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Youth Exposed to Parental Intimate Partner Violence and Bullying at School

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Abstract

Millions of children globally are exposed to multiple forms of violence in their homes, neighborhoods and schools, making it difficult to quantify cumulative exposures. These children are at increased risk for poor health outcomes, such as internalizing and externalizing mental and behavioral symptoms.

Objective: The aim of this analysis are to examine the frequency of bullying experiences in the lives of children who have experienced parental intimate partner violence and to examine the association between health outcomes and being bullied, specifically internalizing and externalizing symptoms.

Method: This study considers sex roles and divides the children by ages over 12 and under 12; however, only the victim role is assessed. For this analysis 52 months data were collected as part of a 7 year prospective study. To our knowledge, this is the first prevalence and health outcomes data reported for this population of children (N=274, average age 11.2) exposed to parental intimate partner violence (IPV) and bullying.

Results: Children experienced higher than national rates of bullying victimization, ranging from 22% to 47.4%, with physical bullying at 35.6% to 45.1%. Indirect bullying was higher in the under 12 age group (32.4%-46%). The only significant gender difference was that boys experienced physical bullying more than girls. Children who scored in the borderline/clinical range on the Child Behavior Checklist experienced significantly higher levels of bullying. Conclusion: Children who experience higher levels of bullying tend to also have significantly greater internalizing and externalizing problems. This study demonstrates that negative mental and behavioral health outcomes are associated with youth who experience both bullying and parental intimate partner violence.

Keywords: Childhood exposure to violence; Intimate partner violence; Bullying; Victimization; Longitudinal

Introduction

Millions of children throughout the world are exposed to multiple forms of violence. It is difficult to quantify the number of times a child has witnessed or been exposed to violence in their lifetime and then to determine what effect such exposures have had on their health and development. Such exposures include witnessing and experiencing home violence, community violence and personal victimization. Exposures can occur in various settings such as the home, the neighborhood and at school. The cumulative nature of such exposures implies child victims may be at increased risk for negative health outcomes, such as internalizing and externalizing mental and behavioral health symptoms [1,2]. The major nationally representative surveys that report bullying behavior have not used consistent measures or time frame, which makes it difficult to determine exact prevalence rates for boys and girls, ethnic groups and vulnerable groups such as children with disabilities, gender, economic or geographic differences among others. To our knowledge, this is the first report of bullying prevalence in in this vulnerable population of youngsters exposed to bullying, as well as intimate partner violence.

Background and Significance

In the past several decades, bullying has spawned much national attention globally and in the United States. Nansel and associates [3] in their seminal, nationally representative study recognized the bullying phenomenon, reporting prevalence rates of over five million or 29 percent of U.S. youth claiming to have experienced some form of bullying behavior and some youth reported experiencing more than one form of bullying. More recent nationally representative prevalence rates report that approximately 20% of high school students were bullied during the past year and 16% of high school students claimed to have been bullied electronically [4]. A smaller but significant percentage (8%) of public school students, age 12-18, claimed to be bullied repeatedly as often as weekly [5]. The recently released consensus report of the National Academies of Sciences, Engineering and Medicine [6] titled Preventing Bullying through Science, Policy and Practice, recognizes that this is a "pivotal time for bullying prevention" (S7). The findings of the consensus report determined that bullying is a serious and prevalent problem that affects the public health of the nation's youth and adolescents in particular. The report recognizes bullying as a complex problem requiring a "concerted and coordinated effort" involving the various groups that care for, educate and influence policy affecting this vulnerable group of developing individuals, our nation's children. It calls for a multi-level approach to address the issue and encourages parents, guardians, families, teachers, administrators, policy makers and health care providers to become actively involved and part of the solution to the bullying problem.

Characteristics and meaning of bullying

Historically, the word bullying has etymological origins in the Dutch and German words of "boele" and "buhle" respectively. Over time the meaning of the word "bully" has evolved from something quite innocuous as lover, brother, sweetie to the current meaning, which is synonymous with one who frightens, threatens, intimidates or abuses

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the weak [7-9]. The word bully is frequently tossed around to describe a range of aggressive or antisocial behaviors from trivial to horrific. In an effort to address the discrepancies in definitions and characteristics that qualify as bullying behavior, the Centers for Disease Control and Prevention put forth a well-accepted definition of what constitutes bullying behavior that builds upon the definition first coined by Olweus in 1994. The Olweus definition described bullying as "aggressive behavior or intentional harm doing" and further characterized the behavior as repetitive and interpersonal [10]. The CDC definition of bullying is "any unwanted aggressive behavior(s) by another youth or group of youths who are not siblings or current dating partners that involves an observed or perceived power imbalance and is repeated multiple times or is highly likely to be repeated" [11]. Bullying may inflict physical, psychological, social, or educational harm or distress on the targeted youth. It can be physical in form such as hitting or tripping, verbal such as name calling, or psychological, which is more difficult to label and assess. An often discounted but extremely painful example is social isolation or exclusion tactics, sometimes referred to as relational aggression [12]. Frequently, these acts of aggression and intimidation involve social media and as a result are far reaching, creating much angst and humiliation for the victims. Such behaviors are termed cyberbullying. Popular media and news reports are often sensationalized and sometimes horrific in nature with devastating consequences. However aside from the aforementioned, cyber-attacks are commonplace and just now beginning to be studied in the literature. One acknowledged difficulty is that they do not easily conform to the CDC definition of traditional bullying [13,14]. However, researchers, advocates and health professionals agree that the problem in all forms is pervasive and can be devastating for youth no matter the circumstance.

Bullying roles

Early emphasis in the literature has primarily focused on the study of victims and characteristics that make them more vulnerable to becoming recipients of bullying behavior. Interventions have focused on making victims more resistant to the behavior and some child advocates and parents have actually encouraged violence to thwart violence without evidence for such an approach. This old school thinking rests with the notion that bullying somehow is a normal passage through childhood and victims can somehow avoid or prevent the behavior from occurring. Situating bullying behavior within the context of an ecological model accounts for the complex mediators and moderators that influence the behavior and recognizes that various roles are involved in the bullying behavior and sometimes these roles overlap [15].

Researchers have described the various roles involved in bullying behavior in an effort to understand the complex mechanisms of what motivates the behavior and what influences others who witness the behavior to step in on behalf of the victim or reinforce the bullying [16-18]. Some are pure victims only; others are pure bullies; some are bystanders who remain uninvolved and others are reinforcers or join in encouraging the bullying. Perhaps the bully-victims, victims who sometimes bully others suffer the most negative health outcomes, compared to those who are only victims or only perpetrators [19]. Age and gender are factors that are frequently studied in the context of bullying behaviors and differences have been reported in the literature. For example, boys tend to be more involved in aggressive and physical bullying and girls are most often the targets of relational aggression and isolation techniques. Less is known about cyber bullying attacks in relation to gender. Traditional bullying behaviors are most prevalent between 6th and 8th grade with cyber bullying peaking later around 10th grade [6]. The consensus report found that 23.7% of the girls and 19.5% of the boys were bullied on school property.

Bullying and health

Bullying experiences have been associated with negative physical, mental and behavioral health outcomes, especially for the victims and bully-victims [1,20-24]. Headaches, stomach aches, gastrointestinal disturbances, anxiety, depression, somatization and sleep issues are among health concerns that have been reported [25-27]. Victimization was associated with hopelessness, isolation, decreased self-esteem, decreased confidence and difficulty making friends [10,28-30]. Socialization was a significant factor for both bullies and victims with friendship is a protective factor [31]. Externalizing symptoms such as acting out, attention getting behaviors and physically fighting have been associated with bullying. Victims reported higher rates of depression than youth who ascribed to the other bullying roles [32], as well as other internalizing health issues [33-35]. However, the bully-victim group had the most occurrences of anxiety and depression, eating issues, psychosomatic complaints, suicidal ideation and reports of self-injury [10,36,37]. Another study [38] found an association between boys who were overweight or obese and membership in the bully-victim group (OR 3.67).

Bullying and intimate partner violence

At least 25% of children are exposed to intimate partner violence in the US thus millions of children under the age of 18 are exposed to domestic violence annually [39]. Population-based surveys estimate two to almost four million children reside in homes where domestic violence occurs. The National Crime Victims Survey [39] reports that more than 50 percent of the time children are present in the homes where parental intimate partner violence (IPV) occurs and approximately 10 percent of domestic disturbance calls are initiated by children [40]. It is reasonable to conclude that these children, who live with the strife of IPV in the family, experience a double whammy effect and are likely to be more at risk than children who live in households without IPV. Many children are not developing in the most ideal of family circumstances. To our knowledge this is the first report of bullying prevalence in this vulnerable population of youngsters exposed to bullying as well as intimate partner violence.

The purpose of this paper is to determine the prevalence of bullying/teasing experiences in the lives of children and adolescents who also have been exposed to IPV and to examine the relationship between the exposures and negative health outcomes, specifically internalizing and externalizing symptoms. This study considers sex roles and divides the children by ages over 12 and under 12; however, only the victim role is assessed. Specifically, the aims of this analysis are to examine the frequency of bullying experiences in the lives of children who have experienced parental IPV and to examine the association between health outcomes and being bullied.

Methods

Sample

Data examined for this analysis is 52 months data collected as part of a larger seven year, prospective study. Included in this study are 274 children of mothers who have sought assistance for the first time either through the justice system for a protection order from their abuser or through the shelter system seeking safety from an abusive partner. Children in this sample were on average 11.20 (SD=4.22) years old. There were relatively equal numbers of boys (n=140, 51.1%) and girls (n=134, 48.9%) in the final sample.

Measures

The Achenbach Child Behavior Checklist (CBCL) provides a standardized parental report of child behavioral problems [41,42] with a form for children 18 months to five years and a form for youth six to 18 years. The CBCL is orally administered to a parent who rates the presence and frequency of certain behaviors on a three-point scale (0=not true, 1=somewhat or sometimes true and 2=very true or often true). Examples of behaviors for younger children include, "physically attacks people" and "doesn't want to sleep alone". Older children behaviors are "bully behavior", "vandalism" and "prefers being with older children". The CBCL consist of two broadband factors of behavioral problems: internalizing and externalizing with mean scale scores for national normative samples as well as clinically referred borderline clinical and non-referred samples of children. Because scores are normalized and standardized, cut off values for clinically significant ranges are dependent on age and gender; however, these specifics are outlined in great detail in Achenbach and Rescorla [41,42]. Extensive psychometric testing has yielded very favorable information regarding the tool's validity and reliability in English and Spanish [41,42]. Scores were categorized into two groups (i.e., normative and borderline/clinical range).

Bullying experiences were measured using the bullying survey created by Schafer and colleagues [43]. This tool measures three types of bullying, including physical (e.g. being hit), verbal (e.g. name calling, threatening) and indirect bullying (e.g. exclusion, lies/rumors). This tool further assesses both the frequency and severity of bullying experiences across these three domains. Lastly, this tool measures psychological trauma in response to bullying (e.g. suicidality, inflicting self-harm and avoidance of school or bullying situations). Reliability of the tool is well established in prior research with acceptable reliability for victimization at the primary (r=0.88) and secondary school level (r=0.87) [43].

Analysis

Differences in reported types of bullying experienced by child gender were examined using a series of cross tabulations computing Pearson's chi square. Chi square tests were also used to examine differences in types of bullying experienced by age group (i.e., less than 12 years old or 12 years or greater). Differences in bullying scores (i.e., physical, verbal, indirect) by child behavioral functioning group (i.e., borderline/clinical range vs. normative range) were tested using analysis of variance (ANOVA) tests. Due to violations of homogeneity of variance and group sizes, all parametric analyses were confirmed using non-parametric equivalencies, yielding similar findings. Therefore, only findings from the parametric analyses are reported. All analyses were conducted in SPSS v. 21 with significance determined at the 0.05 level.

Results

Frequencies and percentages of reported direct and indirect bullying experiences are outlined in Table 1. As shown, rates of bullying across the different forms of bullying behavior ranged from 27.0% (Indirect Bullying-Lies/Rumors) to 46.4% (Verbal Bullying–Name Calling). There were no significant differences in bullying behaviors experienced by age group. Boys, however, did experience significantly greater physical bullying (50.0%) compared to girls (32.8%) (p=0.004). For children over 12 the prevalence of direct bullying ranged from 28% to 44.6% with being physically bullied at 35.6%. For children younger than 12, the prevalence for direct bullying ranged from 22% to 47.4% with physical bullying at 45.1%. Indirect bullying was consistent across age groups with lies and rumors at 26.6% (under 12) and 27.8% (over 12). Exclusion and isolation were remarkably even for both age groups at 32.4% and 37.6%.

Severity of bullying

Bullying severity scores are outlined in Table 2. As shown, younger children had significantly higher levels of reported physical bullying (M=2.05, SD=1.27) compared to older children (M=1.74, SD=1.07). Similarly, boys had higher levels of physical bullying (M=2.14, SD=1.26) compared to girls (M=1.72, SD=1.11). There were no significant differences across other bullying severity scores by age or gender. Bullying severity scores by age and gender are shown in Table 3. Older boys had significantly greater bullying trauma (M=2.03, SD=1.25) compared to younger boys (M=2.00, SD=.96). Younger girls had higher physical bullying (M=1.78, SD=1.18) compared to older girls (M=1.61, SD=0.97). Additionally, older girls had higher bullying trauma scores (M=2.23, SD=1.10) compared to younger girls (M=1.86, SD=0.78). There were no other significant differences found.

Full Sample			<12 Years		≥ 12 Years		p	Boy		Girl		p
	n	%	n	%	n	%		n	%	n	%	
Physical Bullying							0.126					0.004
No	160	58.4	95	54.9	65	64.4		70	50.0	90	67.2	
Yes	114	41.6	78	45.1	36	35.6		70	50.0	44	32.8	
Verbal Bullying - Name Calling							0.649					0.979
No	147	53.6	91	52.6	56	55.4		75	53.6	72	53.7	
Yes	127	46.4	82	47.4	45	44.6		65	46.4	62	46.3	
Verbal Bullying - Threats							0.262					0.071
No	207	75.8	135	78.0	72	72.0		99	71.2	108	80.6	
Yes	66	24.2	38	22.0	28	28.0		40	28.8	26	19.4	
Indirect Bullying - Lies/Rumors							0.839					0.444
No	200	73.0	127	73.4	73	72.3		105	75.0	95	70.9	
Yes	74	27.0	46	26.6	28	27.8		35	25.0	39	29.1	
Indirect Bullying - Excluded							0.472					0.895
No	181	66.1	117	67.6	64	63.4		93	66.4	88	65.7	
Yes	93	33.9	56	32.4	37	37.6		47	33.6	46	34.3	

Table 1: Frequencies and percentages of reported bullying.

	Full Sample (N=274)		<12 Years (N=173)		≥ 12 Years (N=101)		p	Boy (N=140)		Girl (N=134)		p
	M	SD	M	SD	M	SD		M	SD	M	SD	
Physical Bullying	1.93	1.21	2.05	1.27	1.74	1.07	0.039	2.14	1.26	1.72	1.11	0.005
Verbal Bullying	2.18	1.32	2.19	1.35	2.16	1.28	0.845	2.19	1.33	2.17	1.31	0.894
Indirect Bullying	1.98	1.27	1.96	1.28	2.01	1.26	0.742	1.93	1.27	2.03	1.28	0.510
Bully Trauma	2.00	1.00	1.93	0.88	2.12	1.18	0.123	2.01	1.07	1.99	0.92	0.881

Table 2: Bullying severity scores.

	<12 Years (N=173)		≥ 12 Years (N=101)		p
	M	SD	M	SD	
Boy					
Physical Bullying	2.31	1.30	1.85	1.15	0.110
Verbal Bullying	2.30	1.36	2.00	1.27	0.285
Indirect Bullying	2.00	1.32	1.82	1.18	0.126
Bully Trauma	2.00	0.96	2.03	1.25	0.004
Girl					
Physical Bullying	1.78	1.18	1.61	.97	0.040
Verbal Bullying	2.08	1.33	2.33	1.28	0.585
Indirect Bullying	1.92	1.24	2.23	1.33	0.180
Bully Trauma	1.86	0.78	2.23	1.10	0.003

Table 3: Bully severity by gender and age.

	Internalizing				Externalizing			
	n	M	SD	p	n	M	SD	p
Physical Bullying				0.001				0.002
Normative	203	1.76	1.11		203	1.76	1.11	
Borderline/Clinical	66	2.52	1.34		66	2.52	1.34	
Verbal Bullying				<0.001				0.958
Normative	203	1.93	1.21		203	1.93	1.21	
Borderline/Clinical	66	2.98	1.33		66	2.98	1.33	
Indirect Bullying				<0.001				0.004
Normative	203	1.74	1.13		203	1.74	1.13	
Borderline/Clinical	66	2.73	1.40		66	2.73	1.40	
Bully Trauma				<0.001				0.002
Normative	203	1.81	0.88		203	1.81	0.88	
Borderline/Clinical	66	2.64	1.12		66	2.64	1.12	

Table 4: Bullying severity by internalizing and externalizing levels.

Clinical symptoms

Lastly, in order to examine differences in bullying scores by severity of internalizing and externalizing scores, a series of ANOVAs were conducted (Table 4). Additional analyses were computed split by age and gender; however, patterns across groups were similar. As such, results for the full sample are displayed here in detail. For both internalizing and externalizing scores, those in the borderline/clinical range had significantly higher levels of bullying severity scores with the minor exception of verbal bullying scores on externalizing behaviors. Overall, these results suggest that children who experience higher levels of bullying tend to also have significantly greater internalizing and externalizing behavioral problems [44-46].

Discussion

The results demonstrate that in this group of vulnerable children who experience at least one additional form of violence-exposure, IPV, along with being bullied prevalence rates are consistently higher than national rates reported for bullying which range from 14.1% to 27.8% (2013, SCS-NCVS). In this study for children 12 and older the prevalence of experiencing direct bullying ranged from 28% to 44.6% with being physically bullied at 35.6%. For children younger than 12, the prevalence for direct bullying ranged from 22% to 47.4% with physical bullying at 45.1%. Indirect bullying was higher in the younger group (32.4%-46%), although it was still higher than national rates in the older group of youth (27.8%-37.6%). In this study the only statistically significant difference with respect to gender for bullying demonstrated was that boys experience physical bullying more than girls (p=0.004).

As shown in Table 2 mothers of younger children reported that they had significantly higher severity levels of physical bullying (M=2.05, SD=1.27) compared to older children (M=1.74, SD=1.07), meaning that mothers thought the bullying their child suffered was quite serious or extremely serious. Similarly, boys had higher levels of physical bullying (M=2.14, SD=1.26) compared to girls (M=1.72, SD=1.11). Although this is consistent with the reported literature, it is alarming to see more news worthy reports of girls engaging in violent physical acts. It is also noteworthy that there were no significant differences across other bullying severity scores by gender.

Clinical symptoms were reported by using two forms of the well-respected Child Behavior Checklist and categorized as internalizing or externalizing symptoms. Older girls had higher bullying trauma scores (M=2.23, SD=1.10) compared to younger girls (M=1.86, SD=0.78). This is one aspect that warrants further study. Perhaps it is reflective of more social isolation and exclusion tactics that may become harder to measure as children age or that youth do not disclose the more subtle bullying behaviors to their mothers. Cyberbullying was not assessed in this sample and may be more closely associated with trauma than traditional bullying that happens on school property. One student revealed that at school bullying can only go so far before a teacher or another adult will surmise and step in. Beyond school territory bullying has no bounds and this is especially true of social networks.

Overall, these results suggest that children who experience higher levels of bullying tend to also have significantly greater internalizing and externalizing behavioral problems with the exception of verbal bullying on externalizing symptoms. Since there were insignificant differences across age groups and gender results for the full sample were reported. Therefore, youth who were found to have higher severity levels of physical bullying, verbal bullying, indirect bullying and trauma were found to score in the borderline/clinical range for internalizing symptoms. Youth who were found to have higher severity levels of physical bullying, indirect bullying and trauma were found to score in the borderline/clinical range for externalizing symptoms. Although other factors not assessed in this analysis may contribute to the internalizing and externalizing symptomatology, it is important to intervene with these select children as indicated to prevent untoward consequences of combined exposures.

Strengths and Limitations

This is the first study to highlight the potentially precarious state of health and functioning of very vulnerable youth and adolescents,

who are both bullied and exposed to parental IPV. The findings reflect both direct and indirect forms of bullying. The CBCL is internationally standardized and widely used to measure child health outcomes. Mothers report assessed the bullying behavior of the children in this study. It would have been ideal to have an objective measure in addition to the parent report either from the children's own perspective or a concurrent teacher report measure. However, considering the vulnerability of the mothers and children, it was important not to involve the children in the surveying methods or increase the participant burden for this study. The intent was to get a sense of prevalence in this population of children. Building on this study by directly assessing the children who experience both forms of violence (IPV and bullying) at specific ages, grade levels and points in time is warranted. This study does not assess cyberbullying which is an important correlate to traditional bullying assessed in this case.

Clinical implications for community and public health nurses

It is critically important to identify children at risk for bullying to minimize the negative sequelae that often accompanies such experiences. We feel these children may have increased risk placing them at further disadvantage. Their mothers and primary caretakers may be unaware or unable to recognize subtle forms of behavioral dysfunction at a particular point in time. They are likely to be consumed with struggling as a survivor of IPV and possibly the sole provider in the family. Furthermore, their living arrangements may be chaotic or changing. In any event it is critical that health care professionals who care for children assess mothers for IPV and inquire about bullying, indirectly by parent report and directly from the children as appropriate. Guided referrals and follow-up can then be part of the treatment plan. This is consistent with the recommendations of the consensus report on bullying that calls for a multilevel approach and includes health care providers. This approach has the potential to empower and educate in the fight to curb bullying behaviors and nurture positive relationships.

Much of bullying behavior occurs at school. Community and public health nurses can address the problem of bullying and IPV simultaneously by initiating primary prevention efforts at schools, such as conducting a teacher/staff in-service program to educate the members of the school community about the joined problems of bullying and IPV. During the meeting the nurse can discuss the prevalence of bullying and IPV in America, discuss the various roles that are pertinent to bullying, such as the bully, the victim, the bully-victim and the bystander and how youth exposed to IPV in the household maybe more likely to be bullied as well as bully. In addition to universal primary prevention strategies directed at the general student body, the community and public health nurse can tailor education programs to selected and indicated groups. For example, special discussion groups can be formed with select students, who have been exposed to both bullying and IPV or for students, whose behavior indicates that they may need extra support. The community and public health provider is in a position to work with the school to determine if bullying policies are in place in the school system. If no policies exist, the community and public health nurse can assist school administration to develop a school policy for handling bullying with the added knowledge that the child may be a home with ongoing IPV. Offering regular information sessions to parents on community sources for assistance for bullying and IPV can potentially reduce both types of violence and promote schools and families, without violence.

Research implications for healthier communities

Future studies need to assess youth directly about all aspects of bullying behavior rather than use a retrospective measure of parental report. Primary prevention intervention research should target this indicated group of children exposed to IPV in the home, who may be most at-risk for exhibiting bullying behaviors. All aspects of bullying behaviors should be assessed in this population rather than focus on victimization. Children and youth model behavior, they observe and some forms of bullying may be mirroring adult behavior they have witnessed in the context of their exposure to IPV. Giving youth opportunities to develop ways to handle difficult situations such as bullying and to reach out for assistance from trusted adults in their lives is a dynamic solution to the problem.

Conclusion

Most studies have been conducted with samples of school age youth in school settings and in 6th through 8th grade, the time that bullying is thought to be most prevalent. However, high school and college studies also report on bullying. Cyberbullying in recent years has added a new dimension to the problem. Some researchers posit that bullying that occurs in elementary and middle school make may take on different forms in adolescence and young adulthood such as adolescent relationship violence and adult intimate partner violence; thus, linking the phenomena. The current study reports prevalence data for a sample of vulnerable youth who have experienced bullying behavior as victims and have also been exposed to parental IPV, outside of the school setting. Early and recent reports of nationally representative studies, suggest these children experience bullying at considerably higher rates. What needs further study is how their health and behavioral functioning compares with children who have not been exposed to the double effect of IPV in the home and bullying. The potential additive effect of multiple forms of violent exposures and other adverse childhood experiences make it difficult to isolate the effects of bullying and intimate partner violence. However, this study demonstrates that negative mental and behavioral health outcomes are associated with youth who experience both bullying and parental IPV. These exposures impacted the health and behavior of youth in this sample regardless of whether or not other adverse childhood events were also experienced; thus, warranting proactive measures to mitigate the sequelae of multiple exposures especially in high risk groups such as the children in this study.

References

1. Due P, Holstein BE, Lynch J, Diderichsen F, Gabhain SN, et al. (2005) Bullying and symptoms among school-aged children: International comparative cross sectional study in 28 countries. Eur J Public Health 15: 128-132.
2. Fredland NM, Campbell JC, Han H (2008) Effect of violence exposure on health outcomes among young urban adolescents. Nurs Res 57: 157-165.
3. Nansel TR, Overpeck M, Pilla RS, Ruan WJ, Simons-Morton B, et al. (2001) Bullying behaviors among U.S. youth prevalence and association with psychosocial adjustment. JAMA 285: 2094-2100.
4. Centers for Disease Control and Prevention (2016) Youth risk behavior surveillance-United States, 2015. MMWR Morb Mortal Wkly Rep 63: 1-180.
5. Roberts S, Zhang A, Morgan RE, Musu-Gillette L (2015) Indicators of school crime and safety: 2014. Washington, D.C.: National Center for Education Statistics.
6. National Academies of Sciences Engineering and Medicine (2016) Preventing bullying through science, policy and practice. Washington, DC: The National Academies Press.
7. Ciardi J (1980) A browser's dictionary. New York: Harper & Row.
8. Dictionary.com (2016) LLC. Bully.
9. Merriam-Webster (2016) Learner's dictionary.
10. Olweus D (1994) Annotation: Bullying at school: Basic facts and effects of a school-based intervention program. J Child Psychol Psychiatry 53: 1171-1190.

11. Holt JB, Huston SL, Heidari K, Schwartz R, Gollmar CW, et al. (2015) Indicators for chronic disease surveillance - United States, 2013. MMWR Recomm Rep 64: 1-246.

12. Gladden RM, Vivolo-Kantor AM, Hamburger ME, Lumpkin CD (2014) Bullying surveillance among youths: Uniform definitions for public health and recommended data elements, Version 1.0. Atlanta, GA: Centers for Disease Control and Prevention and U.S. Department of Education.

13. Tokunaga RS (2010) Following you home from school: A critical review and synthesis of research on cyberbullying victimization. Comput Hum Behav 26: 277-287.

14. Kota H, Schoohs S, Benson M, Moreno MA (2014) Characterizing cyberbullying, among college students: Hacking dirty laundry and mocking. Societies 4: 549-560.

15. Swearer SM, Doll B (2001) Bullying in Schools: An Ecological Framework. In: Geffner RA, Loring M, Young C (eds.) Bullying Behavior. New York, NY: Hawthorne Press.

16. Jeffrey LR, Miller D, Linn M (2001) Middle school bullying as context for the development of passive observers to the victimization of others. In: Geffner R, Loring M, Young C (eds.) Bullying Behavior: Current Issues, Research and Interventions. New York: The Haworth Press, pp: 143-156.

17. Espelage DL, Asiadao CS (2001) Conversations with Middle School Students About Bullying and Victimization: Should we be Concerned. In: Geffner RA, Loring M, Young C (eds.) Bullying Behavior. New York, NY: Hawthorne.

18. Salmivalli C (2010) Bullying and the peer group: A review. Aggress Violent Behav 15: 112-120.

19. Wolke D, Woods S, Bloomfield L, Karstadt L (2001) Bullying involvement in primary school and common health problems. Arch Dis Child 85: 197-201.

20. Bogart LM, Elliott MN, Klein D, Tortolero SR, Murg S, et al. (2014) Peer victimization in fifth grade and health in tenth grade. Pediatrics 133: 440-447.

21. Gini G, Pozzoli T (2009) Association between bullying and psychosomatic problems: A meta-analysis. Pediatrics 123: 1059-1065.

22. Lereya ST, Copeland WE, Costello EJ, Wolke D (2015) Adult mental health consequences of peer bullying and maltreatment in childhood: two cohorts in two countries. Lancet Psychiatry 2: 524-531.

23. Wilkins-Shurmer A, O'Callaghan MJ, Najman J, Bor W, Williams G, et al. (2003) Association of bullying with adolescent health-related quality of life. J Paediatr Child Health 39: 436-441.

24. van der Wal MF, de Wit CA, Hirasing RA (2003) Psychosocial health among young victims and offenders of direct and indirect bullying. Pediatrics 111: 1312-1317.

25. Arseneault L, Bowes L, Shakoor S (2010) Bullying victimization in youths and mental health problems: 'Much ado about nothing'? Psychol Med 40: 717-729.

26. Hunter SC, Durkin K, Boyle JM, Booth JN, Rasmussen S (2014). Adolescent bullying and sleep difficulties. Eur J Psychol 10: 740-755.

27. Ttofi MM, Farrington DP, Lösel F, Loeber R (2011) Do the victims of school bullies tend to become depressed later in life? A systematic review and meta-analysis of longitudinal studies. J Aggress Confl Peace Res 3: 63-73.

28. Gofin R, Palti H, Gordon L (2002) Bullying in Jerusalem schools: Victims and perpetrators. Public Health 116: 173-178.

29. Juvonen J, Graham S (2014) Bullying in schools: The power of bullies and the plight of victims. Annu Rev Psychol 65:159-185.

30. Mouttapa M, Valente T, Gallaher P, Rohrbach LA, Unger JB (2004) Social network predictors of bullying and victimization. Adolescence 39: 315-335.

31. Bollmer JM, Milich R, Harris MJ, Maras MA (2005) A friend in need: The role of friendship quality as a protective factor in peer victimization and bullying. J Interpers Violence 20: 701-712.

32. Swearer SM, Song SY, Cary PT, Eagle JW, Mickelson WT (2001) Psychosocial correlates in bullying and victimization: The relationship between depression, anxiety and bully/victim status. In: Geffner R, Loring M, Young C (eds.) Bullying behavior: Current issues, research and interventions. New York: The Haworth Press, pp: 95-121.

33. Kidger J, Heron J, Leon DA, Tilling K, Lewis G, et al. (2015). Self-reported school experience as a predictor of self-harm during adolescence: A prospective cohort study in the south west of England (ALSPAC). J Affect Disord 173: 163-169.

34. Klomek AB, Sourander A, Niemelä S, Kumpulainen K, Piha J, et al. (2009) Childhood bullying behaviors as a risk for suicide attempts and completed suicides: A population-based birth cohort study. J Am Acad Child Adolesc Psychiatry 48: 254-261.

35. Brunstein Klomek A, Sourander A, Gould M (2010) The association of suicide and bullying in childhood to young adulthood: A review of cross-sectional and longitudinal research findings. Can J Psychiatry 55: 282-288.

36. Forero R, McLellan L, Rissel C, Bauman A (1999) Bullying behavior and psycholsocial health among school studetns in New South Wales, Australia: Cross sectional survey. BMJ 319: 344-348.

37. Kaltiala-Heino R, Rimpelä M, Rantanen P, Rimpelä A (2000) Bullying at school - An indicator of adolescents at risk for mental disorders. J Adolesc 23: 661-674.

38. Janssen I, Craig WM, Boyce WF, Pickett W (2004) Association between overweight and obesity with bullying behaviors in school-aged children. Pediatrics 113: 1187-1194.

39. Bureau of Justice Statistics (2013) National Crime Victimization Survey.

40. Fantuzzo JW, Mohr WK (1999) Prevalence and effects of child exposure to domestic violence. Future Child 9: 21-32.

41. Achenbach TM, Rescorla LA (2000) Manual for the ASEBA Preschool Forms & Profiles. Burlington, VT: University of Vermont, Department of Psychiatry.

42. Achenbach TM, Rescorla LA (2001) Manual for the ASEBA school-age forms and profiles. Burlington, VT: University of Vermont, Department of Psychiatry.

43. Shafer M, Korn S, Smith PK, Hunter SC, Mora-Merchan J, et al. (2004) Lonely in the crowd: Recollections of bullying. Br J Dev Psychol 2: 379-394.

44. Kim YS, Koh Y, Leventhal B (2005) School bullying and suicidal risk in Korea middle school students. Pediatrics 115: 357-363.

45. Straus MA (1992) Children as witness to marital violence: A risk factor for lifelong problems among, a nationally representative sample of American men and women. Columbus, Ohio: Ross Laboratories.

46. U.S. Department of Justice (2011) Children's exposure to intimate partner violence and other family violence.