Bullying, Social Support, and Psychological Distress: Findings From RELACHS Cohorts of East London’s White British and Bangladeshi Adolescents

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ABSTRACT

Purpose: The purpose of the study is to test whether bullying in adolescents relates to poor mental health and whether social support mitigated this effect.

Methods: In 2001, 28 schools in East London were randomly selected for surveys of two representative mixed ability classes: year 7 (11–12 years) and year 9 (13–14 years). Repeated measures were obtained from the same pupils 2 years later, using the Strengths and Difficulties Questionnaire (total difficulties score [TDS]) as a measure of psychological distress. A simple one-level random intercepts model with measurements nested within pupils was used to investigate the effects of bullying and social support from friends and family on TDS. We also assessed whether culturally congruent friendships offered a mental health advantage.

Results: Bullying was associated with a higher mean TDS (coefficient, 95% confidence interval: White British: 2.15, 1.41–2.88; Bangladeshi: 1.65, .91–2.4); a high level of family social support was associated with a lower TDS (White British: −2.36, −3.33 to −1.39; Bangladeshi: −2.34, −3.15 to −1.49). Social support from friends was helpful for White British adolescents (−1.06, −2.07 to −0.04). Culturally congruent friendships offered no general advantage.

Conclusion: Bullying is associated with psychological distress; family social support independently mitigates the effect, but there is no interaction. Furthermore, friendship support appears important only for White British subjects, and culturally congruent friendships appear not to confer any advantage suggesting that universal interventions focusing on family support may help.

Adolescence is a critical period of development and the time when adult patterns of mental illness become established [1]. Understanding the early causes of mental illnesses and psychological distress in adolescence offers opportunities for primary and secondary prevention, with optimal gains over the life course [2,3]. Bullying is a common and preventable distressing experience in adolescence and may be related to later mental illness, suicide risk, and substance misuse [4–7]. A powerful protective influence during adolescence is social support from family, peer friendships, and social networks [8,9]. Adolescents who are bullied face a number of challenges to forming stable peer group relationships and recruiting social support. These challenges include low self-esteem, internalized emotional distress leading to depression or anxiety, and externalized distress including antisocial or disruptive behaviors, or self-harm...
These can lead to loss of social networks and peer support that lasts into adulthood. The loss of social support can arise because of stigma and a lack of motivation or enjoyment that accompanies depression. Thus, harmful relationships, such as bullying, may be a risk for future mental illnesses.

Some groups of adolescents are especially at risk, including some migrants, minorities by virtue of ethnicity or sexual orientation, those with a wide range of disabilities including intellectual disabilities and autism, and those who are already relatively socially isolated [12–15]. Migration offers specific challenges to young people’s social support and connectedness, as children face transitions between schools, countries, and groups of friends. Friendships are more easily formed with others who share similar backgrounds, interests, cultures, including religious and linguistic heritage [16]. At the same time, if these obstacles can be overcome, forming friendships across these heritage groups can confer an advantage, as a form of bridging (across groups) rather than bonding (within groups) social capital [17].

In our previous research involving adolescents, we recruited from schools in East London (Research with East London Adolescents Community Health Survey [RELACHS]) [18] and the London-wide region (Determinants of young Adult Social wellbeing and Health [DASH]) [19]. We demonstrated in DASH that in both cross-sectional and longitudinal analyses (individuals were tracked over time), culturally congruent or integrated friendships (friends of both their own and other cultural groups) were associated with less psychological distress independent of social support, in all ethnic groups, and for boys and girls. Surprisingly, in the London-wide DASH cohort, we also showed that psychological distress diminished with age over adolescence.

In this article, we attempt to replicate these findings in the East London RELACHS cohort of Bangladeshi and White British adolescents, who live in and attend schools in one of the most deprived inner city area in the UK. We examine whether the adverse effect of bullying on adolescent mental health is moderated by the support from friends and families and whether culturally congruent friendships are influential.

**Methods**

**Design and sample**

“RELACHS” is a prospective cohort study of 30 of 42 secondary schools in Hackney, Newham, and Tower Hamlets. In 2001 (study baseline), schools in East London were randomly selected and balanced to represent single- and mixed-sex schools admissions policies. Eligible schools were stratified by borough and school type (comprehensive, voluntary, and other). In the 28 schools that agreed to participate, two representative mixed ability classes were selected from two age cohorts: year 7 (11–12 years) and year 9 (13–14 years). Of the total 3,322 pupils eligible for the survey, the overall response rate was 84% (2,789 pupils). A total of 2,093 (75%) pupils were also followed up in 2003.

**Procedures**

Pupils and their parents were informed about the RELACHS study, and pupils were asked for written consent. Parents were allowed to opt pupils out of the study if they desired at baseline and follow-up; letters to parents were translated into Urdu, Bengali, Punjabi, and Gujarati. Pupils completed the questionnaire in their classrooms under the supervision of researchers. Although all pupils were taught in English at school, multilingual researchers assisted pupils with language needs as necessary; however, our pilot work showed that less than 1% of pupils needed language assistance. Ethical approval was obtained from the local research ethics committee.

**Social support**

Social support was measured by the Multidimensional Scale of Perceived Social Support [20], a 12-item self-report assessment of total social support; subscales measure support from family, friends, and significant other or special person. Tertiles of the subscale scores were used to measure low, medium, and high social support. The scale has good concurrent, construct, and discriminant validity and high internal and test-retest reliability, with an overall coefficient of .88 [21]. The Multidimensional Scale of Perceived Social Support has been validated in African-American and black youth in the United States [22,23] and in several cultural groups in low-income countries [24–26]. Our previous research in East London showed good internal consistency at baseline (Cronbach’s alpha, .90) and for each ethnic group (White British, .91; Asian Bangladeshi, .90; and black, .87) [27,28]. We also assessed attendance at religious places of worship as a source of support using the question: How often, outside of school, do you go to a church or synagogue or temple or mosque or for religious classes?

**Measures of psychological distress and depressive symptoms**

The Strengths and Difficulties Questionnaire (SDQ) [29] measures psychological distress and has been validated in the UK [30] and non-UK samples, including Bangladeshi adolescents [31]. The SDQ is designed to detect behavioral, emotional, or relationship difficulties. RELACHS used the self-completion version of the SDQ for 11- to 16-year-olds consisting of 25 items across five scales: emotional symptoms; conduct problems; hyperactivity/inattention; peer relationship problems; and prosocial behavior. The sum of the scales (excluding prosocial behavior) generates a total difficulties score (TDS) that we used to assess the psychological distress. TDS ranges between 0 and 40; a score of 17.5 and above was chosen as the threshold for being “high scorers.” This threshold is based on validation approaches in national data where 10% of adolescents score within the “higher” score band [18,29,32]. We applied this threshold to our sample to identify adolescents with scores in the top decile 10%; hence, the threshold of 17.5 was used to ensure that all those scoring greater than 17 (18 or more) were classified as those most likely to need intervention. This threshold was the same as applied in earlier studies of cultural identity in both this and another London-based cohort [17,33,34].

**Ethnicity**

Ethnic group membership was measured by a self-report questionnaire based on an adaptation from the 2001 UK census categories, supplemented by questions on national group. Migration history was captured by country of birth (UK, non-UK) and length of stay in the UK (entire life, over the past 10 years, or less than 10 years). Cultural Identity was measured using two well-validated questions about friendship choices with people.
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