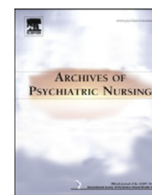
Archives of Psychiatric Nursing 29 (2015) 426–433

Contents lists available at ScienceDirect

Archives of Psychiatric Nursing

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



Implementing a Community Bullying Awareness Intervention in an Adolescent Psychiatric Unit: A Feasibility Study

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ABSTRACT

Problem: Adolescents with a mental health diagnosis are at risk of involvement in bullying. We tested the feasibility of a bullying awareness group intervention in an established inpatient psychiatric unit milieu.
Methods: Adolescents admitted to an urban inpatient adolescent psychiatric unit were eligible to attend two sequential 1-hour Bullying Awareness intervention group sessions. Data were collected before the first session (T1), post-both sessions (T2), and following discharge from the unit (T3).
Findings: A total of 65 adolescents were enrolled; most were female (66.2%), African-American (60%), and in grades 10 to 12 (57%). Intervention feasibility was achieved as >80% of participants completed all components of the intervention and 100% completed all study questionnaires at T1 and T2. Feasibility of the follow-up (T3) was not achieved. Bullying knowledge scores improved significantly from T1 to T2.
Conclusions: The intervention is feasible to implement in an inpatient adolescent psychiatry unit and can improve adolescents' bullying knowledge.

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Bullying is a public health concern for adolescents, and has negative immediate and longer term outcomes for both the perpetrator and for the person being bullied. Outcomes for both include higher incidence of physical and mental illness (addictions, anxiety, depression); withdrawal from others,, involvement in delinquent behaviors as a youth and violence as an adult, injuries, and self-directed injury including suicide and death (Falb et al., 2011; Fung & Raine, 2012; Hawker & Boulton, 2000; Klomek et al., 2009; Menesini, Modena, & Tani, 2009; Van der Wal, de Wit, & Hirasing, 2003). Youth involved in bullying, particularly the victims, have statistically significantly higher reports of emotional-adjustment and school-adjustment problems including poorer relationships with classmates than do youth who report not being involved in bullying (Lemstra, Nielsen, Rogers, Thompson, & Moraros, 2012; Kelleher et al., 2008; Nansel et al., 2004). Victims of bullying have reported being 'very' or 'extremely upset' or afraid because of an incident of being bullied (Ybarra, Mitchell, Wolak, & Finkelhor, 2006). Both cyber and offline bullying are directly related to symptoms of depression, substance abuse, and with the same outcomes as traditional bullying (Luk, Wang, & Simmons-Morton, 2012; Mitchell, Ybarra, & Finkelhor, 2007; Raskauskas & Stoltz, 2007; Ybarra & Mitchell, 2004). The bullying experience and the negative health consequences were recently documented in a 28-country study, indicating that these experiences and consequences are widespread. Concerns about these negative outcomes have prompted 50 states and the District of Columbia in the United States to pass legislation banning bullying and in some states, mandating consequences and implementation of preventive programs (stopbullying.gov, accessed 8/8/2015; Srabstein, Berkman, & Pyntikova, 2008).

The purpose of this pre and post, single-site, intervention feasibility study, guided by the Bullying Risk Reduction Model (BRRM), was to assess the feasibility of implementing a milieu community bullying intervention in an inpatient adolescent psychiatric unit and to assess the adolescents' reports regarding their participation in the intervention. The intervention was intended to provide knowledge to the adolescents about the short- and long-term health outcomes of being bullied, being a bully, or a bystander to bullying and to provide strategies to remove themselves from a bullying situation and to avoid such future situations.

The primary aims were to assess:

1. Feasibility of delivering a two-session verbal group intervention for adolescents hospitalized on a psychiatric unit.
2. Bullying incidence during the past school year and past 30 days as reported by participants at baseline.

Conflict of interest statement: None of the authors have any potential or actual conflicts of interest to report.

Funding Acknowledgement: no external or intramural funding was received; the study was supported by the Department of Nursing Research and Quality Outcomes.

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http://dx.doi.org/10.1016/j.apnu.2015.06.011
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a. Assess incidence of different types of bullying (e.g., direct, indirect and cyber bullying).
b. Examine the factors (e.g., gender, ethnicity, age, mental health diagnosis and family structure) that may be associated with bullying.

The secondary aims were to assess:

1. Change in participant knowledge about bullying from pre-intervention (T1) to post-intervention (T2).
2. Factors (e.g., gender, ethnicity, age, school grade, mental health diagnosis and family structure) that may be associated with improvement in bullying knowledge from T1 to T2.
3. Feasibility of contacting adolescent participants approximately 30 days following discharge from the inpatient unit (T3) to complete the final follow-up study questionnaires.
4. The differences (gender, ethnicity, age, school grade, mental health diagnosis and family structure) in participants who were available to complete T3 versus those who were not.

BACKGROUND

Bullying Defined

A classic definition of bullying used in pediatric care is a human behavior done with the intent to harm another person; it can involve verbal and physical abuse and is typically repeated over time and settings (Olweus, 1993). Most commonly, bullying involves an imbalance in interpersonal power (Turagabeci, Nakamura, & Takano, 2008). Bullying can be further distinguished between direct forms such as display of overt aggressive behaviors through either direct physical contact or verbal attack, and indirect bullying which can take the form of ignoring a person or purposely excluding another from friendship or positive social encounters, or rumor spreading. Direct bullying is believed to be more common among males and indirect bullying among females (Putallaz et al., 2007). Cyber bullying includes aggressive, provocative or pejorative language or photographs that are sent by electronic devices such as cell phones, Internet sites, and electronic mail (Mishna, Cook, Gadalla, Daciuk, & Solomon, 2010; Wang, Iannoti, Luk, & Nansel, 2010). In short, bullying is intentional mistreatment of others.

Bullying as a Public Health Concern

Risk features identified for becoming involved in bullying include select genetic factors, environmental factors such as previously witnessing or experiencing victimization at home, social isolation, and poor peer and classmate relationships. Positive and negative peer support for bullying and environments that indicate no tolerance of bullying have been identified as moderator influences on bullying behavior (Salmivalli, 1999; Srabstein, Joshi, et al., 2008; Williams & Guerra, 2007).

Measuring Bullying

Certain challenges in measuring the true incidence of bullying and its effects have been documented in several studies. The challenges have primarily to do with the type of instrument used and by gender and age differences in reporting. Younger children have indicated a lack of understanding or an uncertainty about the definition or certain of its elements. Self-reporting can also differ by gender, age and ethnicity (Agatston, Kowalski, & Limber, 2007; Sawyer, Bradshaw, & O'Brennan, 2008). Bullying outcomes differ by gender with females reporting depression and suicidal ideation more than males (Van der Wal et al., 2003). Findings in peer victimization based on racial and ethnic differences were mixed with no one particular group experiencing victimization regularly more than the others (Goldweber, Waasdorp, & Bradshaw, 2013; Vitoroulis & Vaillancourt, 2014). Because of these reports, we considered gender, age and ethnicity in our data analysis.

Study Conceptual Model

The Bullying Risk Reduction Model (BRRM), derived from the AIDS Risk Reduction Model used to guide educational interventions in groups of adolescents or adults to prevent their engagement in risky sexual or other behaviors (Boyer & Kegeles, 1991; Catania, Coates, & Kegeles, 1994; Catania, Kegeles, & Coates, 1990), is a three-stage model to engage the inpatient community (staff and patients) in a knowledge and self-reflection intervention specifically related to being a bully or to being bullied: stage 1; identifying own behavior as being at high risk (recognizing being a bully, being a bully/victim or being a victim creates a risk of negative health consequences; recognizing the situations or factors that contribute to high risk behaviors), stage 2; making a verbal or written commitment to reducing high risk behaviors (i.e., making a community pledge to reduce bullying behaviors and to not tolerate bullying in others), and stage 3; taking action (information seeking, looking for solutions, and implementing solutions) (see Fig. 1). Internal and external factors (such as support from others) are often needed for individuals to move through the three stages. The stages can be linear or cyclical.

Bullying Interventions

Different interventions have been attempted including education and no tolerance policies to prevent bullying. The intervention type described as most effective is the community-directed intervention or whole group and peer group intervention (Olweus & Limber, 2010; Black, Washington, Trent, Harner, & Pollock, 2010; Salmivalli, Kaukiainen, & Voeten, 2005; Solberg & Olweus, 2003; Srabstein, Joshi, et al., 2008) which involves a natural microsystem such as a family, classroom or school, or a cluster of patients. Intervention types have included psychoeducation to foster prosocial behavior, promotion of empathy, addressing problems in peer relationships, and reducing reinforcement patterns in peer groups of bullying behavior (Polan, Sieving, & McMorris, 2013; Boulton, 2013; Lamb, Pepler, & Craig, 2009). Outcomes have included decreased bullying and victimization rates, decreased violence, and decreased rates of other antisocial behaviors including theft and truancy (Black et al., 2010; Salmivalli et al., 2005). Differences in outcomes have ranged from no difference in the group as a whole to a 50% decline in target behaviors; however, one finding reported was that while whole group differences may not be noted, subgroup analyses can yield informative and statistically significant differences such as one ethnic group of participants having significantly positive outcomes while another ethnic group did not. Overall, a conclusion reached by researchers is that without intervention, bullying increases (Bauer, Lozano, & Rivara, 2007). Importantly, none of the reviewed intervention studies included adolescents receiving treatment on an inpatient psychiatric unit.

METHODS

The study was approved by the hospital's institutional review board (IRB) and granted expedited status. Screening for eligibility was done by a study team member who confirmed eligibility with the attending or fellow providing care to the adolescent patients.

Inclusion Criteria

Eligible participants were adolescents admitted to the Inpatient Adolescent Psychiatric Unit (APU) who: were between the ages of 13 and 17 years, were anticipated to be admitted for 3 or more days, understood and spoke English, gave written assent to participation, had permission from parents or guardians to participate, and were identified by staff members on the APU as able to function in group activities.

Exclusion Criteria

Adolescents who declined to participate or whose parent/guardian declined to give permission for their participation were considered

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