Social Science & Medicine 71 (2010) 1300–1307

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Bullying victimisation, self harm and associated factors in Irish adolescent boys

Elaine M. McMahon [a,b], Udo Reulbach [a,b], Helen Keeley [c], Ivan J. Perry [b], Ella Arensman [a,*]

[a] National Suicide Research Foundation, 1 Perrott Avenue, College Road, Cork, Ireland
[b] Department of Epidemiology and Public Health, University College Cork, Ireland
[c] Child and Adolescent Mental Health Services, HSE Southern Area, Mallow, Co. Cork, Ireland

ARTICLE INFO

Article history:
Available online 15 July 2010

Keywords:
Bullying
Deliberate self harm
Adolescence
Boys
Risk factors
Mental health
Schools
Ireland

ABSTRACT

School bullying victimisation is associated with poor mental health and self harm. However, little is known about the lifestyle factors and negative life events associated with victimisation, or the factors associated with self harm among boys who experience bullying. The objectives of the study were to examine the prevalence of bullying in Irish adolescent boys, the association between bullying and a broad range of risk factors among boys, and factors associated with self harm among bullied boys and their non-bullied peers. Analyses were based on the data of the Irish centre of the Child and Adolescent Self Harm in Europe (CASE) study (boys $n = 1870$). Information was obtained on demographic factors, school bullying, deliberate self harm and psychological and lifestyle factors including negative life events. In total 363 boys (19.4%) reported having been a victim of school bullying at some point in their lives. The odds ratio of lifetime self harm was four times higher for boys who had been bullied than those without this experience. The factors that remained in the multivariate logistic regression model for lifetime history of bullying victimisation among boys were serious physical abuse and self esteem. Factors associated with self harm among bullied boys included psychological factors, problems with schoolwork, worries about sexual orientation and physical abuse, while family support was protective against self harm. Our findings highlight the mental health problems associated with victimisation, underlining the importance of anti-bullying policies in schools. Factors associated with self harm among boys who have been bullied should be taken into account in the identification of boys at risk of self harm.

Introduction

Self harm is common among adolescents and a wide range of factors, including school bullying victimisation, are associated with self harm in this group (Evans, Hawton, & Rodham, 2004; Fergusson, Beautrais, & Horwood, 2003). Self harm is a major risk factor for repeated self harm and subsequent suicide (Gunnell et al., 2008; Tidemalm, Langstrom, Lichtenstein, & Runeson, 2008), and so pathways to self harm among young men are of particular interest.

Suicide is the leading cause of death in men aged 15–34 years in Ireland, with suicide rates among young men aged 15–19 in Ireland the third highest in the European Union (Eurostat, 2009). A gender paradox in suicidal behaviour has been described whereby suicide mortality is generally higher among men than women in Western cultures, despite lower prevalence of suicidal ideation and non-fatal suicidal behaviour (Canetto & Sakinofsky, 1998). Trends in Irish suicide are somewhat unique as suicide rates peak in young men, unlike most European countries where rates increase with age (Health Service Executive; National Suicide Review Group and Department of Health and Children, 2005). Rates of hospital-treated self harm also peak in men in the 20–24 years age group and have increased significantly in recent years (National Suicide Research Foundation, 2009). These national trends have led to a media, government and research focus on potential causes and prevention of suicide and self harm in young men (Department of Public Health, 2001).

The psychological impact of particularly rapid social change in Ireland over the past three decades has been cited as a potential cause of the increase in suicide and self harm among young men (Cleary & Brannick, 2007; Smyth, MacLachlan, & Clare, 2003). In particular, the doubling of suicide rates in the 1980s and 1990s has been associated with the undermining of traditional institutions and the transition to a wealthy, secular and individualist society. Increasing economic prosperity and personal freedom is generally beneficial, but less so for those with fewer resources at their disposal (Cleary & Brannick, 2007; Eckersley & Dear, 2002).

An Irish study of young men revealed a pessimistic view of Irish life, as 60% believed that "The lot of the average man is getting

* Corresponding author. Tel.: +353 214277499.
E-mail address: ella.nsrf@iol.ie (E. Arensman).

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doi:10.1016/j.socscimed.2010.06.034

worse" (Begley, Chambers, Corcoran, & Gallagher, 2003). However, few causal links between indicators of change and male suicide have been identified (Cleary, 2005). The fact that men are disproportionately affected by suicide has been attributed to the fact that men are more reluctant than women to seek help for psychological problems (Cleary, 2005) and consequently have lower rates of diagnosis and treatment of depression (Rutz, von Knorring, Pihlgren, Rihmer, & Walinder, 1995). Canetto and Sakinofsky (1998) also reported evidence for the influence of "cultural scripts" which sometimes make suicide an acceptable course of action for Western men. However, in Ireland attitudes reflecting justification of suicide showed an upward trend in the 1980s and were reversed in the 1990s (Cleary & Brannick, 2007).

Bullying victimisation is a common problem among adolescents of both sexes (Kaltiala-Heino, Rimpela, Marttunen, Rimpela, & Rantanen, 1999; Nansel et al., 2001; Salmon, James, & Smith, 1998), with lifetime prevalence of between 10.5% and 29.6% reported in a multi-centre European study (Analitis et al., 2009). An Irish study reported that 15.6% of 12–18 year olds had been bullied at some point (O'Moore, Kirkham, & Smith, 1997). Among adolescents, bullying most often takes place within the school environment (Brunstein Klomek, Marrocco, Kleinman, Schonfeld, & Gould, 2007). Boys more often report both bullying others (Juvonen, Graham, & Schuster, 2003) and being the victim of bullying than girls (Brunstein Klomek et al., 2007; Hazemba, Siziya, Muula, & Rudatsikira, 2008; Salmon et al., 1998).

Victims of bullying suffer not only distress but social marginalisation and low status among their peers, while bullies have high social status as rated by their peers and are considered psychologically stronger than victims (Juvonen et al., 2003). Hodges and Perry (1999) described the vicious cycle whereby peer rejection is both an antecedent and a consequence of peer victimisation (Hodges & Perry, 1999). This peer rejection and perceived weakness may be particularly difficult for boys given the associations of failure in the masculine role, and may contribute to the fact that boys are less likely than girls to seek help when they are victimised (Hunter, Boyle, & Warden, 2004).

Bullying victimisation warrants attention in the context of self harm among young men because of its association with suicidal ideation (Rigby & Slee, 1999) and deliberate self harm (Barker, Arseneault, Brendgen, Fontaine, & Maughan, 2008; Cleary, 2000; Kim, Koh, & Leventhal, 2005; Mills, Guerin, Lynch, & Fitzpatrick, 2004) as well as with a wide range of mental health problems, such as depression (Brunstein Klomek et al., 2007; Kaltiala-Heino et al., 1999; Seals & Young, 2003); anxiety (Cleary, 2000), eating disorders (Kaltiala-Heino, Rimpela, Rantanen, & Rimpela, 2000) and poor self esteem (Delfabbro et al., 2006). A Danish longitudinal study reported that boys who were bullied at school were at increased risk of being diagnosed with depression between the ages of 31 and 51 compared with those without the experience of school bullying victimisation (Lund et al., 2009).

Such findings suggest that the distress and peer rejection reported as associated with victimisation are precursors of mental health problems and the associated risk of self harm. On the other hand, Hodges and Perry (1999) reported that pre-existing mental health problems contributed to becoming a victim of bullying, which again increased later symptoms. The direction of causality between bullying and mental health problems such as depression, low self esteem and suicidal behaviour can thus be both ways. Nonetheless, theoretical models of the aetiology of self harm such as a life-course model which postulates that the risk of developing suicidal behaviour depends on accumulation of a broad variety of psychological and social risk factors across the lifespan from childhood into adolescence (Fergusson, Woodward, & Horwood, 2000) can inform the study of bullying and its association with poor mental health and self harm. Bullying victimisation can be viewed as one of the negative life events which make an independent contribution to the development of self harm and one which is particularly relevant in childhood and adolescence.

To date, a small number of Irish studies have highlighted the mental health problems associated with bullying victimisation (Mills et al., 2004; O'Moore et al., 1997), but none has looked at a wide range of potential associated risk and protective factors and none has focused specifically on boys. A small-scale cross-sectional Irish study which examined mental health difficulties associated with bullying in adolescents found that those who had been bullied were significantly more likely to be depressed compared to those without this experience. Moreover, they were more likely to report self harm thoughts, to report serious self harm acts and referrals to psychiatric services (Mills et al., 2004). Several centres of the Child and Adolescent Self Harm in Europe (CASE) study, of which this study is part, found no significant associations between bullying and self harm in their multivariate logistic regression models for history of self harm (De Leo & Heller, 2004; Hawton, Rodham, Evans, & Weatherall, 2002; Ystgaard, Reinholdt, Husby, & Mehlum, 2003), while a Scottish study found an association for both boys and girls (O'Connor, Rasmussen, Miles, & Hawton, 2009). A strong association between school bullying victimisation and self harm among boys (but not among girls) was reported by the Irish centre of the CASE study (McMahon et al., 2010). Given these findings, potential associations between bullying and self harm thoughts and acts in Irish adolescent boys require further investigation.

The aims of the present study were: 1) To investigate the prevalence of self-reported school bullying victimisation among boys (hereafter referred to as simply victimisation); 2) To examine associations between bullying and psychological/mental health factors: depression, anxiety, self esteem and impulsivity; 3) To examine associations between victimisation and a broad range of lifestyle and life event factors among adolescent boys; 4) To compare those boys with and without the experience of victimisation in terms of prevalence of self harm; 5) To identify and compare the factors associated with deliberate self harm among boys with a history of victimisation and those without.

Method

The study used a cross-sectional design. Data were gathered in schools in the Southern region of the Health Service Executive, Ireland, in 2003/2004. Using random selection, 54 schools were invited to take part and 39 schools participated in the survey. Ethical approval for the study was granted by the Clinical Research Ethics Committee of the Cork Teaching Hospitals. The questionnaire was completed by students in a class setting with a member of the research team present. The methodology of the study has been fully described elsewhere (Morey, Corcoran, Arensman, & Perry, 2008).

Participants

Of the 54 schools invited to participate, 39 schools took part. 4583 students were invited to complete the questionnaire and 3881 participated in the survey (85% response rate). The sample was representative of the target population in terms of gender balance, urban/rural school location and school type (single sex or co-educational). Eighty surveys were then disregarded as they did not fit the age criteria of 15, 16 or 17 years, were not filled in seriously, or sex of participant was not stated. Surveys were judged to have not been completed seriously if responses were inconsistent or if they included statements indicating that the questionnaire was not taken seriously. Moreover, 51 surveys were excluded