of bullying that distinguishes it from aggression is that it occurs within the context of a power imbalance. Vaillancourt, Hymel, and McDougal (2003) explored the relationship between the different types of bullying involvement, power, and social status in 555 children in grades five and grades six in Canada. When looking across the different subtypes of bullying (e.g., low power bully, moderate power bully, and high-power bully), different patterns emerged across the different subtypes with respect to social status, competencies, and assets. Children who were described by their peers as powerful were perceived as more popular in comparison to children who were viewed as moderate and low in power. The high-powered children had a greater likelihood of being liked than children who were perceived to have moderate power. Additionally, children who bullied and were perceived as powerful were

described by their peers as more attractive and better leaders in comparison to children who had moderate to low power (Vaillancourt et al., 2003).

Types of Bullying

According to Espelage and Swearer (2003), bullying is typically categorized into three forms: physical, verbal, or relational bullying. Physical bullying is a direct form of bullying where an individual engages in bullying behaviour by taking something that does not belong to them or purposely causes the victim physical harm. Verbal bullying is also a direct form of bullying which involves name-calling, teasing, and threats. Different from physical and verbal bullying, relational bullying is indirect. With indirect bullying, the individual engaging in bullying behaviour spreads rumors, sabotages, and excludes the victim within a social context (Espelage & Swearer, 2003). With the increase of internet use and social media, cyberbullying has been added as a form of bullying and is characterized by electronic harassment (Tokunaga, 2010). Gender influences the type of bullying employed, with boys having shown to gravitate towards physical and sexual bullying (DeSouza, & Ribeiro, 2005; Pepler et al., 2006). Name-calling, which is a form of verbal bullying, is the most common form of bullying (Smith & Sharp, 1994). Following name-calling, physical aggression is the second most common form (Smith & Sharp, 1994). In younger children, bullying takes place most often in the playground whereas, in adolescents, bullying takes place in classrooms and hallways (Smith & Sharp, 1994; Smokowski & Kopasz, 2005). Environments with low supervision increase the likelihood that bullying will occur (Smokowski & Kopasz, 2005).

How bullying involvement is defined and assessed varies widely in the literature (Hamburger, Basile, & Vivolo, 2011; Vivolo-Kantor, Martell, Holland, & Westby, 2014). According to a systematic review by Vivolo-Kantor et al. (2014), to capture the prevalence of

bullying, most studies described the behaviours associated with bullying and victimization. However, some used terminology such as “peer victimization” or “peer aggression,” while others used the term “bullying” outright in the measure. Studies vary in what they include in their definition of bullying. Of the 41 studies included in the review, the distribution across types of bullying included: verbal bullying (82.9%), direct bullying (73.2%), physical bullying (70.7%), relational bullying (53.7%), indirect bullying (41.5%), and cyber-bullying (17.1%). Studies often used a combination of the different types of bullying (Vivolo-Kantor et al., 2014). According to the systematic review, the most common way that bullying involvement was assessed was through the youth-self report (85.4%), with other methods being peer nomination (22%) and self-report and peer notation used in conjunction (9.7%). Resulting from the lack of consistency with definitions and measurements, it becomes challenging to adequately assess the effectiveness of interventions or determine the extent of the phenomenon (Vivolo-Kantor et al., 2014).

Another constraint in measuring the prevalence of bullying involvement is that children and researchers often possess different definitions of bullying involvement. In a study carried out by Vaillancourt et al. (2008), the authors noted that while researchers conceptualize bullying to be intentional, repetitive, and in the context of a power imbalance, these characteristics are often not included in students’ perceptions of bullying. Rather, the presence of negative behaviours was reported by the majority of students. As well, when children were provided with a definition of bullying involvement, the prevalence rates fluctuated systematically, raising methodological concerns about providing definitions when assessing bullying involvement. More specifically, Vaillancourt et al. (2008) found that when all students were provided with a definition of bullying involvement, they were less likely to report victimization. When males specifically were given a definition of bullying, they were more likely to report more bullying. Researchers

concluded that a discrepancy exists between researcher's and student's perception of bullying and victimization. Therefore, to accurately capture bullying behaviour as defined by researchers, a clear definition of bullying and victimization is essential (Vaillancourt et al., 2008).

Recently, bullying has been conceptualized within a human evolutionary process. The evolutionary perspective explains that all human behaviours developed for adaptive purposes (Volk, Farrell, Franklin, Mularczyk, & Provenzano, 2016). The parental investment theory (Trivers, 1972) is an evolutionary theory that explains that caring for an offspring comes at a high cost. Parents can no longer invest as much time and energy into mating, and child-rearing depletes their survival resources. While these costs are high, offspring are advantageous as they increase one's genetic fitness and they can help obtain resources (Geary & Flinn, 2001). Since offspring who can obtain resources through whatever means, which could include engaging in bullying behaviour, are most likely to survive and reproduce, parents are more inclined to invest in those offspring over those who do not (Volk, Dane, & Marini, 2014; Volk et al., 2016).

The Scope of the Bullying Problem

According to the Health Behaviour in School-Aged Children survey, an international survey that gathers information aimed at increasing the understanding of the health of children in grades six through ten, the percentage of students that have been involved in bullying and fighting has decreased since 2010 (Freeman et al., 2016). More specifically, the number of students who report being not involved has increased from 65% to 70% over four years from 2010 to 2014. This is coupled with a 3% decrease in students reporting bullying and victimizing others. As well, it has been found that across all grade levels and gender from 2010 to 2014, the prevalence of students who reported having engaged in physical fighting within a 12-month timeframe has declined (Freeman et al., 2016). Statistics Canada (2012) reported that at least one

in three children was a victim of bullying behaviour. In comparison to the prevalence of bullying in Canada, Nansel et al. (2001) conducted a study to measure the prevalence of bullying in American youth. They gave 15,686 students from grades six to grade ten a self-report questionnaire about bullying and psychosocial adjustment. Students in this study were from across the United States and came from public and private schools. They found that 29.9 % of students had been involved in bullying with 13% of students had engaged in bullying behaviour, 10.6 % have been victimized, and 6.3% had been both a bully and a victim. (Nansel et al., 2001).

Gender has been found to influence the prevalence of bullying involvement (Currie et al., 2008). Across several domains including grade, country, and culture, boys have a greater likelihood of engaging in bullying behaviour than girls (Gruber & Fineran, 2007; Peterson & Ray, 2006; Scheithauer, Hayer, Petermann & Jugert, 2006). When comparing genders, girls are more likely to experience victimization than boys (Currie et al., 2008). While the overall trend that girls are more likely to experience victimization than boys was found, this trend was not consistently found when looking across the age groups (Currie et al., 2008).

Students with disabilities tend to experience more bullying over time than those without disabilities (Pinquart, 2016; Rose & Gage, 2017). A systematic review by Pinquart (2016) looked at bullying involvement across children and adolescents with and without chronic physical illness and/ or physical or sensory disability. They discovered that children and adolescents with a disability whether physical illness, physical, or sensory has a greater likelihood of being victimized. The type of disability was found to influence the likelihood of being victimized in comparison to healthy children. It was found that children with disabilities such as chronic headaches, craniofacial conditions, epilepsy, hearing impairments, obesity, skin disease, visual impairments, or comorbid disabilities were more likely to be bullied than typical children

however, this trend was not seen for children with disabilities such as asthma or spina bifida. Interestingly, children with disabilities are also more likely to bully. Children with epilepsy, obesity, spina bifida, and comorbid disabilities were more likely to bully others than their peers without disabilities. Not surprisingly, visibility of the disability influenced the likelihood of being bullied with children with visible disabilities having greater odds of being bullied than those with less visible disabilities (Pinquart, 2016). In general, students with disabilities report feeling more concerned about school safety, being harmed at school, or being bullied by their classmates (Saylor & Leach, 2009).

Ethnic bullying is defined as bullying that occurs as a result of ethnic or cultural differences (McKenney, Pepler, Craig, & Connolly, 2006; Scherr & Larson, 2010). Ethnic bullying can include racial slurs, offensive comments about customs, food, attire, and exclusion (McKenney et al., 2006). While racial harassment does take place, children from ethnic minorities are not always bullied more than children of non-ethnic minorities (Smith, 2016). It has been suggested that school context plays a role in ethnic bullying with students of the racial minority in that specific environment being more likely to be bullied (Scherr & Larson, 2010).

Students of sexual minorities are 1.7 times more likely than their peers to experience victimization (Friedman et al., 2011). Further, students who identify as LGBT experience high rates of bullying behaviour (Friedman et al., 2011). According to the National School Climate Survey, 74.1% of LGBT students were verbally bullied, and 36.3% of students reported that they experienced physical bullying because of their sexual orientation (Kosciw, Greytak, Palmer, & Boesem, 2014). LGBT students tend to experience more victimization than their peers, have a weaker sense of school belongingness, and experience greater levels of depressive symptoms (Collier, van Beusekom, Bos, & Sandfort, 2013; Smith, 2016).

Bullying Interventions

Although bullying has long been a part of human experience, extensive research on the topic only began in the 1970's after the first empirical study on the topic was conducted. The findings were published in the book *Aggression in the Schools: Bullies and Whipping Boys* (Olweus, 1978) and sparked extensive research on bullying (e.g., Farrington, 1993; Gan et al., 2014; Smith & Sharp, 1994). Most interventions to date are school-based interventions, and a tremendous amount of research has looked at the effectiveness of these interventions (Myron-Wilson & Smith, 1998; Ttofi & Farrington, 2011). However, only a limited amount of studies included the role that parents and families play in bullying and victimization within these school-based studies (Institute of Medicine and National Research Council, 2014; Ttofi & Farrington, 2011). Ttofi and Farrington (2011) conducted a systematic review of the effectiveness of school-based programs to reduce bullying. To be included in this study, six criteria were required: 1) evaluation of a problem to reduce school bullying, 2) a clear definition of bullying was provided, 3) bullying was measured through self-report questionnaires, peer ratings, teacher ratings, or observational data, 4) effectiveness was assessed by comparing those who took part in the intervention with those who did not, 5) any published and unpublished reports that came from developed countries between 1983 and May 2009, 6) information that was necessary for calculating effect size was included. A total of 622 studies relating to bullying interventions were found but only 44 studies met the inclusion criteria (Ttofi & Farrington, 2011).

The results of the meta-analysis by Ttofi and Farrington (2011) found that school-based bullying prevention programs were effective and reduced the rates of bullying by 20-23%. Victimization rates declined by 17-20%. Ttofi and Farrington (2011) noted that bullying intervention programs that contain certain elements were more effective in reducing bullying

rates and victimization than others. These elements included parent training and meetings, greater playground supervision, disciplinary methods, classroom management, teacher training, classroom rules, school-wide bullying policies, school conferences, information for parents, and cooperative group work. Program elements that led to a reduction in victimization included disciplinary methods, parent training and meetings, videos, cooperative group work, and duration of the program. While intervention programs that included parent training were more effective for reducing bullying involvement than those that did not, within the studies that did include parent training, parent involvement was often minimal, generally consisting of informational handouts and several didactic meetings. Based on the findings of their systematic review, the authors recommend that future bullying programs extend beyond the school environment (Tofi & Farrington, 2011).

Having programs that solely aim to reduce school bullying are needed since the characteristics of aggression and bullying behaviour differ. Unlike in aggression and violence, school bullying occurs within the context of a power imbalance (Vaillancourt et al., 2003). In Gorman-Smith's work on family-focused interventions for general aggression and violence, she highlights that family-focused prevention programs should focus on proper parenting skills, improving family stability, increasing emotional connectivity, clear communication, and social support (Institute of Medicine et al., 2014). All of these factors are protective processes for bullying behaviour (Institute of Medicine et al., 2014). Since research has indicated that ineffective parenting skills, insecure attachment styles, and a lack of family cohesion increase children's likelihood of bullying involvement, it is predicted that through proper education in these areas, bullying involvement will decrease (Myron-Wilson & Smith, 1998; Nikiforou, Georgiou, & Stavrinides, 2013; Stevens, De Bourdeaudhuij, & Van Oost, 2002).

Bullying Involvement and Mental Health

Bullying involvement has been found to be associated with several negative health problems across one's lifespan (Kumpulainen & Räsänen, 2000). Children who bully others are often also experiencing attention difficulties, depression, and oppositional-conduct disorders (Smokowski & Kopasz, 2005). These children are more prone to develop antisocial behaviours later on in life (Smokowski & Kopasz, 2005). Moore, Norman, Suetani, Thomas, Sly, and Scott (2017) carried out a systematic review looking at longitudinal and cross-sectional studies exploring the health and psychosocial consequences of victimization. When looking at the psychosocial and health outcomes, children who were victimized frequently reported mental health challenges (e.g., anxiety, depression, self-harm, suicidal behaviour) and a diminished sense of self (e.g., self-esteem, self-concept). Children who were victimized also reported adverse health outcomes such as an increased likelihood of experiencing somatic symptoms (e.g., stomach-aches, sleeping challenges, headaches, dizziness, back pain) and experienced weight difficulties (e.g., overweight, obese). Additionally, children who were victimized were more likely to report difficulties in social functioning (e.g., loneliness, low life satisfaction, low quality of life, social difficulties; Moore et al., 2017). The bully-victim role is the most harmful type of bullying involvement as these individuals are at an increased risk for mental health and behavioural problems in comparison to those who just engage in bullying behaviour or victimization (Smokowski & Kopasz, 2005). Furthermore, according to Kumpulainen and Räsänen (2000) the earlier the individual is involved in bullying as a bully-victim, the more concurrent psychiatric symptoms they tend to experience relative to other children. This trend also extends to more psychiatric symptoms later in life (Kumpulainen & Räsänen, 2000).

Finally, children who are characterized as bully-victims are more prone to suffer from low self-esteem and have a negative self-image (Smokowski & Kopasz, 2005).

In their systematic review, Moore et al. (2017) investigated the causality between bullying involvement and negative health and psychosocial outcomes. While they were unable to conclude that a causal relationship exists between bullying involvement and mental health, convincing evidence exists to suggest a causal relationship. More specifically, a convincing association exists between victimization and anxiety, depression, adverse health and mental health, non-suicidal self-harm, suicide attempts, and suicide ideation (Moore et al., 2017). Probable evidence exists to support a relationship between victimization and tobacco use, and use of illicit drugs (Moore et al., 2017). Additionally, to investigate the causality of bullying and mental health, Singham et al. (2017) investigated the concurrent and longitudinal effects of exposure to bullying in childhood on mental health problems by carrying out a discordance twin study. The results of this study showed that bullying in childhood directly influences the development of mental health problems, mainly anxiety and depression but paranoid thoughts and cognitive disorganization as well (Singham et al., 2017). Further, a longitudinal study carried out by Evans-Lacko et al. (2017) explored the relationship between bullying victimization and the use of mental health services spanning from childhood to midlife. Secondary data from the British Birth Cohort study were analyzed for 9242 participants. Those who were victimized during childhood, either frequently or occasionally, showed a pattern of more incidences of accessing services and greater persistence in mental health service use from childhood to midlife. The authors of this study note that childhood bullying puts added pressure on the already strained health care system (Evans-Lacko et al., 2017).

It is evident that bullying involvement and mental health are closely intertwined such that a bidirectional relationship between bullying behaviour and mental health likely exists. A study carried out by Ha Thi Hai Le et al. (2019) used a cross-lagged panel analysis on a longitudinal database to look at the directionality of mental health problems in adolescents. This study found a reciprocal relationship between victimization and mental health problems. The results of this study showed that children who were categorized as victims or bully-victims at time one reported more depressive symptoms at time two relative to children who were not involved in bullying. Further, children who reported high levels of depressive symptoms at time one were more likely to report being victimized at time two. It was also found that psychological distress at time one increased the odds of victimization for females. For males, psychological distress at time one increased the odds of bullying and victimization. As well, relative to children who were not involved in bullying at time one, children in both the bully-victim and the victim groups had greater odds of reporting suicide ideation at time two. When looking at suicide ideation on victimization, children who reported suicide ideation at time one were more likely to report being bully-victims at time two. This study highlights the complex relationship that exists between bullying and mental health (Ha Thi Hai Le et al., 2019).

Parenting Challenges

A considerable amount of research has shown the relationship between parenting and bullying involvement (Gómez- Ortiz et al., 2016; Pepler et al., 2008; Smokowski & Kopasz, 2005). There is an intergenerational aspect of bullying, meaning that children who engage in bullying behaviour are more likely to have fathers who have aggressive tendencies and engaged in bullying behaviour in their youth (Hazler, 1996; Smith & Sharp, 2014). Children who engage in repetitive aggressive behaviour have been found to view their family in terms of power

hierarchies, and it is possible that as a result, they engage in bullying behaviour at school to assert their status (Smith & Sharp, 2014). It has been found that children who live in homes where they feel a lack of worth and have a lack of guidelines and behaviour monitoring are at higher risk for school bullying (Lepistö, Luukkaala, & Paavilainen 2011; Smith, & Sharp, 2014; Smokowski & Kopasz, 2005).

Research has supported that there is a link between parenting styles and bullying involvement (Gómez- Ortiz et al., 2016; Myron-Wilson & Smith, 1998). Maccoby and Martin (1983) identified four different types of parenting styles which vary on dimensions of responsiveness and demandingness. Responsiveness is the degree that "parents intentionally foster individuality, self-regulation, and self-assertion by being attuned, supportive, and acquiescent to children's special needs and demands" (Baumrind, 1991, p. 62). Demandingness is "the claims parents make on children to become integrated into the family, by their maturity demands, supervision, disciplinary efforts and willingness to confront the child who disobeys" (Baumrind, 1991, p. 61-62). One's parenting style is characterized by how one generally responds to one's child in various situations as a function of these two dimensions (Maher & Komajjani, 2006). An authoritative parenting style is when the parent is high in both demandingness and responsiveness, whereas an authoritarian parenting style is high in demandingness and low in responsiveness (Maccoby & Martin, 1983). A permissive parenting style is where the parent is low in demandingness but high in responsiveness, and a neglecting parenting style is where the parent is low on demandingness and responsiveness (Maccoby & Martin, 1983).

Many research studies have found that authoritarian parenting increases a child's risk for bullying behaviour (Efobi & Nwokolo, 2014; Martínez, Murgui, Garcia, & Garcia, 2019).

Parents who use an authoritarian parenting style are controlling, demanding, and give little room for the child to have an opinion (Efobi & Nwokolo, 2014). In addition to authoritarian parenting, parents who use discipline styles that use punishment increase children's risk of engaging in bullying behaviour (Gómez- Ortiz et al., 2016; Myron-Wilson & Smith, 1998).

While it is traditionally said that authoritative parenting produces well-adjusted children, Martínez et al. (2019) claim that permissive parenting is the most protective parenting style for bullying involvement. Their study found that permissive parenting was associated with the lowest level of bullying or victimization in traditional bullying and cyberbullying in girls and boys. This parenting style is protective against adolescent maladjustment, antisocial behaviour, and substance abuse (Martínez et al., 2019). The finding that a permissive parenting style is a protective factor for bullying is consistent with previous studies carried out in European and Latin-American countries. This finding marks an essential difference in parenting styles between Europe and North America where permissive parenting has been found to be equal or better in the former than authoritative parenting (e.g., Calafat, García, Juan, Becoña, & Fernández-Hermida, 2014; Rodrigues, Veiga, Fuentes, & García, 2013; Valente, Cogo-Moreira, & Sanchez, 2017).

Rigby (1993) explored the association between children's perceptions of their parents and families in relation to the children's prosocial behaviours. The results of the study showed that bullying involvement was associated with weak family functioning and weak relationships with their parents. Challenges in family functioning were weakly related, but the results were statistically significant. In terms of bullying behaviour, boys seemed to be more affected by weak family functioning than girls. Concerning parental relationships, males and females who engaged in bullying behaviour indicated weaker relationships with their fathers, but males also indicated

weaker relationships with their mothers (Rigby, 1993). While genetic heritability plays a large role in behavioural outcomes, there is evidence to support the influence of the environment on behavioural problems even when accounting for genetic heritability (Jaffee, Hanscombe, Haworth, Davis, & Plomin, 2012).

Because of the long-term implications of one's attachment to significant others, there is evidence to support a relationship between attachment and bullying behaviour. This bond is established between an infant and the primary caregiver with this relationship acting as the prototype for future relationships (Bowlby, 1979; Fraley, Roisman, Booth-LaForce, Owen, & Holland, 2013). Ainsworth and Bell (1970) note that the intensity of this attachment often varies based on situational conditions, but once established, it never dissipates. Through their research, Ainsworth, Blehar, Waters, and Wall (1978) classified three distinct attachment styles: secure, resistant, and avoidant, and a fourth attachment style, disorganized, was added later (Main & Solomon, 1986). Individuals who engage in bullying behaviour and a combination of bullying behaviour and victimization, often have a weaker quality of attachment with their parents and peers. Those who are uninvolved in bullying tend to have a more positive attachment quality (Nikiforou et al., 2013). Koiv (2012) explored the attachment styles of bullying, victimized, and non-involved students in grades four to nine in Estonia. The results of this study showed statistically significant differences in bullying involvement as a function of adolescent attachment style. Those who engaged in bullying behaviour scored higher in an avoidant attachment in comparison to victimized and non-involved children. Ireland and Power (2004) noted that when looking at attachment, emotional loneliness and bullying behaviour in adolescent and adult offenders, those who engaged in bullying behaviour and were victimized reported higher scores on the avoidant attachment style. Individuals who only engaged in

bullying behaviour were found to be lower in avoidant scores than those who bullied and were also victimized. While there appears to be a link between attachment styles, there are inconsistent findings of which attachment style is associated with bullying behaviour (Ireland & Powers, 2004).

A study carried out by Stevens et al. (2002) looked at the impact that family cohesion has on bullying behaviour. The results of this study showed a relationship between these variables. This study consisted of 1719 students in grades five and six spanning 38 schools. The data were collected through questionnaires that were administered to students and one of their parents. One of the main findings of this study is that a significant discrepancy exists between the perceptions of cohesion of parents and their children, with parents rating cohesion more positively than children. This significant difference between parents and children extended to family functioning variables such as expressiveness, conflict, organization, control, and social orientation. Children who bullied others described their families as more conflictual and less cohesive, organized, and controlled. Children who were victimized were more likely to describe their families as more cohesive and more controlling in comparison to children who bully. Children who exhibited both bullying behaviour and victimization reported higher levels of conflict and punishment and reported more distant relationships with their parents. This study highlights the importance of obtaining children's reports when assessing family functioning (Stevens et al., 2002). As noted by Bowers, Smith, and Binny (1994), children who bully report the least amount of family cohesion followed by children who bully and are victimized, children who are not involved in bullying, and children who are victimized. While cohesion is typically adaptive, too much cohesion is also problematic (Bowers et al., 1994). It is hypothesized that when parents are overly involved in their children's lives, their children do not develop the skills to navigate new

situations, cope with conflict, or discomfort (Espelage, & Swearer, 2011). Further, maternal anxiety and overprotection are associated with passivity and submissiveness in children, potentially influencing the chance of victimization (Georgiou, 2008). It has been found that parents of children who are victimized are often overly involved in their children's lives, which sometimes leads them to develop skill deficiencies (Smokowski & Kopasz, 2005). Not only does family cohesion influence the type of bullying involvement, but research has shown a link between family cohesion and the development of mental health issues. More specifically, adolescents with weak family cohesion were at greater risk for developing major depression disorders (Goodyer, 1998).

Factors including the home environment, school climate, and community influence bullying involvement (Chaux & Castellanos, 2015; Donnon & Hammond, 2007). A study conducted by Lepistö et al. (2011) looked at the experiences of adolescent who witnessed and experienced domestic violence. The results of the study found that the exposure of adolescents to domestic violence is not an anomaly with 12% of participants having witnessed parental violence and 8% having seen parent-child violence. Researchers found a link between witnessing violence at home and school bullying involvement where witnessing domestic violence (e.g., parent-parent, mother- sibling, sibling-sibling) was associated with victimization. So too, it was found that there are weaker family relationships in homes with domestic violence (Lepistö et al., 2011). According to Baldry (2003), females are more strongly affected by interparental physical violence. When females were exposed to aggression from the father to the mother, they were more likely to engage in bullying behaviour (Baldry, 2003). Living in a violent neighborhood also increases one's likelihood of engaging in bullying behaviour (Chaux & Castellanos, 2015).

Individual Strengths

To understand why some children with a host of risk factors are not involved in bullying behaviour, researchers have turned to resiliency. According to Luthar (2006), resiliency is the ability to overcome adversity through positive adaptation. Olsson, Bond, Burns, Vella-Brodrick and Sawyer (2003), describe how resiliency has been found to lead to a positive influence on mental health, ability, and social skills. When exploring aspects that promote resiliency within a child, intrinsic mechanisms and extrinsic mechanisms influence one's ability to overcome and thrive in the face of adversity (Donnon & Hammond, 2007; Rutter, 1987). Olsson et al. (2003), notes that resilience is multi-factorial, meaning that resilience is a cumulation of one's risks and protective factors. Therefore, assessing resiliency should be based upon an assessment of the full range of ecological subsystems since increasing risk factors or protective processes within one area of a child's life has the potential to have a cumulative adverse effect on resiliency (Sameroff, Bartko, Baldwin, Baldwin, & Seifer, 1998). When looking at resilience in relation to bullying involvement, a correlation exists between bullying involvement and resiliency (Donnon & Hammond, 2007).

Individual characteristics such as self-esteem, self-concept, self-efficacy, hope, optimism, and intellectual functioning have emerged as common traits that influence resilience and reduce the likelihood of being involved in bullying (Donnon & Hammond, 2007; van Hoof et al., 2008). Having strong problem-solving skills increases the likelihood of not being involved in bullying (Baldry & Farrington, 2005; Cassidy & Taylor, 2005). In a study by Donnon and Hammond (2007), looking at the relationship between resiliency and bullying in adolescence in Junior High School, they found that children who possessed greater individual strengths had a greater likelihood of behaving adaptively. More specifically, children with greater strengths including a supportive family, feeling accepted, and who had greater school engagement were less likely to

use illicit substances (e.g., drugs, alcohol, tobacco), skip classes, gamble, steal, bully, carry a weapon, and vandalize (Donnon & Hammond, 2007). Cook, Williams, Guerra, Kim and Sadek (2010) conducted a meta-analysis and looked at factors that influenced bullying and victimization in children. When looking at individual predictors of bullying type including self-related cognitions (e.g., self-respect, self-esteem, self-efficacy) and peer status (e.g., the nature of their peer relationships), they found that self-related cognition was negatively associated with bullying ($r=-.07$), peer status was negatively associated with victimization ($r=-.35$), and self-related cognitions was negatively associated with bullying and victimization ($r=-.40$). The findings of this study suggest a relationship between bullying involvement and individual strengths (Cook et al., 2010).

In sum, bullying involvement is a pervasive problem that has captured the attention of researchers around the globe (Smith, 2016). The majority of the research has focused on decreasing bullying through school-based interventions, whereas fewer evaluated intervention programs have incorporated parenting into their efforts to reduce bullying involvement (Ttofi & Farrington, 2011). As recommended by Craig, Lambe, and McIver (2016), emphasizing the relational aspect of bullying behaviour may be advantageous in addressing bullying involvement. While it is the role of the parents to establish healthy relationships with their children by being attuned and responsive to their needs and fostering a positive and supportive environment, at-risk children often lack these healthy relationships (Craig et al., 2016; National Scientific Council on the Developing Child, 2004). As such, Craig et al. (2016) have suggested that effective prevention and intervention programs should support children to learn the skills to develop and maintain healthy relationships. By helping children and youth to develop the necessary relational skills to handle conflict and differences, the rates of bullying may decrease. These skills lay the

foundation for the development of other healthy relationships, and therefore these skills have the potential to carry over into other domains of the children's lives (Craig et al., 2016).

Tackling this pervasive issue is crucial as bullying involvement is associated with negative mental health and academic outcomes (Craig, Cummings, & Pepler, 2014). The relationship between bullying involvement and mental health outcomes has been found to be bidirectional. Put simply, the presence of mental health problems increases one's likelihood of bullying involvement and bullying involvement is associated with the development of mental health problems (Ha Thi Hai Le et al., 2019; Kumpulainen Räsänen, & Puura, 2001; Singham et al., 2017). As well, parenting challenges and individual strengths have been found to act as protective processes, potentially increasing or decreasing the likelihood of bullying involvement (Smokowski & Kopasz, 2005; Cook et al., 2010). The purpose of this study is to better understand the associations among mental health indicators (e.g., internalizing behaviours, externalizing behaviours), parenting challenges, and the child's strengths across the different types of bullying involvement.

Conceptual Framework

This study uses the Bioecological Theory's Process-Person-Context Time (PPCT; Bronfenbrenner, 1995) model and the Multiple Risks Model (Sameroff et al., 1998) to explain the interconnectedness of bullying involvement, mental health indicators, parenting challenges, and the individual strengths of the child (Bronfenbrenner, 1995). Bioecological Theory portrays human development through a holistic lens and proposes that it is reciprocally influenced by various environmental systems (Bronfenbrenner, 1995). This theory informs the approach to the current study by providing a framework for understanding bullying as a formative social process that can have long-term effects on human development.

Within the Bioecological Process-Person-Context-Time (PPCT; Bronfenbrenner & Morris, 1998) model, proximal processes refer to the reciprocal interactions that children have with people and objects in their environments and which propel development. This model conceptualizes a child's context through five nested environmental systems that impact development. A child's context is evaluated through time which is the final concept of the Process-Person-Context-Time (PPCT) model (Bronfenbrenner & Morris, 1998). The concept of time occurs on three levels including micro-time (e.g., what is occurring within an interaction), meso-time (e.g., the level of consistency within interactions and activities in the child's environment), and macro-time (e.g., historical changes that take place over time) (Bronfenbrenner & Morris, 1998). Given that this study is cross-sectional in nature, it is limited in that it only encapsulates the micro-time level, relating to what is happening for the children in a specific period of time (i.e., a bullying incident). Yet, bullying also unfolds at the meso-time level when bullying is conceptualized as a relational problem (Craig et al., 2016): Over time, the individuals in the relationship become more consolidated in their roles (e.g., bully, victim, bully-victim), and as the relationships evolve, it becomes challenging for these individuals to pull themselves out of their consolidated roles. Furthermore, these established relational patterns also drive development at the macro-time level, as they continue to influence the child's relationships with others over time.

The Bioecological Process-Person-Context-Time (PPCT) model guides this study by providing a framework to help understand how bullying involvement is influenced by the reciprocal interaction of the child's characteristics as well as the environments that a child interacts within (Bronfenbrenner & Morris, 1998). Bullying involvement is not solely attributed to the individual characteristics of the child but rather an interaction between several domains

within the child's life (Swearer & Hymel, 2005). The person refers to the biological characteristics of the individual. According to Bronfenbrenner and Morris (1998), individual traits are made up of the individual's demand, resources, and force. Demand characteristics include age, gender, and physical appearance. Resources encompass the child's skills, abilities, knowledge, parents, as well as mental and emotional resources. These characteristics influence the child's ability to function (Bronfenbrenner & Morris, 1998). Lastly, force characteristics deal with enduring traits such as temperament, persistence, or motivation (Bronfenbrenner & Morris, 1998; Tudge, Morkova, Hatfield, & Karnik, 2009). As such, the individual can either have a passive role in which they influence their environment through their demand characteristics or have an active impact based on their resources and force characteristics (Tudge et al., 2009).

The "context" within this model comprises five nested environmental systems. Microsystems are defined by immediate environments (e.g., home, school) within which an individual interacts with other people and objects (Bronfenbrenner, 1994). Mesosystems are created when people from different microsystems that contain the child come into contact (Bronfenbrenner, 1994). Exosystems are environments where the child is not directly involved, but these environments indirectly affect the child (Bronfenbrenner, 1994). The macrosystem encompasses cultural values, customs, and laws (Berk, 2000). Chronosystems represent the change that occurs within the individual and the environment over time.

This study also draws from the Multiple Risk Model (Sameroff et al., 1998) which builds on the Bioecological Theory's Process-Person-Context-Time (PPCT; Bronfenbrenner & Morris, 1998) model by taking into account the cumulative effect that risk factors within the nest systems have on child's development. The Multiple Risk Model (Sameroff et al., 1998) can be applied to bullying involvement as the more risk factors that a child has within the different contexts of

their life, the more likely they are to engage in school bullying, which has adverse effects on child development. According to Sameroff, Gutman, and Peck (2003), identifying the contexts where a child is experiencing challenges is essential for creating effective interventions. For example, to best help children who are experiencing difficulty in multiple domains of their life such as within their home environment (e.g., parenting challenges), school environment (e.g., bullying, victimization, bully-victim), and their personal characteristics (e.g., individual strengths), effective anti-bullying interventions should seek to address the challenges within each of those contexts (Sameroff et al., 2003). This framework offers a way to conceptualize the experiences of the children within this sample and offer suggestions as how to best support them.

Research Questions

The guiding research questions for this study are as follows:

- (1) Do children referred for mental health services and who display specific patterns of involvement in school bullying show significant differences on selected mental health indicators (internalizing and externalizing symptoms)?
- (2) Do children referred for mental health services and who display specific patterns of involvement in school bullying show significant differences on parenting challenges?
- (3) Do children referred for mental health services and who display specific patterns of involvement in school bullying show significant differences on individual strengths?

Methodology

Data

This study made use of de-identified clinical data gathered in routine intake assessments at Crossroads Children's Mental Health Centre (CCMHC) in Ottawa, Ontario. This project was approved by the University of Ottawa Ethics Board (Appendix D) to use secondary data from

Running Head: BULLYING ON MENTAL HEALTH, PARENTING, AND STRENGTHS

CCMHC. This non-profit organization provides a variety of services for children and their families. Clients who utilize Crossroads services can be referred from various community services such as Children's Aid Society, school-based mental health services, hospitals, the Arson Prevention Program for Children, or the police. Parents and guardians can seek out professional support from Crossroads and access their services. Whether referred through an agency or self-referred to Crossroads, clients are administered an intake battery of scales before accessing the variety of services that Crossroads Children's Mental Health Centre offers. The intake battery consists of basic demographic information, information about the presenting problem, the Child and Adolescent and Childs Needs and Strength (CANS) measure and the Strengths and Difficulties Questionnaire (SDQ). To gauge progress, the CANS, and SDQ measures are administered at every intake and discharge. Some clients of CCMHC have been referred (by self-and/or others) multiple times over several months or years and consequently, repeat the intake and discharge procedures on multiple occasions. It is impossible to determine from the dataset provided to the researchers whether or not the scale scores represent a first-time or a subsequent intake assessment. The data from this study came from clients who were seen between May 2019 and January 2020.

Procedure

On January 13, 2020, the demographic information and the Child and Adolescent Needs and Strengths (CANS) item-level responses were obtained from Crossroads Children's Mental Health Centre's (CCMHC) online client data storage software (<https://www.emhware.com>). Item level responses on the Strength and Difficulties questionnaire were manually inputted into the dataset, based on a list provided by Crossroads. The list contained clients seen at CCMC after May 1, 2019, the date when paper copies of the SDQ began being placed in client's paper files.

Paper copies of the SDQ measure were necessary because unlike with the CANS measure, individual item responses were not saved on the data storage software. Rather, subscale scores based on the individual items (e.g., emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems, prosocial behaviour) are kept on the data storage software, as they convey helpful clinician information to the agency.

Measures

The Child and Adolescent Needs and Strengths (CANS). The CANS measure is a multi-purpose assessment used to assess children's functioning in multiple domains and to assess the parenting skills of the caregiver (Appendix A; Cordell, Snowden, & Hoiser, 2016; Lyons, 2009). The CANS measure is described as a communimetric tool, meaning that modified versions of the CANS are co-constructed to fit the specific needs of the agency while still being a valid and reliable tool (Lyons, 2009). This customized version used by CCMHC consists of 28 items that address the unique assessment needs of the agency who provided the data for this study. The CANS measure is completed by the clinician based on the information provided by the parent or caregiver. The six domains that make up this measure include Mental Health Needs (e.g. Anxiety, oppositional behaviour, parent-child relations), Risk Behaviours (suicide risk, danger to others), Educational Needs (school attendance, school discipline), Child/Youth Individual Strengths (peer relations, adaptability to change), Parents/Family/Caregiver Needs and Strengths (knowledge of the child, ability to communicate), and Family Needs and Strengths (family stress). Questions are scored on a 4-point Likert scale: 0) no evidence or no reason to believe that the related item requires any action 1) need for watchful waiting, monitoring, or possibly preventive action, 2) need for action. Some strategy is needed to address the problem/need, and 3) a need for immediate or intensive action. This final level indicates an

immediate safety concern or a priority for intervention. The CANS is a valid and reliable measure (Alamdari & Kelber, 2016). The CANS demonstrated construct validity with variations between diagnostic categories for internalizing and externalizing categories (Alamdari & Kelber, 2016). The CANS measure displays concurrent validity when compared to the Youth Outcome Questionnaire (YOQ; Burlingame et al. 2005). This latter scale is used to assess treatment progress in youth receiving mental health services, and the internalizing ($r=.37, p <.01$), externalizing categories ($r=.39, p <.01$), and family functioning ($r=.51, p <.01$) on the CANS measure were correlated to the YOQ (Alamdari & Kelber, 2016).

A Cronbach's Alpha analysis was carried out to assess the internal consistency of the measure to capture the dependent variables in the current study (Table 1): mental health indicators (internalizing and externalizing issues), parenting challenges, and children's individual strengths. Internalizing behaviour was made up of four questions (e.g., anxiety, mood disturbance, suicide risk, self-injuring behaviours). The subscale had a low level of internal consistency, as determined by a Cronbach's alpha of 0.52. Another construct, externalizing behaviour consisted of seven questions (e.g., attention-hyperactivity, impulse control, oppositional behaviour, aggression-objects, danger to others, school discipline) and the scale had a high level of internal consistency, as determined by a Cronbach's alpha of 0.86. The construct parenting challenges which is denoted in the CANS measure as Parents/Family/Caregiver Needs and Strengths consisted of six items (e.g., parent-child relations, discipline/parenting skills, problem-solving, knowledge of child, parental responsiveness, ability to communicate, understanding the impact of your own behaviour on children). Within the CANS measure, items are scored based on increasing severity whereby parents who have greater strengths have a lower score than those who have greater needs. Therefore, in order to best capture the needs and

strengths of parents in one variable, it was decided to use the term parenting challenges.

Parenting challenges had high levels of internal consistency, as determined by a Cronbach's alpha of .83. The construct of individual strengths was made up of four questions (e.g., peer-relations, self-expression, adaptability to change, family) and it had relatively low levels of internal consistency, as determined by a Cronbach's alpha of .60.

Strengths and Difficulties Questionnaire. The SDQ is a widely used behavioural screening questionnaire used to assess children and adolescents aged 4-16 years old and is completed by an adult caregiver (Appendix B; Goodman, 1997; Stone, Janssens, Vermulst, Van Der Maten, & Engels, 2015). The measure's 25 items are organized into five categories, which include emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems, and prosocial behaviour (Goodman, 1997). Items are scored on a 3-point Likert scale ranging from 0) not true, 1) somewhat true, and 2) certainly true. The SDQ shows evidence of concurrent validity, with the scores from the SDQ and the Rutter Children's Behaviour Questionnaire being highly correlated for parent ratings ($r=0.88$; Goodman, 1997; Stone et al., 2015). The SDQ has exhibited moderate test-retest reliability over an eight-week period ($r=0.71$; Yao, Zhang, Zhu, McWhinnie, & Abeia, 2009). The Strengths and Difficulty Questionnaire has been shown to have strong internal consistency with a Cronbach's alpha of 0.81 (Yao et al., 2009) and was found to be generally satisfactory in a sample of 5 to 15-year-olds in the general population (Goodman, 2001).

Bullying Grouping Criteria

The SDQ was used to capture bullying involvement, and four bullying-involvement groups were created: the non-involved, bully, victim, and bully-victim. Groups were decided based on responses to the bullying and victimization items on the SDQ. The data collected from

the SDQ is from the perspective of the caregiver. Children with a score of 0 on the bullying and victimization items were coded as non-involved. Children with a score of 1 or 2 on bullying and a 0 on victimization were classified in the bully group. To be classified as a victim, it required a score of 1 or 2 on the victimization item and a score of 0 on the bullying item. The bully-victim group comprised children with a score of 1 or 2 on the bullying and victimization items.

The selected cut-off scores on the bullying and victimization items in this study were assessed based on the existing trends in the literature in which similar bullying-involvement groupings were created based on scale items. The cut-off scores for bullying involvement vary widely across studies (Zych, Ortega-Ruiz, & Marin-Lopez, 2016). As a result, the cut-off for group inclusion was based on the recommendation of Solberg and Olweus (2003). They found that reporting being involved in bullying “2 or 3 times a month” is an acceptable lower-bound cut-off score. Being involved in bullying “2 or 3 times a month” has been likened to the term “sometimes” or “now and then”, and has been used in several questionnaires (Olweus, 1993; Smith and Sharp, 1994; Solberg & Olweus, 2003). On the SDQ measure, a score of “1” is used to represent “somewhat true” and therefore was selected as the cut-off score. Table 1 presents all study variables and the scale items comprising variables drawn from the two scales that were used in this study.

Studies vary in the way they capture bullying involvement, with some studies using single-items to capture the behaviour (e.g., Earnshaw, Carrol-Scott, & McCaslin, 2014; Holt, Kantor, & Finkelhor, 2009; Konishi, Hymel, Zumbo, & Li, 2010) and others using multi-items (e.g., Shaw, Julián, Cross, Zubrick, & Waters, 2013). This study chose to use a single item to capture bullying and victimization. Previous research has suggested that using single-items and multi-items to capture bullying involvement are both effective method for assessing bullying

involvement (Catone et al., 2019). Single items enable researchers to categorize groups of bullying involvement and their prevalence, while multi-items are able to capture the phenomenon in greater detail. A multi-item assessment of bullying involvement is advantageous because it is more valid since it can fully capture the bullying involvement, it is more accurate because it can better distinguish between minute aspects of bullying involvement, and is more reliable than single-item measures because it is less likely to have a random error (Thomas, Connor, & Scott, 2015). However, the decision of whether to use a single or a multi-item measure to capture bullying involvement should depend on the overarching goal of the study (Thomas et al., 2015). If the purpose of the study is to estimate or compare bullying and victimization, a single item should be sufficient, however, if the objective is to capture the bullying involvement in greater detail, using a multi-item measure is preferred (Thomas et al., 2015). Based on this study's use of secondary data and that there is only one item that captures bullying involvement on the SDQ, this study opted to use a single item to assess bullying involvement.

Table 1

Variable Conceptualization

Variable	Individual Items
Bullying behaviour	<i>Often fights with other children or bullies them. *</i>
Victimization	<i>Picked on or bullied by other children. *</i>
Parenting Challenges	<i>Discipline/parenting skill. **</i> <i>Problem-solving. **</i> <i>Knowledge of child. **</i> <i>Parental Responsibility. **</i> <i>Ability to communicate. **</i> <i>Understanding of impact of own behaviour on child. **</i>

Externalizing behaviour	<i>Attention/ hyperactivity.</i> ** <i>Impulse control.</i> ** <i>Oppositional behaviour.</i> ** <i>Aggression objects.</i> ** <i>Danger to others.</i> ** <i>School discipline.</i> **
Internalizing behaviour	<i>Anxiety.</i> ** <i>Mood disturbances</i> ** <i>Suicide risk.</i> ** <i>Self-injuring behaviour.</i> **
Individual Strengths	<i>Peer relations,</i> ** <i>Self-expression.</i> ** <i>Adaptability to change.</i> ** <i>Family.</i> **

**Strengths and Difficulties Questionnaire **Child and Adolescents Needs and Strengths*

Questionnaire

Data Analyses

A cross-sectional study design was used to compare the differences in mental health, parenting challenges, and individual strengths across the four types of bullying involvement in school-aged children seeking mental health services in Canada (Table 1). To better understand the relationship, descriptive statistics, correlations, and a MANOVA with post hoc tests were run.

Results

Sample Characteristics

This study used data from Crossroads Children's Mental Health Centre. Typically, children who utilize this agency have been identified by their parents and or their teachers as experiencing emotional, behavioural, or social difficulties. According to the standard practices of

the agency, demographic information is provided by the child's parent during the intake interview.

This study consisted of 91 children (48.4% female, 51.6 % male) who sought out mental health services at CCMHC between May 1, 2019, and January 13, 2020. Demographic characteristics are outlined in Table 2. The mean age of participants was $M=8.02$ ($SD=1.73$), with ages ranging from four years-old to 11 years-old. Within the sample, 97.8% were attending school and 2.2% were not. The 2.2% of participants who were not attending school were below the age of six and therefore, they are not required to attend school. The ethnic background of participants included African (8.8%), Caribbean (1.1%), Latino (2.2%), North American (75.8%), European (4.4%), West Asian (2.2%), and Other (2.2). Although 29.7% of the sample either did not know their income, preferred not to answer, or had missing data, children in this sample came from low, middle, and high socioeconomic status.

Table 2

Sample Characteristics (N=91)

Variables	N	%
Grade		
Kindergarten (Year 1)	1	1.1
Kindergarten (Year 2)	2	2.2
One	18	19.8
Two	21	23.1
Three	16	17.6
Four	14	15.4
Five	14	15.4
Six	5	5.5
Gender		
Male	47	51.6
Female	44	48.4
Income		
\$0-\$29,999	15	16.5

\$30,000-\$59,999	11	12.1
\$60,000-\$89,000	7	7.7
\$90,000-\$119,000	12	13.2
\$120,000-\$149,000	8	8.8
\$150,000 or more	11	12.1
Do not know	5	5.5
Prefer not to answer	9	9.9
Missing	13	14.29
Bully Type		
Non-involved	15	16.5
Bully	17	18.7
Victim	24	26.4
Bully-victim	35	38.5

Within this sample (Table 2), a plurality of children fell into the bully-victim group (38.5%), followed by the victim group (26.4%), the bully group (18.7%), and the non-involved group (16.5%). Table 3 outlines the breakdown of the four bullying involvement groups by gender.

Table 3

Sample Characteristics by Bully Type (N=91)

Bully Type	N	Female	Male
Non-involved	15	53.3%	46.7%
Bully	17	52.9%	47.1%
Victim	24	50.0%	50.0%
Bully-victim	35	42.9%	57.1%

To determine the relationship between the constructs, a Pearson's correlation analysis was conducted. There were statistically significant relationships between most variables included in this study (see Table 4). To determine the correlation between the variables, the raw, continuous data for bullying behaviour and victimization were used. These two items were used for grouping and then not used again. A negative correlation of moderate size was found between bullying behaviour and internalizing behaviour. Bullying behaviour had a large positive

correlation with externalizing behaviour and had a medium correlation with parenting challenges and individual strengths. Victimization had a small correlation with internalizing behaviour and a medium correlation with individual strengths.

Table 4

Pearson's Correlation Matrix N=91

Variable	1	2	3	4	5	6
1. Bullying Behaviour	-					
2. Victimization	.120	-				
3. Internalizing Behaviour	-.258	.232*	-			
4. Externalizing Behaviour	.452*	.079	-.164*	-		
5. Parenting Challenges	.350*	.059	-.034	.624*	-	
6. Individual Strengths	-.269*	-.241*	.003	-.148	-.107	-

* $p < .05$.

Mean Scores Across Dependent Variables

The means and standard deviations of the bully involvement types across the dependent variables (Table 1) (e.g., internalizing behaviour, externalizing behaviour, parenting challenges, individual strengths) are summarized in Figure 1.

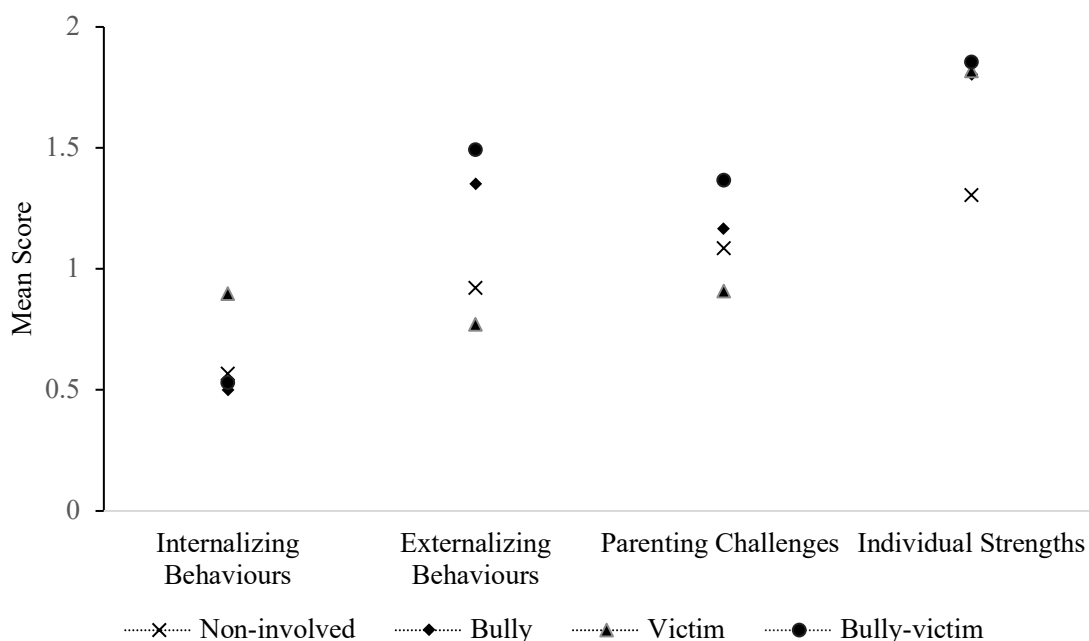


Figure 1. Mean scores of bullying involvement ratings across internalizing behaviours, externalizing behaviours, parenting challenges, and individual strengths.

Bully Group Comparisons

A one-way multivariate analysis of variance was run to determine the different behaviour patterns between the types of bullying involvement on internalizing behaviour, externalizing behaviour, parenting challenges, and individual strengths. There were four types of bullying involvement: non-involved, bully, victim, and bully-victim. The differences among the bully groups across the set of dependent variables were statistically significant, $F(12, 246) = 4.956, p = .000, \Lambda = .584$. Results from the follow-up univariate analyses indicate that the effect of bullying involvement grouping on each of the dependent variables reached statistical significance. An explanation of the univariate results will follow.

Internalizing Behaviour. A follow-up univariate ANOVA revealed a significant effect of bullying involvement on internalizing behaviour, $F(3, 83) = 6.391, p = .001$. Tukey post-hoc

tests showed that victimized children differed from the three other bullying involvement groups on the internalizing variable. Specifically, compared to children in the non-involved, bullying, and bully-victim groups, children in the victim group were significantly more likely to experience internalizing symptoms (respectively, .331, 95% CI [.030, .632]; .398, 95% CI [.108, .688]; .367, 95% CI [.120, .615]).

Externalizing Behaviour. A follow-up univariate ANOVA showed that externalizing behaviour, $F(3, 83) = 9.433, p = .000$, was statistically significant between the bullying involvement groups. Tukey post-hoc tests revealed that compared to children in the victim group, children in the bully and the bully-victim groups were significantly more likely to experience externalizing symptoms (respectively, .580 95% CI [.118, 1.042]; .722 95% CI [.329, 1.116]). In contrast to the children in the non-involved group, children in the bully group were significantly more likely to experience externalizing symptoms (.573 95% CI [.127, 1.018]).

Parenting Challenges. A follow-up univariate ANOVA showed that parenting challenges, $F(3, 83) = 4.935, p = .003$, varied significantly among the bullying involvement groups, although compared to the other dependent variables, there was much less variation in parenting challenges among the bullying involvement groups. Tukey post-hoc tests showed that in comparison to the victim group, bully-victims were more likely to have parents experiencing parenting challenges (.459 95% CI [.140, .778]). No other between-group comparisons reach statistical significance.

Individual Strengths. A follow-up univariate ANOVA showed that the child's strengths, $F(3, 83) = 6.014, p = .001$, varied significantly among the bullying involvement groups. Tukey post-hoc tests revealed that the group of non-involved children stood apart from the three groups of bullying-involved children. Results revealed that compared to the bully group (.494 95% CI

[.091, .906]), the victim group (.513 95% CI [.127, .898]), and the bully-victim group (.551 95% CI [.192, .909]), children in the non-involved group were significantly more likely to have more individual strengths. Furthermore, the data indicated that there were no significant differences in levels of individual strengths among children in the bullying, bully-victim, and victim groups.

Discussion

Bullying is a complex social process that is experienced by children and youth across the globe (Gan et al., 2014). Bullying has captured the attention of researchers and has led to a wealth of research to better understand this complex social phenomenon (Smith, 2016). Four decades of research has shed light on the numerous factors and processes that influence the nature of bullying (Smith, 2016). The purpose of this study was to investigate a subset of factors drawn from the psychological and the social spheres of children's lives that are possibly associated with the distinct patterns of children's involvement in school bullying. This study looked at the association between the type of bullying involvement, on the one hand, and mental health, parenting challenges, and the child's strengths, on the other, for children accessing services at a children's mental health agency.

The findings of this study suggest a relationship between mental health indicators and bullying involvement. The severity of internalizing behaviour was found to differ across the levels of bullying involvement. Most notably, children who were victimized were more likely to have more internalizing symptoms relative to children in the bully, bully-victim, and non-involved groups. This finding is congruent with previous literature which suggests an association between victimization and internalizing behaviours (Cook et al., 2010; Moore et al., 2017; Smokowski & Kopasz, 2005). Like internalizing behaviour, externalizing behaviour significantly varied across the four levels of bullying involvement. Children in the bully group displayed

statistically significantly more externalizing behaviours than those in the victim group. Children who were in the bully-victim group experienced greater levels of externalizing behaviour than children in the non-involved group and children in the victim group. The findings of this study point to an association between children who perpetrate bullying in some capacity, whether as a bully or as a bully-victim, and externalizing behaviour. As well, the findings suggest a link between bullying involvement and parenting challenges. When looking at parenting challenges across the different levels of bullying involvement, the children in the bully-victim group were more likely to have parents who report greater parenting difficulty than the victim group. Within this study, parenting challenges are characterized by challenges in disciplining skills, problem-solving, parent's knowledge of their child, communication, and understanding the impact of their own actions on their child. While the findings were not statistically significant across the other groups of bullying involvement, there were a small difference in the overall predicted directions for parenting challenges. The individual strengths of the children were compared across the non-involved, bully, victim, and bully-victim groups. A clear pattern emerged whereby those who were not involved in bullying had significantly more individual strengths than children in the victim group, bully group, and bully-victim group. The children in the non-involved group possessed stronger peer relationships, self-expression, the ability to adapt to change, and stronger family units.

To our knowledge, only a limited number of bullying involvement studies have explored the relationship between individual and contextual factors for children accessing mental health services. Within the sparse research looking at mental health indicators, parenting challenges and individual strengths across the types of bullying involvement in children accessing services from a mental health agency, this study offers insight into the unique needs and strengths of children

in this niche population. One aspect that makes this study unique is its multi-informant perspective. How bullying is assessed varies across studies, with some studies assessing bullying involvement through parents, teachers, peers, self-report, and observation (Swearer & Hymel, 2015). Instead of drawing conclusions from a single perspective, this study incorporates the perspectives of the parents and the clinicians to capture a wider understanding, relative to sampling a narrower single perspective, of the needs and strengths of children referred for mental health services and are involved in bullying. In this study, bullying involvement, the independent variable, was derived from the reports of the parents, whereas the four dependent variables were rated by the clinicians.

Another aspect of this study that adds to its scholarly value is that it sheds light on the experiences of a population of children who have high needs yet have been under-researched, at least with respect to bully-victim problems. Typically, bullying studies involve community surveys of elementary, middle school, or high school students (Ttofi & Farrington, 2011). These studies tend to give researchers a broad picture of what is happening for students across the board in relation to bullying involvement and other factors, whereas this study explores the relationship for children who have been identified as being at higher risk for bullying involvement (Gómez- Ortiz, et al., 2016). When looking at the general population, according to the Health Behaviour in School-Aged Children study in 2014, 70% of children across Canada were not involved, 22% had been victimized, 3% had bullied others, and 5% had bullied others and been victimized (Freeman et al., 2016). When looking at bullying involvement across gender in students in grade seven, 3% of boys and 2% of girls reported bullying others, 21% of boys and 29% of girls report being victimized, and 6% of boys and 5% of girls report bullying others and being victimized (Freeman et al., 2016). In contrast to the findings of the Health Behaviour in

School-Aged Children, children in this clinical sample are on average substantially more involved in bullying, with the prevalence of bullying involvement within this study standing at 83.5%. This rate far exceeds the national norm of bullying involvement found in community samples in a Canadian context, which stands around 30% (Freeman et al., 2016).

By examining the relationship between bullying involvement and mental health, parenting challenges, and the child's strengths in children who are already at higher risk of bullying involvement (Gómez- Ortiz, et al., 2016), this study sheds light into the specific challenges and needs of children in this population. By better understanding the needs and strengths of this niche population, interventions, programs, and resources can be refined to best support these children and their families.

Needs and Strengths of Children Involved in Bullying

Mental Health Indicators

Internalizing behaviours. This study found that children in the victim group were more likely to be experiencing internalizing behaviour difficulties than children in the non-involved group and the bully-victim group. The results of our study, in light of earlier findings in this domain, suggest that children who are victimized are likely experiencing difficulties with anxiety, mood disturbances, elevated suicide risk, and engaging in self-injuring behaviours. This suggests that interventions addressing internalizing behaviours in children who have a history of victimization could be helpful.

Previous research has suggested that bullying involvement is linked with negative mental health outcomes in children (Moore et al., 2017). Victimization has been found to be moderately correlated with internalizing behaviour (Cook et al., 2010). Research indicates that children who are victimized often experience insecurity, anxiety, tend to be sensitive, quiet, and are less likely

to take risks (Olweus, 1994; Fleisher, 2003). It is not uncommon for children who are victimized to experience suicidal ideation, putting them at greater risk for suicide attempts as well as non-suicidal self-harm behaviours (Moore et al., 2017). In terms of suicidal attempts, males and females who are victimized are three times more likely to make an attempt (Moore et al., 2017). When the victimization is frequent, children are at an even greater risk (Moore et al., 2017). It is not uncommon for children who are victimized to be experiencing self-blame and negative self-image, possibly as a result of being victimized (Carney & Merrell, 2001; Smokowski & Kopasz, 2005). While internalizing behaviour is often viewed as more characteristic of victimization, there is a small association between bullying behaviour and internalizing behaviours (Cook et al., 2010). It has been well-documented that bully-victims experience the most severe mental health outcomes as opposed to non-involved children, children who bully, or victims (Smokowski & Kopasz, 2005). Not only are children who bully and are victimized more likely to have greater psychiatric concerns relative to other children, but Kumpulainen and Räsänen (2000) also suggest long-term implications in that they are more likely to have greater psychiatric concerns for many years following the initial bullying involvement. The Multiple Risk Model can help explain why children in the bully-victim group experience the most complex challenges (Sameroff et al., 1998). The Multiple Risk Models (Sameroff et al., 1998) suggests that the greater number of risk factors that a child has, the increased likelihood that they will experience a negative outcome (Hyppolite, 2017). When looking at these children through the lens of the Multiple Risk Model (Sameroff et al., 1998), it is not surprising that the bully-victim group experiences the greatest challenges.

Externalizing behaviours. The findings of this study are in line with previous research that explores the relationship between bullying involvement and externalizing behaviours.

Regarding externalizing behaviours, our study suggests that children in the bully group exhibit more externalizing behaviour as compared to the victim group. Additionally, the bully-victim group was more likely to be experiencing externalizing behaviour problems than the non-involved and the victim group. This suggests that interventions addressing externalizing behaviours could be helpful for some of the children in this sample.

When looking across the different bullying groups, researchers have found different patterns of externalizing behaviours. Children who bully and children who both bully and are victimized are more likely to be engaging in externalizing behaviours (Cook et al., 2010). A systematic review by Cook et al. (2010) found that externalizing behaviour, such as actions that are aggressive, defiant, and disruptive, were predictive of bullying and bully-victim status. Within the Cook et al. (2010) study, a medium effect size was found for this relationship. In contrast, only a small effect size was found for externalizing behaviours being predictive of victimization (Cook et al., 2010). Based on the literature, children who bully others are often experiencing attention difficulties, depression, and oppositional-conduct disorders (Smokowski & Kopasz, 2005).

Parenting Challenges

While in this study only children in the bully group were significantly more likely to be experiencing parenting challenges than children in the victim groups, it is hypothesized that within this sample there is an association between parents' challenges and their children's mental health needs. It is possible that as a result of these difficulties that parents have reached out for help so that they can get the necessary support to best help their child. Previous research has suggested that having a child with mental health challenges is a predictor of caregiver strain, which impacts their ability to support their child (Mendenhall & Mount, 2011). However, the

type of strain experienced by the caregiver is influenced by the type of difficulty experienced by the child with parents of children with internalizing behaviours less strain than parents of children with externalizing behaviours (Mendenhall & Mount, 2011).

According to Johnson and Lipski (2006), having a family member with an illness can impact the whole family. The strain on the family can impact daily living, health and well-being, social and family relationships, careers and financial security. Caregivers of children experiencing mental health issues, as in our sample, often describe their situation as unpredictable and chaotic. The stress of caring for a family member with mental health issues has a negative impact on caregiver's health and well-being and they often experience self-blame, depression, anxiety, and confusion. They found that it is not uncommon for caregivers to feel stigmatized for having a child with mental health issues. Often, these parents have to act in multiple roles, advocating for their child, navigating the mental health system, provide crisis intervention, and care for their child's basic needs in addition to managing their other responsibilities (Johnson & Lipski, 2006). Specifically, within Crossroads Children's Mental Health Centre (CCMHC), the focus of the agency is to support children and their parents in the walk-in service which offers access to mental health services without a referral. With parents being central to their children's mental health, supporting the needs of these parents has the potential to have positive implications.

In a systematic review by Nocentini et al. (2019), which looked at the role of parents, family characteristics and bullying involvement, they found evidence to suggest that relational factors influence bullying involvement. Children who bully, are bullied, and who bully and victimize others are often experiencing challenges communicating with their parents. These children often communicate less with their parents and have difficulties sharing their troubles.

Parent-child communication has the potential to act as a protective factor, with children who discuss their lives with their parents on their own volition are less likely to be involved in bullying. This finding highlights the importance of fostering an environment where children feel safe and able to share their inner worlds with their parents (Nocentini et al., 2019). Another factor that was found to be protective against bullying behaviour in Nocentini et al.'s (2019) systematic review was parental involvement, family cohesion and support. When parents listen to their children, praise them, give them affection, empathize, trust and respect their children, children were less likely to bully others and be victimized. Even more than that, when parents are supportive and are there for their children who are victimized, it decreases the chances of future victimization. Parental warmth and responsiveness play a protective role in bullying involvement. When children have a secure attachment with their primary caregivers, they are less likely to be involved in bullying. When it comes to maladaptive parenting, the risk is primarily for bullying behaviour (Nocentini et al., 2019). Given parents protective role in bullying behaviour and the stress and constraints that they experience, providing parents with resources and relevant supports could help not only alleviate some of the pressures on parents but also help reduce the prevalence of bullying involvement in children accessing mental health services.

When applying the Bioecological Theory's Process-Person-Context Time (PPCT) model (Bronfenbrenner & Morris, 1998) and the Multiple Risks model (Sameroff et al. 1998), it is understandable that when children are experiencing difficulties in one domain of their life, the impact of those challenges has the potential to extend to other aspects of their life as well. For example, children who are experiencing greater difficulties at home may also be having difficulties at school. In this study, this was seen in the children in the bully-victim group. Not

only were these children involved in bullying in a dual role, but they were also experiencing greater difficulties at home. By recognizing that there is a reciprocal influence between the home and school environment, it may be possible for educators and health care professionals to identify families who are experiencing difficulty and offer them support and resources. While it is important to recognize that there are numerous factors that influence a child's behaviours and that bullying involvement cannot always be attributed to challenges at home, for families who are having greater difficulty, being offered resources and support might ease the burden that caregivers experience while caring for a child who is struggling.

Individual Strengths

Within this study, a clear trend emerged whereby children in the non-involved group had significantly more individual strengths than children in the bully, victim, and bully-victim groups. When comparing the individual strengths of the child across the types of bullying involvement, there is a significant difference between the non-involved group and the victim, bully, and bully-victim groups. It is possible that children not involved in bullying had more intrinsic strengths, leading them to be more resilient against bullying involvement. Based on Bronfenbrenner's Process-Person-Context-Time (PPCT) model, what happens in one context of the child's life has the potential to influence other areas (Bronfenbrenner & Morris, 1998). This framework can be used to explain the findings of this study that children who have stronger individual strengths are less likely to be experiencing difficulty in the school environment (Franks, Rawana, & Brownlee, 2013). For example, when children possess greater individual strengths such as stronger peer relationships, stronger family units, greater adaptability to change, and self-expression, they experience fewer risk factors making them less likely to be involved in bullying.

The results of this study regarding individual strengths are consistent with the findings of a systematic review carried out by Ttofi, Bowes, Farrington, and Lösel (2014) looking at the protective factors that mitigate the long-term ramifications of bullying involvement. Strong social skills and positive school achievements have been found to be protective against bullying and victimization. As well, supportive and stable family units moderate the relationship between the externalizing behaviours associated with bullying and the internalizing behaviours associated with victimization. The presence of strong and supportive relationships with parents, teachers, siblings, and friends reduce the likelihood of being victimized. It has been hypothesized that the presence of strong relationships positively influences a child's self-esteem which can in turn reduce the chance of victimization (Ttofi et al., 2014). Based on our understanding of non-involved children, they are more likely to report higher peer acceptance than children who bully and are victimized (Perren & Hornung, 2005). As found by Spriggs, Iannotti, Nansel, and Haynie (2007), when compared to children who bully and children who are victimized, children who are not involved in bullying were more likely to be active in school activities and have better peer relationships. Across all three types of bullying involvement, children not involved in bullying were more likely to perform better in school and feel safe in the school environment (Spriggs et al., 2007). While children who bully others often have more friends and are viewed as popular by their peers, these children are not always liked (Vaillancourt et al., 2003).

Based on our understanding of the relationship between bullying involvement and the child's strengths, coupled with the prevalence of bullying involvement, it is possible that many children today are lacking the tools to help them thrive. For example, children involved in bullying might be lacking the necessary skills to successfully navigate situations that arise in the school environment. According to Greene (2008), it is understandable that children lacking skills

for managing transitions, experiencing difficulty anticipating the outcomes of their actions, having difficulty with problem-solving, seeing things in black and white rather than grey, coping with uncertainty, and understanding the impact of their actions on others, would be at greater risk for bullying involvement. An example of a framework that helps children develop the necessary skills is Collaborative Problem Solving which is a framework that posits that “children do well when they can,” or specifically, they do well when they have the requisite psychosocial skills to effectively navigate the challenges at home, school, and in peer groups (Greene, 2008). For this reason, strength-based interventions could help address the relevant skill deficit to bullying and help provide children with the essential skills to help them thrive in the school environment and beyond (Craig et al., 2016).

Implications for Research and Practice

With the understanding that there is an association between the type of bullying involvement on a child’s mental health, parenting challenges, and individual strengths, the findings of this study have significant implications. A trend within this study and studies at large is that children who bully others and are victimized experience significant challenges. As such, more efficacious screening for bullying involvement would be advantageous. Given that the symptom profile across the different levels of bullying involvement varies, as noted by Kelly et al. (2015), more effective screening methods in mental health agencies would be helpful so that targeted interventions can be provided to these children. It has been found that the risk of bullying involvement varies amongst children and therefore, the type of intervention should reflect the level of risk (Craig & Pepler, 2003). As found by Craig and Pepler (2003) for children not involved in bullying behaviour, interventions which develop an awareness of bullying and help children intervene when they witness bullying is the most beneficial. Children who are

infrequently involved in bullying would benefit most from interventions that target the risk factors that make them more prone to future bullying. Children who are at the greatest risk for bullying involvement require interventions that not only address their emotional, psychological, physical, educational, and social adjustment needs but also address the relational challenges that these children face within their various social environments (Craig & Pepler, 2003). According to our understanding of the Multiple Risks Model (Sameroff et al., 1998), effective bullying interventions should extend beyond the school environment and address the challenges in the various domains of the child's life (Sameroff et al., 2003). Even more than offering appropriate interventions to children based on their level of involvement and offering interventions in the relevant domains of their life, because of the tremendous impact that bullying behaviour can have on a child, every family, high or low risk, could potentially benefit from receiving information outlining ways they can protect their children against bullying involvement (Booth & Dunn, 1996).

While much of the research has sought to better understand common problems experienced by youth including mental health concerns and bullying involvement, it has been suggested that helping children develop the skills to help them thrive would be beneficial (Donnon & Hammond, 2007). The findings of this study suggest that individual strengths have the potential to act as a protective process for bullying involvement. To help address the prevalence of bullying involvement in this high-risk population, mental health agencies might find it helpful to use a strength-based treatment approach when addressing bullying involvement. By fostering the child's strengths including social skills, self-expression, and adaptability to change, there is the potential to decrease bullying involvement while providing benefits in other aspects of the child's life. A strength-based approach opts to focus on the strengths and

capabilities of the individual which can enable them to overcome their challenges rather than focus on their weaknesses (Brun & Rapps, 2001). Alternatively, taking on a Collaborative Problem-Solving Approach which is a framework that helps children develop the appropriate skills so that they can effectively navigate the challenges within their various environments could be advantageous within this context (Greene, 2008).

According to Pepler and Craig (2014), children would likely benefit from greater collaboration between schools and mental health agencies. They noted that within the school environment, teachers play an important part in the peer dynamics, having the capability to address concerning peer dynamics and reinforce safe environments for all children. They shared that one way that this can be done is through social architecture. Social architecture is where teachers actively arrange groupings for class activities to ensure that exclusion and marginalization is not taking place but instead, the groupings will foster positive dynamics and positive behaviours (Pepler & Craig, 2014). In addition to teachers, Pepler and Craig (2014) note that another key element in a whole school approach to bullying prevention and intervention is working with community partnerships including mental health agencies. By incorporating community partnerships within the school's efforts for bullying prevention and intervention, it offers the school greater support to assist children who are experiencing severe challenges that would be difficult to address solely within the school context. With teachers and community partnerships both playing important roles in bullying prevention and intervention, fostering greater communication has the potential to bring alignment and collaboration across the two contexts leading to a more holistic care (Pepler & Craig, 2014).

Synthesizing the findings and limitations of this study, there are several avenues for future research. While this study was unique that it encompassed the reports of clinicians and the

parents, a missing voice in this story is the voice of the children. To gather a more robust account of bullying involvement, future studies would benefit from including the perspective of the child. Doing so would give voice to the experiences of the child which can differ from the perspectives of the parents, and clinicians. Presumably because teachers and parents do not witness the bullying as bullying typically takes place in situations with low supervision, they are not always aware of the bullying that is occurring within the school environment (Fekkes, Pijpers, & Verloove-Vanhorick, 2005; Holt et al., 2009; Smokowski & Kopasz, 2005).

This study captures a snapshot of what was happening for children at a specific moment in time. To expand on the findings of this study, it is suggested that this study be carried out using a longitudinal design with data collection beginning at the first point of contact within the agency. This would allow researchers to capture a baseline measure of mental health concerns, parenting challenges, and individual strengths prior to treatment interventions and enable researchers to explore the causal links amongst the variables. Additionally, using a longitudinal design would enable researchers to track changes in mental health, parenting challenges, and individual strengths over several years. This would help researchers assess the effectiveness of treatment interventions.

There are some indications that suggest that parents do not always provide accurate reports of their children's involvement (Holt et al., 2009). It is possible that one of the reasons why parents do not always provide accurate reports of bullying involvement is because many children do not disclose the bullying involvement when the involvement is perceived as mild to moderate (Holt et al., 2009). Therefore, future research would benefit from creating the bully group categorization based on the reports of children rather than their parents.

While the findings of this study provide an interesting glimpse into the experiences of

children who are displaying varying patterns of bullying involvement and are accessing mental health services, it is important to remember that the findings provide only a narrow perspective of these children and their families. While the variables shed light into the experiences of these children, we do not know why and how these families are struggling and what specifically led them to seek assistance from Crossroads Children's Mental Health Agency. Future research would benefit from taking a broad perspective to help answer how and why these families are struggling as well as what led them to seek out help. This would provide greater insight into what is happening for these families and provide insight on how mental health agencies can best support them.

Limitations

By working within a mental health agency, this study was limited by the measures already being used. Therefore, the categorization of bullying involvement was based on two items, one gauging bullying and the other assessing victimization. These items came from the Strengths and Difficulty Questionnaire which is filled out by the parents. While previous literature has shown that the categorization of bullying groups can be done using a single item rather than using several items to capture bullying involvement (Catone et al., 2019), using single items is typically advised against whenever possible. While it is preferred to gather a robust understanding of the problem by using multiple items, doing so is not always practical or useful, especially in mental health agencies. With time, money, and resources typically being a constraint, it is likely more sensible for agencies to be able to gather the essential data to be able to then identify core areas of concern and necessary services for the child.

Further, the internalizing behaviour and individual strengths scales have barely adequate alpha reliability. It is possible that the low Cronbach alpha reliability for internalizing behaviours

and individual strengths could be attributed to the limited number of questions within the scales, the scale items being unrelated to one another, and the homogeneity of the population (Bademci, 2013; Falissard, 1999; Tavakol & Dennik, 2011). Being that the participants are accessing services at a children's mental health agency, it is not surprising that there is limited variability within the responses of the population in terms of internalizing behaviours and individual strengths (Bademci, 2013). Future studies would benefit from addressing these concerns to make sure that these constructs are accurately being captured.

Since this study uses pre-existing data from the mental health agency, the first date of contact is not indicated and therefore it is unknown if the client had previously received services from the agency. Using the child's first general intake, which would serve as a pre-treatment measure, would be the most valid assessment of the relationship between bullying involvement and parenting challenges before any interventions were administered. Given the cross-sectional nature of this study, this study captures what is happening for the children at a point where their troubles are peaking, irrespective of their first point of contact. Since the data comes from different stages of treatment, it is possible that there are fundamental differences between the children seen at differing points of contact with the agency. For some children, it is possible that the data included in this study is their first point of contact, this might be their second or third point of contact with the agency, possibly indicating a greater severity of the problem.

Conclusion

The purpose of this study was to better understand the association that mental health, parenting challenges and the child's strengths have on the type of bullying involvement in children seeking mental health services. Bullying is a prevalent problem that causes long-term negative impacts on everyone involved (World Health Organization, 2008). Recognizing the bi-

directional relationship that exists between bullying involvement and mental health as well as the influence of parenting challenges and individual characteristics, this study explored the differences on these variables among children accessing mental health services falling into the various types of bullying involvement. This study found differences across the type of bullying involvement exist for internalizing behaviour, externalizing behaviour, parenting challenges, and individual strengths. Children who had greater individual strengths were more likely to be not involved in bullying. The victim group was more likely to be experiencing internalizing behaviour and the bully group and bully-victim group tended to experience higher levels of externalizing behaviour. The bully-victim group experienced the most complex challenges, experiencing more externalizing behaviour, and parenting challenges. Children involved in bullying, whether as a bully, victim, or bully-victim, possess fewer individual strengths than children who were not involved in bullying. While there were several limitations to this study, the findings of this study highlight the needs and strengths of children seeking mental health services. Children would benefit from better screening for the type of bullying involvement so that target prevention can be provided, offer support and resources to parents about how they can best support their children, better coordination of care with between schools and mental health agencies, and continuing to use strength-based approaches to foster skill-building within the children. Future research would benefit from including the voice of the children to provide a richer understanding of the impact that mental health, parenting challenges, and the child's strengths have on the types of bullying involvement.

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Appendix A: Child and Adolescent Needs and Strengths (CANS)

CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS) ©					CCC MINI-CANS SCHOOL AGE				
Please ✓ appropriate use:		<input type="checkbox"/> Intake	<input type="checkbox"/> Admission/Reassessment		Date: <input type="text"/> M <input type="text"/> M <input type="text"/> D <input type="text"/> D <input type="text"/> Y <input type="text"/> Y				
		<input type="checkbox"/> Discharge	<input type="text"/> M <input type="text"/> D <input type="text"/> J <input type="text"/> Y <input type="text"/> Y		<input type="checkbox"/> M	<input type="checkbox"/> F			
Youth's Name		DOB		Gender		Mother Tongue			
Mental Health Needs									
	0= No Evidence	1=watch/prevent			2=causing problems		3=causing severe or dangerous problems		
1. Anxiety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Mood disturbance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Attention/Hyperactivity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Impulse Control	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Oppositional Behaviour	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Conduct Behaviour	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Adjustment to Trauma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Attachment Difficulties	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Parent-Child Relations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Risk Behaviours									
	0 = no evidence	1 = history, watch/prevent			2=Recent, Act		3=Acute, Act Immediately		
	0	1	2	3		0	1	2	3
10. Suicide Risk	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	13. Aggression – Objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Self Injuring Behaviours	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	14. Cruelty to Animals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Other Self Harm	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	15. Danger to Others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Educational Needs									
	0 = no evidence	1 = watch/prevent			2=Act		3=Act Now/Intensive		
	0	1	2	3		0	1	2	3
16. School attendance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	17. School discipline	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Child/Youth Individual Strengths									
	0 = centerpiece	1 = useful			2=Identified		3=Not Yet Identified		
	0	1	2	3		0	1	2	3
18. Peer Relations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	20. Adaptability to Change	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. Self expression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	21. Family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Parents/Family/Caregiver Needs and Strengths									
	0 = no evidence	1 = watch/prevent			2=Recent/Act		3=Act Now/Intensive		
22. Discipline/Parenting skills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>					
23. Problem-solving	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>					
24. Knowledge of child	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>					
25. Parental responsiveness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>					
26. Ability to communicate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>					
27. Understanding impact of own behaviour on children	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>					
Family Needs and Strengths									
	0 = no evidence	1 = watch/prevent			2=Recent/Act		3=Act Now/Intensive		
	0	1	2	3					
28. Family stress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>					

Appendix B: Strengths and Difficulties Questions

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child's behaviour over the last six months or this school year.

Child's Name

Male/Female

Date of Birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless, overactive, cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often complains of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shares readily with other children (treats, toys, pencils etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often has temper tantrums or hot tempers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rather solitary, tends to play alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally obedient, usually does what adults request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many worries, often seems worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other children or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, down-hearted or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally liked by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous or clingy in new situations, easily loses confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often lies or cheats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picked on or bullied by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often volunteers to help others (parents, teachers, other children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinks things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steals from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets on better with adults than with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sees tasks through to the end, good attention span	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature Date

Appendix C: CCMHC-Intake Information

CCMHC-Intake InformationCHILD INFORMATION

Date of Initial Call: _____ Referred to CCMHC by: _____

Child's Name: _____ DOB: month ____ day ____ year: ____ Age: ____

What is your child's current Gender identity? _____ What sex was your child assigned at birth (if relevant): _____

Who is the child's Legal Guardian? _____ Who is the child currently living with? _____

Copy of Legal Guardianship obtained? Yes No

School/Child Care Centre name: _____ Grade: _____ School Board: _____

Diagnosis: OCD ODD ADHD Bipolar Depression Anxiety ASD Other: _____

By whom: _____ Year of diagnosis: _____ Medications: _____

Doctors involved: _____ Allergies: _____

CONCERNS: Home School Child Care Community

Previous CCMHC Services: _____ Year: _____

Other Services: _____

CULTURAL INFORMATION

- 1) What is your Mother tongue? _____ (if English, go to #2)
 a) In which official language would you like to receive services? (if Mother tongue is not English) English French
 b) Reason for service in language other than Mother tongue?: _____

- 2) What language is spoken at home? Child: _____ Caregiver 1: _____ Caregiver 2: _____
 a) Are you comfortable speaking with your worker in English? Yes No
 b) Are you comfortable receiving written information in English? Yes No

- 3) Do you identify with any Aboriginal cultural group? Yes No
 First Nations-Community: Cree Algonquin Mohawk Mi'kmaq Ojibway Other: _____
 Metis-Community: _____ Inuit-Region/Community: _____
 Other (specify): _____ Prefer not to answer
 a) Do you wish to receive services from an Aboriginal agency? Yes No

- 4) Where we you born? Canada Outside of Canada
 a) If not Canada, identify country: _____ What year did you arrive in Canada? _____ Prefer not to answer
 b) Legal status in Canada? Citizen Permanent Resident Refugee Temporary Resident Prefer not to answer

- 5) Which race do you identify with? _____ (ex: White, Black, Arab, Chinese)

- 6) Which Ethnic cultural group do you identify with? _____ (ex: North American, European, African)

- 7) Do you identify as a person with one or more disabilities? Yes No Prefer not to answer
 a) If yes, identify the disability(s): _____

<p><u>PARENT / GUARDIAN INFORMATION:</u></p> <p>Adult 1 (bio-s-m-sep-d-cl): _____</p> <p>Relationship to Child: _____</p> <p>Caller: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Child resides with this person: <input type="checkbox"/> Yes, __% of time <input type="checkbox"/> No</p> <p>Custody: <input type="checkbox"/> Sole <input type="checkbox"/> Joint <input type="checkbox"/> Both</p> <p><input type="checkbox"/> CCMHC to obtain consent from other legal guardian</p> <p>Area/Community: _____</p> <p>Address: _____ Unit: _____</p> <p>City: _____, ON Postal: _____</p> <p>Home #: _____ Detailed msg? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cell #: _____ Detailed msg? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Work #: _____ Detailed msg? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>May we contact by email? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Email: _____</p> <p>Current living situation? _____</p> <p>Others residing in home: _____</p> <p>Pets in home? _____</p> <p>Step Parent/Partner: _____</p> <p>Contact #: _____</p> <p>Emergency Contact: _____</p> <p>Relationship: _____ #: _____</p>	<p><u>PARENT / GUARDIAN INFORMATION:</u></p> <p>Adult 2 (bio-s-m-sep-d-cl): _____</p> <p>Relationship to Child: _____</p> <p>Caller: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Child resides with this person: <input type="checkbox"/> Yes, __% of time <input type="checkbox"/> No</p> <p>Custody: <input type="checkbox"/> Sole <input type="checkbox"/> Joint <input type="checkbox"/> Both</p> <p><input type="checkbox"/> CCMHC to obtain consent from other legal guardian</p> <p>Area/Community: _____</p> <p>Address: _____ Unit: _____</p> <p>City: _____, ON Postal: _____</p> <p>Home #: _____ Detailed msg? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cell #: _____ Detailed msg? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Work #: _____ Detailed msg? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>May we contact by email? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Email: _____</p> <p>Current living situation? _____</p> <p>Others residing in home: _____</p> <p>Pets in home? _____</p> <p>Step Parent/Partner: _____</p> <p>Contact #: _____</p> <p>Emergency Contact: _____</p> <p>Relationship: _____ #: _____</p>
---	---

Date of Intake Interview: _____	Name of Parent: _____
Phone Number for Interview: _____	Time of Interview: _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
SCYW: _____	Add to cancellation list: <input type="checkbox"/> Yes <input type="checkbox"/> No

Appendix D: REB Ethics Approval

15/10/2019

Université d'Ottawa

Bureau d'éthique et d'intégrité de la recherche

University of Ottawa

Office of Research Ethics and Integrity

CERTIFICAT D'APPROBATION ÉTHIQUE | CERTIFICATE OF ETHICS APPROVAL

Numéro du dossier / Ethics File Number	S-10-19-4956
Titre du projet / Project Title	The Impact of Family Factors and Mental Health on Bullying Involvement
Type de projet / Project Type	Thèse de maîtrise / Master's thesis
Statut du projet / Project Status	Approuvé / Approved
Date d'approbation (jj/mm/aaaa) / Approval Date (dd/mm/yyyy)	15/10/2019
Date d'expiration (jj/mm/aaaa) / Expiry Date (dd/mm/yyyy)	14/10/2020

Équipe de recherche / Research Team

Chercheur / Researcher	Affiliation	Role
Briana GOLDBERG	Faculté d'éducation / Faculty of Education	Chercheur Principal / Principal Investigator
David SMITH	Faculté d'éducation / Faculty of Education	Superviseur / Supervisor

Conditions spéciales ou commentaires / Special conditions or comments

550, rue Cumberland, pièce 154 550 Cumberland Street, Room 154
Ottawa (Ontario) K1N 6N5 Canada Ottawa, Ontario K1N 6N5 Canada

613-562-5387 • 613-562-5338 • ethique@uOttawa.ca / ethics@uOttawa.ca
www.recherche.uottawa.ca/deontologie | www.recherche.uottawa.ca/ethics