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Bullying Involvement among Children Receiving Clinical Care: Links to Mental Health Indicators, Individual Strengths, and Parenting Challenges

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ABSTRACT

Bullying has harmful effects on mental health, and it is particularly toxic to children already struggling with mental health challenges. We explored mental health indicators in children, their individual strengths, and challenges in parenting in relation to children's bullying involvement, assessed through parent and clinician reports. Results of our study involving 91 children (ages 4–11 years) receiving services at a children's mental health agency indicated significant differences on dependent variables across four different bullying involvement groups: bully, victim, bully-victim, and non-involved. Results indicated children in our clinical sample were involved in school bullying at much higher rates and many more were involved as bully-victims than what is observed in community samples. Children in the bully-victim group were assessed as having the highest level of externalizing behavior and their parents as having the most challenges. Victims presented the highest level of internalizing problems, and non-involved children were assessed as having higher individual strengths than all children that were involved in bullying. Findings suggest that children's mental health service providers should routinely screen for bullying problems, and interventions targeting bullying involvement and its consequences should be part of mental health care for these children.

KEYWORDS

Bullying; mental health; parenting; social-emotional skills

Bullying is a pernicious global social phenomenon that has been described as "one of the most prevalent forms of youth violence," and it is known to have numerous negative impacts on children's development (Inchley et al., 2020, p. 32). Bullying involvement, which includes bullying others, victimization, and combined bully-victim roles, is characterized by repeated aggressive behavior toward a peer (Farrington, 1993; Olweus, 1997). Bullying is distinguished from other forms of aggression by the relational power imbalance between perpetrators and victims (Vaillancourt et al., 2003). Children dealing with mental health issues are at increased risk of bullying involvement (Clark et al., 2021), yet there is scant research

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addressing the particular experiences and the needs of these children as they relate to bullying. Our research objective is to examine links between the needs and strengths of children who are receiving mental health services as well as challenges faced by their parents, on the one hand, and involvement in peer bullying, on the other.

Bullying involvement and mental health

Bullying involvement is associated with several negative health problems across the lifespan (Kumpulainen & Räsänen, 2000). Children who bully others often experience attention difficulties, depression, and oppositional-conduct disorders (Smokowski & Kopasz, 2005). Victimized children frequently report mental health challenges and a diminished sense of self as well as adverse health and social outcomes, such as increased likelihood of experiencing somatic symptoms, weight difficulties, and difficulties in social functioning (Moore et al., 2017). The bully-victim role is the most harmful type of bullying involvement as these children are at highest risk for mental health and behavioral problems, concurrent psychiatric symptoms, and low self-esteem and negative self-image (Kumpulainen & Räsänen, 2000; Smokowski & Kopasz, 2005).

A growing knowledge base indicates that there are causal relationships between bullying involvement and mental health problems. Moore et al. (2017) meta-analyzed a set of 165 cross-sectional and longitudinal studies that examined links between bullying victimization and a wide range of mental health indicators in children and adolescents. The authors concluded that there was "convincing evidence" that victimization leads to mental health issues, including anxiety, depression, non-suicidal self-harm, suicide attempts, and suicide ideation. Their findings also indicated a robust, predictable dose-response effect: More frequent victimization is worse for children's health. Other studies also point to complex links among the variables, including bi-directional pathways between victimization and mental health issues (Le et al., 2019; Reijntjes et al., 2010, 2011). In a positive vein, Singham et al. (2017) found that the direct contributions of bullying to mental health problems dissipated within 2–5 years, suggesting an important role of resilience in recovery from the ill effects of victimization.

Parenting and bullying

Parenting exerts its effects on children through several mechanisms, including social learning and attachment, impacting how children navigate relationships formed in other settings, like schools. Recent research indicates that parenting based on a punitive discipline style increases children's risk of involvement in peer bullying (Gómez-Ortiz et al., 2016). For example,

Duong et al. (2009) examined links between mothers' use of physical punishment and children's victimization by peers and found a moderately strong link, but only in children already displaying high levels of aggression. Zottis et al. (2014) found that parents' use of psychological aggression and corporal punishment more than any other aspects of punitive discipline were linked to their children's bullying of peers.

There is evidence that points to a link between parenting attachment relationships and bullying behavior. Children involved in either the bullying or bully-victim role often have weaker attachments with their parents and peers, in contrast to children not involved in bullying, who tend to have more positive parental attachments (Nikiforou et al., 2013). Additionally, a relationship exists between family cohesion (i.e., the emotional bonds among family members) and bullying behavior. As noted by Bowers et al. (1994), children who bully report the least amount of family cohesion followed by children in the bully/victim role, non-involved children, and finally victimized children with the highest cohesion scores. While cohesion is typically adaptive, too much cohesion may also be problematic. There is some evidence indicating that when parents take an out-sized role in solving social and emotional challenges children encounter, these children lag in developing the skills to navigate new situations, cope with conflict, and tolerate emotional discomfort (Smokowski & Kopasz, 2005).

Children's skills and capacities

Individual characteristics such as self-esteem, self-concept, self-efficacy, hope, optimism, and intellectual functioning have emerged as common traits that influence resilience and reduce the likelihood of being involved in bullying (Donnon & Hammond, 2007; van Hoof et al., 2008). Effective problem-solving skills have been associated with noninvolvement in bullying (Baldry & Farrington, 2005), whereas ineffective problem solving is observed most consistently in children who are victimized or are bully/victims (Cassidy & Taylor, 2005). Cook et al. (2010) meta-analyzed 153 effect sizes linking 13 individual and contextual characteristics and involvement in one of three bullying groups (i.e., bully, victim, or bully/victim). Five of the 13 variables in their analysis constitute "individual strengths" and are relevant to the current study: social competence, self-related cognitions (e.g., self-respect, self-efficacy), other-related cognitions (e.g., normative beliefs, empathy), social problem-solving, and academic performance. All five variables yielded significant negative effects for each of the three bullying groups, ranging from small to medium in size, with the bully-victim group displaying the most detrimental pattern of results across this set of individual characteristics.

The current study

The purpose of this study is to gain greater insight into children who are receiving mental health services and are displaying specific patterns of bullying involvement. We used a cross-sectional design to explore the different patterns of mental health indicators, parenting challenges, and child social-emotional skills in relation to specific patterns of involvement in bullying. This is important, as children and youth are increasingly presenting in clinical settings with significant histories of bullying involvement along with a range of behavioral and emotional symptoms (Waseem et al., 2013). Based on limited empirical data on this group of children (Paradeisioti et al., 2019), we tentatively expected to observe higher-than-normative rates of bullying involvement, as well positive associations with externalizing and internalizing, and a negative association with social-emotional skills in our clinical sample of children. We also hypothesized that parenting challenges would be positively associated with bullying involvement (cf. Lereya et al., 2013).

Methodology

Participants

This study, approved by the University of Ottawa Ethics Board, made use of de-identified clinical data gathered in routine intake assessments at Crossroads Children's Mental Health Center (CCMHC) in Ottawa, Ontario. The intake battery consists of a basic demographic questionnaire, questions about the presenting problem, the Child and Adolescent and Childs Needs and Strength (CANS) measure, and the Strengths and Difficulties Questionnaire (SDQ). We analyzed clinical data relating to 91 children (48.4% female) who sought mental health services during an 8-month interval in 2019. The mean age of participants was 8 years (SD = 1.73), with ages ranging from 4 to 11 years old. All but one child in the sample were attending school at the time of their referral to CCMHC, and the sample was distributed across grades k-6. Seventy percent of parents reported family income and indicated a wide range of socio-economic levels. Demographic data collected at the agency show that the sample is mostly White (83.5%) and nearly all Canadian born (93.4%).

Measures

Child and Adolescent Needs and Strengths (CANS)

The CANS measure is used to assess children's psychosocial functioning in multiple domains and the needs and strengths of the parent/caregiver (Cordell et al., 2016; Lyons, 2009). The scale is completed by clinicians

based on information provided by parents and children collected during the initial clinical interview. Items are scored on a 4-point Likert scale: 0—no evidence or no reason to believe that the issue requires any action; 1—need for watchful waiting, monitoring, or possibly preventive action; 2—need for action, strategy is needed to address a moderate mental health problem or need; and 3—need for immediate, intensive action to address an acute, severe problem.

Table 1 provides all descriptive information about the four dependent measures that were derived from the CANS. We calculated Cronbach's alpha to assess the internal consistency of the measures and found high levels of reliability for the Externalizing and Parenting Challenges subscales and modest to low reliability for the Social-Emotional Skills and Internalizing subscales. Given these uneven results, we conducted a principal components analysis of all scale items. We set a fixed number of factors (four) for extraction, given the parameters of our measurement strategy for this study. We used Promax (oblique) rotation of items of the four extracted factors, since we expected these factors to be correlated. Table 1 displays the results of these analyses. These results show that all but one (ability to communicate) of the 20 scale items aligned with their corresponding subscales, as indicated with an asterisk in Table 1. Notably, the items for the two subscales with the lowest alpha reliabilities (child social-emotional skills and internalizing) produced factor results that aligned exactly with the subscale composition, providing evidence of the construct validity of these subscales, despite the low alpha reliabilities.

Strengths and Difficulties Questionnaire (SDQ)

The SDQ is a widely used behavioral screening questionnaire used to assess children and adolescents aged 4–16 years old, which is completed by an adult caregiver (Goodman, 2001). The measure's 25 items are scored on a 3-point Likert scale: 0—not true; 1—somewhat true; and 2—certainly true. Only two items from the SDQ were used in this study in order to capture bullying involvement: "Often fights with other children or bullies them" and "Picked on or bullied by other children." For each of the items, scores of 0 were coded as non-involved, and 1 and 2 were coded as involved. The selected cutoff scores on the bullying and victimization items in this study replicate trends in the literature in which similar bullying-involvement groupings were created based on scale items (Solberg & Olweus, 2003).

Data analyses

The study data were analyzed using MANOVA and appropriate post-hoc tests to compare score patterns on dependent variables (internalizing,

Table 1. Factor matrix for dependent variables.

Variable (alpha reliability)	Scale item	Item description	F 1	F 2	F 3	F 4
Externalizing (.86)	Impulse control	Problems with impulse control and impulsive behaviors	−.01	.85	−.07	.03
	Danger to others	Actual and threatened violence, and imagined violence when extreme	−.08	.85	−.12	−.12
	Aggression—objects	Physical aggression toward objects	−.10	.78	.18	.10
	Oppositional behavior	Non-compliance to authority	.34	.67	−.15	−.01
	School discipline	Behavior problems at school	.26	.46	.30	.12
	Attention/Hyperactivity	Symptoms of ADHD	.21	.43	.01	−.16
Internalizing (.52)	Anxiety	Excessive fear and anxiety and related behavioral disturbances (e.g., avoidance)	−.02	−.02	.13	.74
	Mood disturbance	Depressed mood, hypomania, or mania	.00	−.02	−.05	.69
	Suicide risk	Suicidal thoughts or behavior	.30	−.10	−.27	.37
	Self-injuring behaviors	Intentional self-harming behavior that does not have a suicidal intent.	.23	−.32	.07	.36
Parenting challenges (.83)	Knowledge of child	Knowledge of child's specific strengths and problems and ability to understand the rationale for management of these problems.	.91	−.12	.00	−.03
	Parental responsiveness	Ability to understand child's expression of emotion and respond in an emotionally effective manner	.91	−.09	−.02	−.05
	Discipline/Parenting skills	Using discipline appropriately and applying effective parenting techniques	.70	.26	.08	−.07
	Understanding impact of own behavior on children	Self-awareness regarding how parents' actions and behavior affect their child	.67	.14	−.13	.28
	Problem-solving	Resolving conflicts in family and finding solutions to family functioning problems	.67	.26	.08	−.11
	Ability to communicate[a]	Ability to articulate thoughts, feelings, beliefs, and concerns regarding parenting and their child's needs and strengths	.39	−.24	.07	−.54
Child social-emotional skills (.60)	Self-expression	Ability to identify and express thoughts and feelings	−.07	−.07	.79	−.15
	Adaptability to change	Ability to adapt to change and to resolve feelings related to difficult experiences	−.22	.10	.69	.18
	Peer relations	Interpersonal skills with peers	.10	.08	.60	−.14
	Family	Ongoing contact with family members and other individuals with relationships with family	.27	−.15	.59	.18
Eigenvalues (rotation)			4.1	3.3	2.0	1.8

Note: [a]subscale item with a higher factor loading on another subscale.

Table 2. Study variables: descriptives[a] and bi-variate correlations.

Variable	1	2	3	4	5	6
1. Bullying	.74 (.74)					
2. Victimization	.12	.87 (.75)				
3. Internalizing	−.26	.23*	.63 (.37)			
4. Externalizing	.45*	.08	−.16*	1.19 (.62)		
5. Parenting challenges	.35*	.06	−.03	.62*	1.18 (.43)	
6. Child S-E skills	−.27*	−.24*	.00	−.15	−.11	2.27 (.48)

Notes: *$p < .05$. [a]Scale means and SDs reported on the diagonal.

externalizing, parenting challenges, and child social-emotional skills) across the four bullying involvement groups, the independent variable in our analysis.

Results

Table 2 displays descriptive statistics (on the diagonal) along with the bi-variate Pearson's correlation coefficients for the six study variables. Bullying behavior is significantly correlated with externalizing, parenting challenges, and child social-emotional skills, and externalizing and parenting challenges are also highly correlated. Victimization is significantly correlated at moderate levels with internalizing and social-emotional skills. All correlations are in expected directions.

Four bullying-involvement groups were created using the scores on the two SDQ items that indexed involvement in peer bullying as victim and bully. The bully-victim group (42.9% female) was the largest group, comprising 38.5% of the total sample, followed by the victim group (50% female) at 26.4%, the bully group (52.9% female) at 18.7%, and the non-involved group (53.3% female) at 16.5%.

Results by bullying involvement group

Figure 1 displays the mean scores on the four dependent variables across the four bullying-involvement groups. A one-way MANOVA tested the different score patterns on the dependent variables across the four bullying groups. The result was statistically significant, $F(12, 258) = 4.562$, $p < .0001$, $\eta^2 = .175$, and the effect size falls within the large category ($\eta^2 > .14$). Results from the follow-up univariate analyses indicate that the effect of the type of bullying involvement on each of the four dependent variables reached statistical significance, with all but one (parenting challenges) of the four effect sizes falling within the large category.

Internalizing behavior

A follow-up ANOVA revealed a significant effect of bullying involvement on internalizing behavior, $F(3, 87) = 5.270$, $p = .002$, $\eta^2 = .154$. Tukey

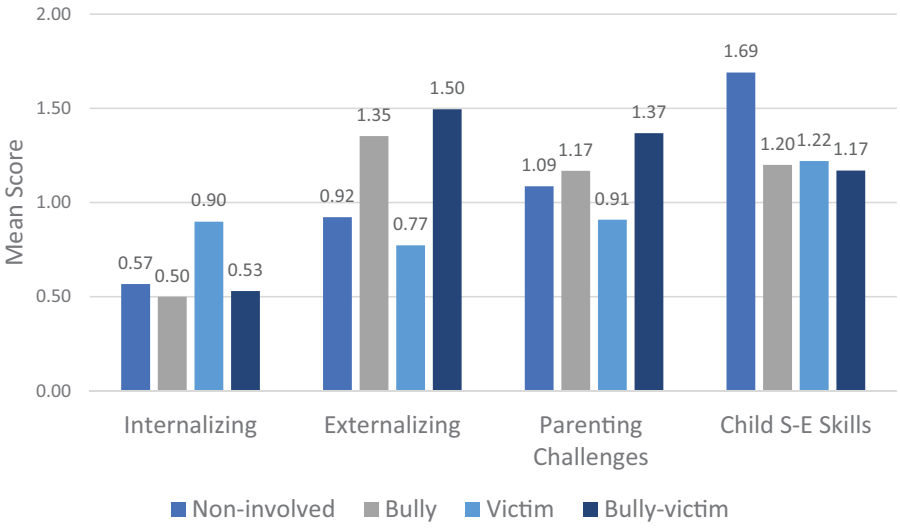

Figure 1. Mean dependent variable scores by bullying group.

post-hoc tests showed that victimized children differed from the three other bullying involvement groups on internalizing. Specifically, compared to children in the non-involved group ($M_{diff} = -.30$), the bullying group ($M_{diff} = -.36$), and the bully-victim group ($M_{diff} = -.32$), children in the victim group were significantly more likely to experience internalizing symptoms.

Externalizing behavior

A follow-up ANOVA showed that differences on externalizing behavior among the bullying involvement groups were statistically significant, $F(3, 87) = 9.871$, $p < .0001$, $\eta^2 = .254$. Tukey post-hoc tests revealed that compared to children in the victim group, children in the bully group ($M_{diff} = -.56$) and the bully-victim group ($M_{diff} = -.71$) were significantly more likely to experience externalizing symptoms. In contrast to the children in the non-involved group, children in the bully-victim group were significantly more likely to experience externalizing symptoms ($M_{diff} = -.58$).

Parenting challenges

A follow-up ANOVA showed that parenting challenges varied significantly among the bullying involvement groups, $F(3, 87) = 4.410$, $p = .006$, $\eta^2 = .132$. Compared to the other dependent variables, however, there was much less variation in parenting challenges across groups. Tukey post-hoc tests showed that in comparison to the victim group, the parents of bully-victims were more likely to experience challenges ($M_{diff} = -.37$). No other between-group comparisons reached statistical significance.

Child social-emotional skills

A follow-up ANOVA showed that child social-emotional skills varied significantly among the bullying involvement groups, $F(3, 87) = 5.415$, $p = .002$, $\eta^2 = .157$. Tukey post-hoc tests showed that the group of non-involved children stood apart from the three groups of bullying-involved children. These results revealed that compared to the bully group ($M_{diff} = -.50$), the victim group ($M_{diff} = -.48$), and the bully-victim group ($M_{diff} = -.52$), children in the non-involved group were significantly more likely to have effective social-emotional skills. Furthermore, the data indicated that there were no significant differences in levels of social-emotional skills among children in the bullying, bully-victim, and victim groups.

Discussion

Children who struggle with mental health difficulties are at increased risk of bullying involvement, and research is clear that these stressful social experiences aggravate underlying mental health issues (Arseneault et al., 2006; Clark et al., 2021). The current study is intended to contribute to the very limited knowledge base on the bullying-related experiences and needs of these children. We investigated the association between the type of bullying involvement, on the one hand, and mental health indicators (internalizing and externalizing), parenting challenges, and the child's social-emotional skills, on the other, in a sample of children accessing community mental health services.

We know very little about bullying as it relates to children receiving clinical care, as vast majority of studies on bullying involve school samples. In Canada, where the current study was undertaken, the population-based Health Behavior in School-aged Children survey (HBSC; see www.hbsc.org) indicates that rates of total bullying involvement hover around 30%, with 22% reporting having been victimized on a regular basis, 3% bullying others, and 5% bulling others and being victimized (Freeman et al., 2016). Data on bullying among young children, like those in our sample (M age = 8), indicate similarly high rates of bullying and victimization: Arseneault et al. (2006) reported bullying and victimization rates of 17.3% and 12.1%, respectively, in their large, nationally representative sample ($N = 2232$) of 7-year-old children in the UK. In contrast, total bullying involvement of the children in our clinical sample stands at 83.5%, far exceeding typical rates of bullying involvement found in community samples. We located only one other similar study, which assessed bullying involvement rates among adolescents (M age = 13) receiving mental health services, and it revealed a similar trend, with rates of bullying involvement significantly

exceeding rates in the general population of youth (Paradeisioti et al., 2019).

Another striking contrast with trends in population-based findings is the vastly larger proportion of children involved as bully-victims: 38.5%, and the largest of the four bullying groups in our sample. This is particularly concerning, given that numerous prior studies have identified these children as having the highest risks for negative effects of bullying involvement. For example, in one recent study of Australian middle school youth (Kelly et al., 2015), students in the bully-victim group displayed the highest levels of suicidality, internalizing, and externalizing problems relative to students in the three other bullying groups, with one-third of them reporting frequent suicidal ideation compared to 5% among non-involved youth. Our own findings largely replicate this trend for children in the bully-victim group who displayed the highest levels of psychosocial issues (see Figure 1).

On their own, the prevalence of bullying involvement among children receiving clinical care is very concerning, but the literature on bullying suggests that the combination of school bullying and concurrent mental health difficulties points to reasons for additional concern. There are well documented bi-directional causal links between bullying and mental health difficulties (cf. Reijntjes et al., 2010, 2011), and in light of what is known about cumulative risks across social contexts on child development (Evans et al., 2013), it seems reasonable to expect that these negative school experiences will contribute to worsening of mental health issues for these children. This signals an urgent need to find ways to meaningfully connect the different systems in which these children live: the family, the school, and the mental health system. Synergistic and coordinated action across systems seems particularly urgent to help these children navigate a range of psychosocial hurdles in these closely linked social contexts. There have been significant efforts to connect school and mental health systems for the benefit of children in recent decades, but challenges remain: Schools and mental health systems more often operate in parallel with little collaboration (Power, 2003). More needs to be done to connect these systems, so that efforts in one context are not undone by the adversity encountered in another.

Our analysis of concurrent links between mental health indicators and bullying involvement showed that children who were victimized were likely to have more internalizing symptoms relative to children in the bully, bully-victim, and non-involved groups. This finding is aligned with previous findings, which shows a consistent and robust association between victimization and internalizing behaviors. Cook et al. (2010) in their meta-analysis found that internalizing was one of the strongest predictors of victimization ($r = .25$) in their set of 14 individual and contextual predictors.

The findings of this study point to an association between children who perpetrate bullying, whether as a bully or as a bully-victim, and externalizing behavior. This result certainly was anticipated by earlier research that has consistently identified links between externalizing and bullying perpetration (Fergusson et al., 2014). Lee et al. (2016) studied how bullying behavior related to trajectories of externalizing from childhood to adolescence. The researchers found that children with high or increasing bullying behavior into adolescence also showed increasing rates of externalizing behavior. On the other hand, children with decreasing bullying into adolescence showed decreasing externalizing. The authors noted the continued importance of addressing bullying in young children, given the recovery observed on externalizing when bullying decreases.

Our findings also revealed differences across bullying involvement groups in relation to challenges faced by parents. The parents of children in the bully-victim group were assessed as having the most significant challenges followed by parents of children in the bully, non-involved, and the victim groups. Numerous studies in recent decades have probed multiple, complex links between family life and school bullying. For example, coercive cycles in parenting interactions in which parents initially use coercion to assert their will and then end up "giving up" when their child refuses to desist serve to reinforce conduct problems and aggression in children (Granic & Patterson, 2006). Modeling and vicarious learning can also be pathways to peer aggression, as Gómez-Ortiz et al. (2016) explain how children learn the tactics of psychological aggression from parents and turn these against their peers at school.

We examined a subset of children's social-emotional skills and how they relate to bullying involvement. A clear pattern emerged whereby those who were not involved in bullying were assessed by clinicians as having stronger skills than children in the victim group, bully group, and bully-victim groups, who did not differ in their assessed strengths. Hilliard et al. (2014), who studied links between type of bullying involvement and character virtues (moral, civic, and performance) found a similar pattern of individual strengths, with youth in bullying and bully-victim groups showing lower levels of character virtues than non-involved youth. There is also some limited evidence suggesting that developing social-emotional skills can curtail bullying and boost classroom climate. Rawana et al. (2011) evaluated a strengths-based bullying prevention program called Strengths in Motion (SIM) and found that reports of victimization decreased, and classroom climate and students' personal awareness of their strengths increased at follow-up assessment several months after program implementation.

Study strengths and limitations

One aspect that makes this study unique is its multi-informant perspective. Our study incorporates the perspectives of parents and clinicians to capture a wider understanding about challenges and strengths faced by children in our sample. This strength at the same time also points to a limitation: the missing voice of the children themselves. To gather a more robust account of bullying involvement, future studies would benefit from including the perspective of the child in addition to the parents' perspective, as many children do not disclose bullying when involvement is perceived as mild to moderate (Holt et al., 2008). The study is both strengthened and limited by the clinical origins of our dataset. Its strength lies primarily in the external validity of the dataset. However, as the dataset was not conceived originally for research purposes, some information that would be valuable for this study was missing (e.g., the history of prior contacts between families in this study and the agency).

Our measure strategy for bullying involvement also imposes limits. We used a single item measure for bullying and for victimization, and participants were not provided with an operational definition of bully as recommended by Vaillancourt et al. (2008). Finally, our study is limited by the low alpha reliability for the internalizing behavior and individual strengths scales, which invites caution in interpreting and generalizing our findings.

Implications for practice and research

Given the very high rates of bullying involvement in our sample of children receiving mental health services and considering the toxic effects of bullying on mental health, it seems advisable that mental health professionals in community settings conduct routine screening for bullying involvement at intake with their child and youth clients. An example of such a screening tool that might be appropriate for child/youth mental health agencies is the Bullying and Ostracism Screening Scale (BOSS; Saylor et al., 2012). This brief (16-item) scale was developed and validated for use in pediatric health care settings and is available on a noncommercial basis, with 8 items assessing perceptions of school climate and 8 items assessing bullying involvement (4 assessing bullying others and 4 assessing victimization). The later 8 items can used to identify bullying involvement types, as we did in the current study. This seems particularly relevant for child/youth-serving agencies, given the different symptom profiles and family challenges that are associated with the different bullying involvement types, and these differences will have implications for treatment planning (Kelly et al., 2015). Unfortunately, at this time there are very few resources available to community agencies to guide their intervention planning in relation to bullying.

Shetgiri et al. (2015) offers one such resource for clinicians providing mental health treatment to children and youth involved in bullying. The sparse resources on this important issue also highlight an urgent need to develop and evaluate clinical interventions for children who are accessing mental health services and are involved in bullying at school.

The findings of this study suggest that child skills and strengths have the potential to act as a protective process for bullying involvement, and this seems particularly important for children with mental health challenges who likely have gaps in this regard. To help address the prevalence of bullying involvement in this high-risk population, mental health agencies might find it helpful to use a strength-based treatment approach when addressing bullying involvement. By fostering the child's strengths including social skills, self-expression, and adaptability to change, there is the potential to decrease bullying involvement while providing benefits in other aspects of the child's life. For example, children who are lagging in the skills required to effectively navigate difficult social situations at school would be at greater risk for bullying involvement. An example of a framework that helps children develop the necessary skills is Collaborative Problem Solving (see https://www.livesinthebalance.org/about-cps), which is a framework that posits that "children do well when they can," that is when they have the requisite psychosocial skills to effectively navigate the challenges at home, school, and in their peer groups (Greene, 2008). Pepler and Craig (2014) present a strengths-based framework for working with children who bully and those who are victimized. While conceptualized for use in a school context, we believe that the assessment and intervention guidelines could be easily adapted for use in a clinical context. Finally, it is vital to support these efforts with open communication between the school and mental health agencies with the goals of bringing alignment and collaboration across contexts and a more holistic and integrated approach to address peer bullying involvement among vulnerable children who are accessing clinical care (Pepler & Craig, 2014).

Ethical approval

This study was approved by the University of Ottawa Ethics Board.

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