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Impact of Bullying Behavior on Mental Health and Quality of Life Among Pre-Adolescents and Adolescents in Sialkot-Pakistan

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ABSTRACT

Bullying in children and adolescents has become a serious social problem and a stern threat to mental health and well-being, leaving a shadow for severe psychopathology. Previous research has highlighted bullying behavior is a leading cause of emotional disturbances in children and adolescents, worsening their physical, psychological, and social sense of well-being. The aim of the present research was to explore the influence of bullying behavior on pre-adolescents, and adolescents' mental health and quality of life. Further, age group and gender differences were also explored. For this purpose, a random sample of 400 children and adolescents, aged 8-18 years from different schools and colleges of Sialkot-Pakistan were considered for assessment of bullying behavior. A self-develop demographic sheet along with different scales to assess bullying behavior, mental health and quality of life was administered. The results suggest that bullying behavior was negatively and significantly associated with mental health problems and quality of life in the whole sample. Findings further indicates the significant difference among pre-adolescents and adolescents on the variables of bullying behavior (t=13.34, ***p<0.01), QOL (t=-3.37, ***p<0.01) and mental health problems (t=-3.69, ***p<0.01). Gender differences on the variables of bullying behavior (t=13.34, ***p<0.01), QOL (t=-3.75, ***p<0.01) and mental health problems (t=-3.69, ***p<0.01) were also found significant. Bullying behavior exerts a greater impact on the mental health and well-being of children and adolescents. There is an immense need to devise preventive strategies to enhance the emotional, psychological well-being of this group.

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1. Introduction

Bullying is defined as the violent and aggressive behavior that is the focus of attention as a major prevailing social problem in families, educational institutions, in media, and in whole society as well. It occurs in different forms (Calbo, de Bastani Busnello, Rigoli, Schaefer, & Kristensen, 2009; Silva & Cabral, 2014). Typically, it involves intentional and repeated physical behavior that is manifested by the perpetrator on an individual who is less in power and autonomy (Dellazzana, Sattler, & Freitas, 2010; Stelko-Pereira & Williams, 2012; Waseem & Nickerson, 2017). Bullying has been reported as physical and verbal form; the physical form includes violence and aggressive acts, hitting, punching, pushing, use of a weapon to harm others, stealing, etc. while verbal form encompasses threats, curses, spreading rumors, insult, using bad names, hence, both these forms lead towards unhealthy and unstable relations (Bandeira & Hutz, 2012; Dellazzana et al., 2010; Hui, Tsang, & Law, 2011; Stelko-Pereira & Williams, 2012). The person who victimizes is called an aggressor/perpetrator, who bullies others is called a victim, and those who observe some bully behaviors are called a witness. An aggressor can be anyone, a child or an adolescent, or some adult but who is a victim in one

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time tend to be a perpetrator in some other time (Bandeira & Hutz, 2012). Bullying is known as a common problem among school-age children and adolescents with immediate or late consequences of direct or indirect bullying on their lives (Oliveira, Silva, Yoshinaga, & Silva, 2015).

A National School Health Survey in Brazil was conducted in 2015 it showed that the prevalence of victims by bullying at the school level among adolescents was 7.4% and it was more common in boys than girls, with the consequence of loneliness, insomnia, class bunking, and use of tobacco (Malta et al., 2019). Other findings have also shown wide-ranging prevalence among adolescents of 10 and 35% who had experienced bullying (Cross et al., 2009; Nansel et al., 2001). In a multi-country cross-sectional survey, the bullying victimization ratio was found from 2.4% to 31.9% among boys and in girls, it was from 1.5% to 34.4%, moreover in the physical form of bullying was prevalent in a low ratio of 7% in Ethiopia, Peru, and Vietnam, while this type of bullying behavior was reported in the high ratio in India at 17.3% among adolescents and 12.2% among (Nguyen, Bradshaw, Townsend, & Bass, 2020). Hence, the prevalence and form of bullying differ by age groups and gender as well as boys were found more involved in bullying acts than girls (Cook, Williams, Guerra, Kim, & Sadek, 2010) and the ratio of bullying was highest among adolescents of secondary school and was less in adolescents in high schools (Hymel & Swearer, 2015). Bullying behavior causes emotional disturbances among victims with intense deterioration of different aspects of QOL i.e., physical, psychological, and social sense of well-being. Many suffer from psychological disturbances such as high levels of anxiety (Malecki et al., 2015), low levels of self-esteem, relationship problems, depressive symptoms (Sino et al., 2014) and in more severe cases the victims attempt suicide (Silva & Cabral, 2014).

By considering bullying as a prevailing public health problem, this research distinguishes the gaps related to the field of child and adolescent mental health in the context of Pakistan. This research exerts great emphasis on the dynamics of mental health that is affected by bullying behavior. In our culture, overt behaviors i.e., neglect, physical violence is given much attention in a psychological point of view, hence, if someone abuses others verbally or use unsophisticated language and bully others is considered a normal pattern and its negative emotional and psychological consequences are ignored largely. This research has great implications for stakeholders to establish some mental health policies for youngsters of Pakistan that will be applied at different educational institutes, adopted by parents as well. For creating and shaping a healthy environment, they have to comprehend the crucial value of tolerance and respect. The role and duty of society and especially of parents and educational institutes become very vital to cherish the well-being of children and adolescents (Meter & Bauman, 2018). Keeping into consideration the importance of this phenomenon following objectives were devised: Firstly, to explore how much bullying behavior is affecting our children and adolescent's mental health. And how it is influencing their quality of life. Secondly, to determine whether bullying behavior has a greater impact on children's mental health, affecting their QOL or the adolescents are at greater risk. Thirdly, to assess whether the male victims from bully are at greater risk of low mental health and poor QOL or the female is more increased in female children and adolescents.

2. Literature Review

Ample of data is available on the adverse effects of bullying behavior on the mental health and well-being of bully-victims. As it has been described earlier that school-age children and adolescents are affected mostly by this bullying. Adverse health and psychosocial problems associated with bullying victimi-zation were also reported by many researchers. Santos, Perkoski, and Kienen (2015) found fear, sadness, negative feelings, and aggression among bully-victims in school-age that can further worsen the physical, psychological, and social well-being. The most common mental health problems reported in other findings were anxiety, depression, self-destructive and suicidal behavior (Haraldstad, Kvarme, Christophersen, & Helseth, 2019; Hawker & Boulton, 2000; Moore et al., 2014). Moreover, bullying was found in teenagers as a trigger of depressive and anxiety disorders with greater risk-off suicidal thoughts and suicide attempts (Moore et al., 2017). Other research found consistent findings in which depression, anxiety, and suicide behavior was commonly found in bully-victims, and these effects are so strong that they last for a longer time even bully behavior is stopped (Arseneault, 2017; Oliveira-Menegotto, Pasini, & Levandowski, 2013). In some cases, PTSD symptoms were also reported (Albuquerque, Williams, & D'Affonseca, 2013).

Further, family is considered as a key element that plays a part in determining the well-being and QOL of individuals. The relationship between family members and healthy communication patterns creates a sense of security in children. Feeling of being loved and previous research have highlighted that sense of belongingness work as protective factors for children to face bullying like harmful life experiences (Anna Costanza Baldry, Farrington, & Sorrentino, 2017; Gini, 2004). Much data has supported the harmful effects of bullying on mental health and well-being. As those students who are victims of bullying suffered from a low level of self-esteem, depression, intense post-traumatic stress (Houbre, Tarquinio, Thuillier, & Hergott, 2006). Some other findings reported by Kaltiala-Heino, Fröjd, and Marttunen (2010) in which relationship of bully victimization was found with depression in later life as this relates with the psychoanalytic theory of Sigmund Freud. Moreover, exposure to bully victimization can weaken the physical and general sense of well-being of health and the wellbeing of exposed persons with greater risk of developing poor QOL, bodily symptoms, i.e., nausea, lack of sleep and appetite, and headache (Kumpulainen et al., 1998). Adolescence is a period of transition and a more vulnerable stage of life to bullying as they are dependent on others and are less autonomous, peers exert more influence on them which is a major factor of bullying and plays an important role in the quality of life (Finkelhor, 2008). Ample of research data has focused on the negative consequences of bullying on mental health issues and QOL in Western culture but once we talk about Pakistan; this phenomenon is known little. Much emphasis has been done on violence and aggression in Pakistan and this phenomenon is called "bullying". moreover, behavioral problems, poor impulse control, and violence, in youth have been reported in a variety of situations (Hussein, 2008; Khan, Quadri, & Aziz, 2014), hence, very little data is available on bullying victimization at school level (Hanif, Nadeem, & Tariq, 2011), as research in Pakistan has highlighted that public schools and male gender as more important factors of bully victimization and violent behavior (Shujja, Atta, & Shujjat, 2014).

3. Methodology

3.1 Study Area

Data was collected from different private and government schools and colleges of Sialkot i.e., Govt. Christian H/S Haji Pura Sialkot, New Chamdrage Haji Pura, Govt. College for Women Haji Pura Sialkot, Quaid-e-Millat Girls Public High School Haji Pura Road Sialkot, Quaid-e-Millat Boys Public High school, Concordia College Haji Pura Sialkot. These academic institutes were selected because students enrolled there belong to different areas and backgrounds, with different communication and familial patterns so the phenomenon that we want to assess was better understandable side by side the role of academic institutes in the provision of pieces of training.

3.2 Study Design, Duration, Sampling:

This was a cross-sectional study conducted from September 3rd, 2020, till February 2021. For data collection, simple random sampling techniques were used.

3.3 Inclusion and Exclusion Criteria:

- A sample of 400 pre-adolescents and adolescents covering the age groups of 8-11 and 12-18 was included.
- Sample was recruited from both government & private schools and colleges.
- Those sample was included whom education level was less than primary till intermediate.
- The lower, middle, and high socio-economic statuses were included based on their income level.
- For sample recruitment, both nuclear and joint family setups were included.

3.4 Data Collection

At first, permission was taken from the Ethical Review Committee, Department of Psychology-GCWUS for conducting this research. After that consent was taken from authors of scales and from the administration of different schools. After getting permission from heads of academic institutes participants were approached. They were told about the purpose of the study and written consent was taken from them. After that self-developed demographic sheet along with study measures were administered to assess the bullying behavior, mental health, and QOL.

3.5 Measures

A demographic sheet which was consists of name, age, gender, education, birth order, No. of a sibling, the family set up, family status, and residential area.

3.5.1 Illinois Bullying Scale (Espelage 2001)

The Illinois bullying scale consists of 18 items. It has three subscales; the first subscale measures occurrence of victimization by the peer group is called the victim subscale and it is comprised of items: 4,5,6 and 7. Its score ranged between 0-16 and a higher score indicates a high level of victimization. The second subscale is the bully scale that measures the frequency of bully behavior of youth through items; 1,2,8,9,14,15,16,17, and 18. Its scores ranged from 0 to 26 and a high score indicates a high level of bullying action. The third subscale is the fighting scale that assesses physical disputes and threat of violence through items; 3,10,11,12 and 12. Its scores ranged between 0 to 20 and high scores indicate more fighting behavior. Cronbach's alpha reliability for the total score of scale is .87, for victims, bully, and fighting subscales are .71, .77, and .76 respectively.

3.5.2 Depression Anxiety Stress scale (Lovibond 1995)

This scale is comprised of three self-report scales intended to quantify the adverse effects of despair, apprehension, and anxiety. The original DASS contains a questionnaire of 42 items, while the brief form of DASS-21 contained 21 statements. It also has good reliability of 0.84, 0.74, and 0.79, respectively for the stress, anxiety, and stress subscale. Cut scores were used to describe the lowest/moderate/heavy scores on each subscale.

3.5.3 Quality of life brief (WHO 1998)

This is a 5-point Likert-type scale originally developed by the WHO Group. Its brief version is comprised of 26 items and has our sub-domains: physical domain, psychological domain, social domain, and environmental domain. The higher score in each domain reflects a higher level of QOL. Overall scales' Cronbach alpha reliability is .88 while for subdomains reliability is .77 for psychological, .75 for environmental, .81 for physical and .42 for social domain respectively.

3.6 Ethical considerations

Following ethical considerations were considered. First, consent was obtained from authors of scales used in this study, from authorities of different private and government schools and colleges to conduct a study and collecting data from their esteemed institutions. The purpose of the study was explained to the participants before the survey. Confidentiality and privacy of data were assured. They were explained about the right to withdraw from the study at any stage. They were assured that their information will only be used for academic and research purposes and would not be disclosed to anyone.

3.6 Statistical Analysis

For analysis, Descriptive analysis, Pearson Product Moment Coefficient Correlation was computed through SPSS and further means difference was also computed through t-test.

4. Results

This section presents descriptive analysis (frequency and percentages), correlation, and mean difference through (SPSS, v21).

Table 1: Summary of socio-demographic characteristics and variables of sample

Variables	Category	f	%
Gender	Male	200	50%
	Female	200	50 %
No of Siblings	1-3	126	31.5
	4 – 6	199	49.9
	7 – 9	75	18.8
Education	Less than primary	65	16.3
	Primary	118	29.6
	Matric	103	25.8
	Intermediate	101	25.3
	Other	1	3.3
Family System	Joint	143	35.8

	Nuclear	218	54.5
	1	218	54.5
	2	138	34.5
Earning members	3	35	8.8
	4	8	2.0
	5	1	.3
	Business	193	48.3
	Less than 10,000	70	17.5
Income Level	11-30,000	190	47.6
	31-50,000	95	23.8
	51,000 – above	45	6.8
Residential Area	City	271	67.8
	Village	129	32.3

N = 400

Table 2: Pearson Product Correlation Coefficient of bullying behavior (BB), quality of life (QOL), and mental health problems (MHP)

Variables	M	SD	α	1	2	3
Bullying behavior	19.79	11.01	.81	-	-.197**	-.119*
Quality of life	96.36	12.36	.66		-	-.022
DASS	22.18	11.10	.83			-

N=400, **p< 0.01, * p< 0.05

The findings of the above table revealed that bullying behavior has a significant negative relationship with quality of life and mental health problems.

Table 3: Mean difference among pre-adolescents and adolescents on the variables of bullying behavior, quality of life, and mental health problems

Variables	Categories	N	M	SD	df	t	Sig.
Bullying Behavior	Pre-Adolescents	132	28.19	12.47	398	2.787	.006
	Adolescents	268	24.54	12.26			
Quality of Life	Pre-Adolescents	132	86.38	9.62	398	-6.004	.000
	Adolescents	268	94.39	13.75			
DASS	Pre-Adolescents	132	18.31	10.07	398	-2.832	.007
	Adolescents	268	21.09	8.76			

N=400, ***p< 0.01

The above table indicates a statistically significant difference in the variables of bullying behavior, quality of life, depression, anxiety, and stress (p<0.01) among pre-adolescents and adolescents. It is further concluded that the pre-adolescent group tends to have a high level of mean score on bullying behavior (M=28.19) as compared to the adolescent group. While adolescent group tends to have a high mean score on the quality of life (M=13.75) and DASS (M=21.09) than the pre-adolescent group.

Table 4: Gender difference among pre-adolescents and adolescents on the variables of bullying behavior, quality of life, and mental health problems

Variables	Categories	N	M	SD	df	t	Sig.
Bullying Behavior	Male	200	32.65	10.46	398	13.341	.000
	Female	200	18.84	10.24			
Quality of Life	Male	200	89.33	13.69	398	-3.758	.000
	Female	200	94.17	12.01			
DASS	Male	200	18.48	8.79	398	-3.699	.000
	Female	200	21.87	9.49			

N=400, ***p< 0.01

The above table shows statistically significant gender differences on the variables of BB, QOL, and MHP (p<0.01) among pre-adolescents and adolescents. It is further concluded male group tends to have a high level of mean score on bullying behavior (M=32.65) as compared

to the female group. While females tend to show a high mean score on QOL (M=94.17) and MHP (M=21.87) than the male group.

5. Discussion

This study examined the impact of bullying behavior (BB) on mental health problems (MHP) and quality of life (QOL) among preadolescents and adolescents, age group and gender differences were also explored. As findings of table 1 indicated that bullying behavior is negatively correlated with MHP and QOL among the pre-adolescent and adolescent population (table 2). Further, a significant difference was found on the variables of BB, QOL, and MHP among pre-adolescents and adolescents. Moreover, the pre-adolescent group tends to have a high level of mean score on bullying behavior as compared to the adolescent group. While the adolescent group tends to have a high mean score on QOL and MHP than the pre-adolescent group (table 3). Furthermore, a significant gender difference was found on the variables of BB, QOL, and MHP among pre-adolescents and adolescents and the male group tends to have a high level of mean score on bullying behavior as compared to the female group while females tend to show a high mean score on QOL and DASS than the male group.

As findings of current research show that BB is one of the major factors of poor mental health and lower QOL in pre-adolescents (children and teenagers) and adolescents and it can happen to anyone whether to boy/male or girl/female at any age. It is evident by the findings that pre-adolescents and males are more victimized by the BB and suffer from more MHP and lower QOL than adolescents and females. These are evident by previous research as well that preadolescent boys are more at risk of being victimized by BB than girls (Anna Costanza Baldry et al., 2017; Hymel & Swearer, 2015; Tsitsika et al., 2014).

It has been observed that family environment, authoritarian parenting, income level of families, lack of parental monitoring and involvement, unhealthy communication patterns, and peer's influence play vital roles in getting affected by BB and suffering from MHP. Much previous research has validated these reasons too. Those families who treat their children harshly and maliciously, use insulting and aggressive behavior and words in interactions lead their children towards not victimized by their bully behavior but also to become perpetrators (Anna C Baldry, 2004; Anna Costanza Baldry et al., 2017; Oliveira et al., 2015; Smith, 2014). If a child is not dealt with affection in childhood but rather deal with a negative attitude, the child learns this behavior and tends to apply it in later life that affects their social well-being (Usman, 2020). On the contrary, adequate ministering of parents prevents adolescents from being bullied or becoming a perpetrator (Abdirahman, Fleming, & Jacobsen, 2013; Meter & Bauman, 2018). In current findings as described earlier, being bullied is negatively associated with QOL so this is also consistent with the researchers reported earlier that being bullied negatively affects personal, social, and psychological well-being.

6. Conclusion

The study concluded that bullying behavior has a strong impact on the mental health and quality of life of children and adolescents. In the pre-adolescent stages of life, bullying victimization negatively affects mental health leading towards some severe pathology in later life. It not only affects at the initial stage but in the adolescence, level as well affecting personal, social, psychological well-being.

There is an immense need to formulate some intervention programs and mental health policies to reduce bullying behavior and to promote well-being at educational institutes. Psycho education programs for parents are also needed to devise to control malicious ways of treatment at any stage for their children.

References

Abdirahman, H., Fleming, L., & Jacobsen, K. H. (2013). Parental involvement and bullying among middle school students in North Africa. *EMHJ-Eastern Mediterranean Health Journal, 19*(3), 227-233.

Albuquerque, P. P. d., Williams, L. C. d. A., & D'Affonseca, S. M. (2013). Efeitos tardios do bullying e transtorno de estresse pós-traumático: uma revisão crítica. *Psicologia: Teoria e Pesquisa, 29*(1), 91-98. doi:https://doi.org/10.1590/S0102-37722013000010001

Arseneault, L. (2017). The long-term impact of bullying victimization on mental health. *World psychiatry, 16*(1), 27-28. doi:https://doi.org/10.1002/wps.20399.
Baldry, A. C. (2004). The impact of direct and indirect bullying on the mental and physical health of Italian youngsters. *Aggressive Behavior: Official Journal of the International Society for Research on Aggression, 30*(5), 343-355. doi:https://doi.org/10.1002/ab.20043
Baldry, A. C., Farrington, D. P., & Sorrentino, A. (2017). School bullying and cyberbullying among boys and girls: Roles and overlap. *Journal of Aggression, Maltreatment & Trauma, 26*(9), 937-951. doi:https://doi.org/10.1080/10926771.2017.1330793
Bandeira, C. d. M., & Hutz, C. S. (2012). Bullying: prevalência, implicações e diferenças entre os gêneros. *Psicologia Escolar e Educacional, 16*(1), 35-44.
Calbo, A. S., de Bastani Busnello, F., Rigoli, M. M., Schaefer, L. S., & Kristensen, C. H. (2009). Bullying na escola: comportamento agressivo, vitimização e conduta pró-social entre pares. *Contextos Clínicos, 2*(2), 73-80. doi:https://doi.org/10.4013/4915
Cook, C. R., Williams, K. R., Guerra, N. G., Kim, T. E., & Sadek, S. (2010). Predictors of bullying and victimization in childhood and adolescence: A meta-analytic investigation. *School psychology quarterly, 25*(2), 65-83.
Cross, D., Shaw, T., Hearn, L., Epstein, M., Monks, H., Lester, L., & Thomas, L. (2009). Australian covert bullying prevalence study. In. Perth: Australia Child Health Promotion Research Centre, Edith Cowan University.
Dellazzana, L. L., Sattler, M. K., & Freitas, L. B. d. L. (2010). A importância da inclusão da família na intervenção contra o bullying. *Pensando fam, 14*(1), 109-120.
Finkelhor, D. (2008). *Childhood victimization: Violence, crime, and abuse in the lives of young people*. US: oxford university Press.
Gini, G. (2004). Bullying in Italian schools: An overview of intervention programmes. *School Psychology International, 25*(1), 106-116. doi:https://doi.org/10.1177/0143034304028042
Hanif, R., Nadeem, M., & Tariq, S. (2011). Bullying in schools: attitudes of children, teachers and parents. *Interdisciplinary journal of contemporary research in business, 3*(8), 1055-1061.
Haraldstad, K., Kvarme, L. G., Christophersen, K.-A., & Helseth, S. (2019). Associations between self-efficacy, bullying and health-related quality of life in a school sample of adolescents: a cross-sectional study. *BMC Public Health, 19*(1), 1-9. doi:https://doi.org/10.1186/s12889-019-7115-4
Hawker, D. S., & Boulton, M. J. (2000). Twenty years' research on peer victimization and psychosocial maladjustment: A meta-analytic review of cross-sectional studies. *The Journal of Child Psychology and Psychiatry and Allied Disciplines, 41*(4), 441-455. doi:https://doi.org/10.1111/1469-7610.00629
Houbre, B., Tarquinio, C., Thuillier, I., & Hergott, E. (2006). Bullying among students and its consequences on health. *European Journal of Psychology of Education, 21*(2), 183-208. doi:https://doi.org/10.1007/BF03173576
Hui, E. K., Tsang, S. K., & Law, B. (2011). Combating school bullying through developmental guidance for positive youth development and promoting harmonious school culture. *TheScientificWorldJOURNAL, 11*, 2266-2277. doi:https://doi.org/10.1100/2011/705824
Hussein, S. A. (2008). Behavioral problems among children attending private and community schools in Karachi, Pakistan. *Pakistan Journal of Psychological Research, 23*(1), 1-11.
Hymel, S., & Swearer, S. M. (2015). Four decades of research on school bullying: An introduction. *American Psychologist, 70*(4), 293-299. doi:https://doi.org/10.1037/a0038928ss
Kaltiala-Heino, R., Fröjd, S., & Marttunen, M. (2010). Involvement in bullying and depression in a 2-year follow-up in middle adolescence. *European child & adolescent psychiatry, 19*(1), 45-55. doi:https://doi.org/10.1007/s00787-009-0039-2
Khan, M., Quadri, S. M. A., & Aziz, S. (2014). Association of family structure and its environment with aggressive behaviour of children (6-8 years) in a rural community. *Journal of Child Adolescents Behavior, 2*(125), 1-4.
Kumpulainen, K., Räsänen, E., Henttonen, I., Almqvist, F., Kresanov, K., Linna, S.-L., . . . Tamminen, T. (1998). Bullying and psychiatric symptoms among elementary school-age children. *Child abuse & neglect, 22*(7), 705-717. doi:https://doi.org/10.1016/S0145-2134(98)00049-0
Malecki, C. K., Demaray, M. K., Coyle, S., Geosling, R., Rueger, S. Y., & Becker, L. D. (2015). Frequency, power differential, and intentionality and the relationship to anxiety,

depression, and self-esteem for victims of bullying. *Child & Youth Care Forum, 44*(1), 115-131. doi:https://doi.org/10.1007/s10566-014-9273-y

Malta, D. C., Mello, F. C. M. d., Prado, R. R. d., Sá, A. C. M. G. N. d., Marinho, F., Pinto, I. V., . . . Silva, M. A. I. (2019). Prevalence of bullying and associated factors among Brazilian schoolchildren in 2015. *Ciência & Saúde Coletiva, 24*(4), 1359-1368. doi:https://doi.org/10.1590/1413-81232018244.15492017

Meter, D. J., & Bauman, S. (2018). Moral disengagement about cyberbullying and parental monitoring: Effects on traditional bullying and victimization via cyberbullying involvement. *The Journal of Early Adolescence, 38*(3), 303-326. doi:https://doi.org/10.1177/0272431616670752

Moore, S. E., Norman, R. E., Sly, P. D., Whitehouse, A. J., Zubrick, S. R., & Scott, J. (2014). Adolescent peer aggression and its association with mental health and substance use in an Australian cohort. *Journal of Adolescence, 37*(1), 11-21. doi:https://doi.org/10.1016/j.adolescence.2013.10.006

Moore, S. E., Norman, R. E., Suetani, S., Thomas, H. J., Sly, P. D., & Scott, J. G. (2017). Consequences of bullying victimization in childhood and adolescence: A systematic review and meta-analysis. *World journal of psychiatry, 7*(1), 60-76. doi:https://doi.org/10.5498/wjp.v7.i1.60

Nansel, T. R., Overpeck, M., Pilla, R. S., Ruan, W. J., Simons-Morton, B., & Scheidt, P. (2001). Bullying behaviors among US youth: Prevalence and association with psychosocial adjustment. *Jama, 285*(16), 2094-2100. doi:https://doi.org/10.1001/jama.285.16.2094

Nguyen, A. J., Bradshaw, C., Townsend, L., & Bass, J. (2020). Prevalence and correlates of bullying victimization in four low-resource countries. *Journal of interpersonal violence, 35*(19-20), 3767-3790. doi:https://doi.org/10.1177/0886260517709799

Oliveira-Menegotto, L. M. d., Pasini, A. I., & Levandowski, G. (2013). O bullying escolar no Brasil: uma revisão de artigos científicos. *Psicologia: teoria e prática, 15*(2), 203-215.

Oliveira, W. A. d., Silva, J. L. d., Yoshinaga, A. C. M., & Silva, M. A. I. (2015). Interfaces entre família e bullying escolar: uma revisão sistemática. *Psico-USF, 20*(1), 121-132. doi: https://doi.org/10.1590/1413-82712015200111

Santos, M. M., Perkoski, I. R., & Kienen, N. (2015). Bullying: atitudes, consequências e medidas preventivas na percepção de professores e alunos do ensino fundamental. *Temas em Psicologia, 23*(4), 1017-1033.

Shujja, S., Atta, M., & Shujjat, J. M. (2014). Prevalence of bullying and victimization among sixth graders with reference to gender, socio-economic status and type of schools. *Journal of Social Sciences, 38*(2), 159-165. doi:https://doi.org/10.1080/09718923.2014.11893246

Silva, E., & Cabral, R. (2014). *Como combater o bullying na escola e na sociedade (p. 1).* Paper presented at the Resumos do Congresso Internacional de educação e inclusão.

Sino, R., Arnold, E., Dourada, S., Langdon, S., Anderson, U., & Bryant, U. (2014). Percepções e correlatos psicossociais do bullying entre os jovens indianos de Lumbee. *American Indian and Alaska Native Mental Health Research, 21*(1), 1-17.

Smith, P. K. (2014). *Understanding school bullying: Its nature and prevention strategies*. London: Sage.

Stelko-Pereira, A. C., & Williams, L. C. d. A. (2012). Desenvolvimento de rede para enfrentar o bullying: lições canadenses. *Psicologia Escolar e Educacional, 16*(2), 349-351. doi:https://doi.org/10.1590/S1413-85572012000200019

Tsitsika, A. K., Barlou, E., Andrie, E., Dimitropoulou, C., Tzavela, E. C., Janikian, M., & Tsolia, M. (2014). Bullying behaviors in children and adolescents:"an ongoing story". *Frontiers in public health, 2*(7), 1-4. doi:https://doi.org/10.3389/fpubh.2014.00007

Usman, I. (2020). Personality, communication, peer groups, school climate and Bullying behaviour (in Bahasa). *Humanities, 10*(1), 49-59.

Waseem, M., & Nickerson, A. (2017). Bullying, Treasure Island. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK441930/