BULLYING AND VICTIMIZATION AMONG STUDENTS WITH EXCEPTIONALITIES

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Abstract

Children and youth with exceptionalities are at increased risk to be marginalized in their peer group because of their exceptionalities; they are hence more vulnerable to victimization by peers who have higher status and more social power. Research also suggests that children and youth with exceptionalities may be more likely to bully others. Without supportive relationships with peers and with adults, children and youth who have physical, learning, intellectual or emotional disabilities may be less able to achieve important developmental tasks and full quality of life. Using a developmental and systemic-ecological perspective we outline bullying prevention and intervention strategies to scaffold individual students' healthy relationship skills and to create a positive and inclusive social climate at school.
Introduction

Bullying is wrong and it hurts

The UN Convention on the Rights of the Child (UNCRC) (United Nations, 1998) identifies adults as responsible to protect children from all forms of physical and mental violence, injury or abuse. The UNCRC further asserts that children with mental or physical disabilities “should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child’s active participation in the community.” Bullying and harassment constitute abuse at the hands of peers and violate the rights of children and youth. In this article we review international and Canadian research indicating that children and youth with exceptionalities are more vulnerable to bullying and victimization problems than their peers. In fulfilling the responsibility to provide support to children and youth with exceptionalities and ensuring their right to be safe, adults must be sensitized to their peer relationships and proactive in promoting a positive social context in a way that respects their dignity.

In this article we focus mainly on the school experiences of children and youth with exceptionalities; however, it is imperative to remember that experiences within the family and within the community play a key role in determining children’s quality of life. After the family, school represents the most dominant social context for children, and the overt and covert messages that children and youth receive determine their feelings of self-worth and identity as they move towards adulthood. Friendship and positive peer relationships are critical for children’s healthy development (Cairns & Cairns, 1994).

Being bullied by peers can be extremely painful and undermine children and youths’ self-worth. The experience of victimization is associated with psychosomatic symptoms, social withdrawal, depression, and suicidal ideation (Forero et al., 1999; Kaltiala-Heino et al., 1999). Children who bully others are also at risk for depression and suicidal ideation (Kaltiala-Heino et al., 1999) as well as antisocial development more generally (see Pepler, Lamb & Craig, 2006 for a review). The World Health Organization (WHO) stresses the importance of “participation” (engagement in a full range of developmentally appropriate social, recreational, and skill-building activities) in determining quality of life (Colver, 2005). According to the WHO, quality of life indicators include emotional, material and physical well-being; interpersonal relations, absence of pain and discomfort, self-esteem, self-determination, social inclusion, and individual rights. Research indicates that the experience of being bullied has the
potential to undermine all of these elements of quality of life (Pepler, Lamb, et al., 2006).

**Bullying is a relationship problem**

Through our research, we have come to understand bullying as a relationship problem, rather than a problem with an individual child's aggression. The child who bullies is repeatedly learning how to use power and aggression to control and distress another. The child who is repeatedly victimized becomes trapped in a relationship in which he or she is being abused and is increasingly unable to escape. Unequal power between the child who bullies and the child who is victimized is the defining feature of bullying. Bullying comprises a power dynamic that tends to consolidate over time. The child who bullies is increasingly reinforced by feelings of power and by attention from the peer group. Conversely, the child who is victimized becomes increasingly distressed and humiliated, stigmatized in front of peers, and increasingly vulnerable and excluded. Bullying behaviour occurs covertly, and children who are victimized are reluctant to tell adults because of fears of retaliation from those who are bullying them and feelings of shame.

**Promoting relationships and eliminating violence is everyone's responsibility**

The “social model of disability” highlights the importance of individuals' social and environmental context in determining the extent to which their exceptionalities are actually disabling (Antle, 2004; Oliver, 1990). Unlike the “medical model” in which disability is seen as a characteristic residing within individuals, the “social model” is based on the recognition that disability arises from individuals’ transactions with their social contexts. Each individual is embedded in an ecological framework of family and peer relationships, nested within neighbourhood, schools and other institutions, operating within communities, various levels of government, and society (Bronfenbrenner, 1979). Within their multiple social contexts children with exceptionalities may experience acceptance, positive validation for their strengths and talents, and support in coping with their weaknesses; but all too often they experience rejection, negative reflections of their worth, and barriers to inclusion and participation (Antle, 2004). The social model of disability points to children's social relationship contexts as the appropriate focus for bullying prevention and intervention efforts. This social disability model is consistent with a systemic-ecological framework that has been advocated to address bullying (Mishna, 2003; Pepler & Craig, 2000; Pepler, 2006; Smith, Pepler, & Rigby, 2004).
Adults are responsible for creating positive environments that promote children’s healthy relationships and minimizing opportunities for negative peer interactions. By observing children’s relationships, adults can organize social activities in ways that protect and support children’s developing relationship skills and minimize the likelihood of bullying. All adults are models for children and must lead by example and refrain from using their power aggressively. To prevent bullying in the relationships of children and youth with exceptionalities and to intervene to transform relationships in which bullying has emerged, we use a conceptual framework that is bifocal, with simultaneous attention to both a developmental and a systemic-ecological perspective (Pepler, 2006). Using the developmental perspective, we focus on the individual child who bullies, is being bullied, or witnessing bullying and we consider issues such as age, gender, capacity, risks, and protective factors. Using the systemic-ecological perspective, we focus on the dynamics in the child’s relationships within the family, school and community (Germain & Bloom, 1999). We consider systemic processes and identify needed change in the child’s social contexts in order to promote healthy, inclusive, respectful relationships.

In this article we first review research on the links between exceptionality and involvement in bullying and victimization. In the second part of this article, we outline suggestions for preventing bullying through building awareness of the issue of bullying and promoting a positive and inclusive social climate. We conclude by suggesting strategies for intervention. Although the focus of this literature is on children and youth with disabilities, it is essential to maintain a dual focus on the child and the relationships in which the child is embedded.

Our research has shown that peers are present in 85% of bullying episodes on the elementary school playground (Craig & Pepler, 1997; Atlas & Pepler, 1998). Peers spend most of their time passively watching the bullying event unfold, but some of the time they also join in the bullying behaviour or intervene (O’Connell, Pepler & Craig, 1999). When children do intervene, they are just as likely to use appropriate strategies as aggressive strategies (Hawkins, Pepler & Craig, 2001). Regardless of the type of strategy used, in the majority of cases peer intervention is successful in stopping the bullying within ten seconds (Hawkins et al., 2001). These findings highlight the pivotal role that peers play: as passive witnesses or joiners they send the message that bullying is acceptable; when they intervene to stop the bullying, peers can effectively change the power dynamics in bullying.
Prevalence of Bullying and Victimization Problems among Children with Exceptionalities

Our discussion of children with exceptionalities includes children with physical, learning, intellectual, and emotional disabilities, in keeping with the perspective of the Canadian Council on Social Development (CCSD) (2003). While the following literature review focuses on raising awareness of the increased vulnerability for bullying and victimization problems of children and youth with exceptionalities, it should be recognized that there are substantial individual differences among these children and youth, and the majority enjoy positive relationships with peers. According to the CCSD (2003), using data from the 1998 National Longitudinal Survey of Children and Youth (NLSCY), 24.5% of children with special needs, aged 10-15, feel left out at school, compared to 17.5% of children without special needs. Children with special needs, aged 10-11, reported that they are bullied more often than their peers: 10.6% reported that they are bullied "all or most of the time" (versus 5% of peers) and an additional 12.2% reported they are bullied "some of the time" (versus 6.4% of peers). Fewer children with special needs reported that they get extra help from their teachers when they need it "most or all of the time" (80.1%) than did children with no special needs (85.4%). Seventy-seven percent of children with special needs reported that their teachers treat them fairly "all or most of the time," compared to 90% of children with no special needs. Taken together these data indicate that Canadian children with special needs are at an increased risk of victimization and marginalization at school.

There is substantial evidence that children in special education classes, compared to mainstream students, are stigmatized, more socially rejected and more frequently victimized by peers (Mishna, 2003). Like the Canadian research cited above (CCSD, 2003), this research groups together students with diverse disabilities so it is difficult to ascertain the risk for bullying and victimization that specific exceptionalities entail (Mishna, 2003). Unfortunately, there is very little research focusing specifically on bullying problems among children and youth with physical disabilities (Yude, Goodman, & McConachie, 1998) and even less concerning children and youth with intellectual disabilities (Horner-Johnson & Drum, 2006). In the following section we review a few studies that, taken together, paint a disturbing picture of the social vulnerabilities of children and youth with disabilities.
Children and youth with physical disabilities

Physical disabilities comprise mobility, sight, and hearing problems. Hemiplegia is one such disability and involves partial paralysis or weakness in an arm and leg on the same side of the body, most often resulting from cerebral palsy or childhood stroke, and is often associated with subtle neuropsychological deficits and slightly lowered IQ (Yude et al., 1998). Yude and colleagues (1998) conducted a study in Great Britain of 55 mainstreamed 9-10 year old children with hemiplegia (the “index” children) and each of their classmates. All of the index children were able to walk independently; the severity of impairment ranged from mild to severe. This age group was chosen because the children had all been together in the same school since the beginning of primary school and were consequently well known to one another. Classmates of the index children served as ‘controls’ and were matched for age and socio-economic status.

Yude and colleagues assessed peer relationships through sociometry (Coie & Dodge, 1983); that is, all children in the index children’s classrooms were interviewed individually and asked to name the three classmates they liked to play with most and the three classmates they liked to play with least. Summing the positive and negative nominations allows researchers to place children in the following social status categories: popular (high level of positive nominations), controversial (high positive nominations and high negative nominations), average, neglected (low level of both positive and negative nominations), and rejected (high level of negative nominations). Children were also asked to “nominate” classmates who best fit two behavioral descriptions, “the child who is teased and picked on the most” and “the child who starts fights or picks on others the most.”

Results showed that children with hemiplegia received significantly fewer positive nominations. Twenty-four percent of index children were classified as rejected (compared to 13% of their peers) and 5% were classified as popular (compared to 15% of their peers). Index children had significantly fewer reciprocated friendships. Given their lower status within the peer group, and lack of reciprocated friendships, it is not surprising that they were victimized significantly more than their non-disabled peers, with 45% of the index children moderately or severely victimized compared to 13% of peers. There was no significant difference between the two groups in terms of bullying others.

A study of 59 mainstreamed children with Cerebral Palsy (CP), aged 9 to 12 years, was conducted in Canada by Nadeau and Tessier (2006) and also...
utilized sociometric data. Peer nominations were collected for peer acceptance, peer rejection, reciprocated friendships, and for sociability/leadership, aggression, and social isolation. An additional peer nomination scale was used to assess children’s perceptions of classmates’ verbal and physical victimization. Index children were 60 children (25 females, 35 males) with either hemiplegia or diplegia. Diplegia is a weakness of both legs, and although children with diplegia can walk, they have difficulty with spasticity and coordination. The index children were compared to classmates matched to index children for sex, age, parents’ education, and family income. IQ was statistically held constant in all analyses in order to rule out IQ as a factor responsible for obtained sociometric differences.

The peer nominations indicated that children with CP experienced significantly more verbal victimization, and marginally more physical victimization. Girls with CP were significantly less accepted and more rejected than comparison girls although boys with CP did not differ from same-sex peers. Girls with CP also had significantly fewer reciprocated friendships, were perceived by peers to be more socially isolated and to show fewer traits of sociability/leadership; again there were no significant differences between boys with and without CP on these measures. Nadeau and Tessier (2006) discuss the pronounced gender findings in light of the different social strategies that female and male children use to gain status in the peer group. Girls in middle childhood tend to affiliate with smaller groups of friends whom they perceive as similar to themselves, while boys affiliate in larger groups and are not as selective at this age (Cairns & Cairns, 1994).

Research findings concerning hard-of-hearing (HOH) students in mainstream education settings have been mixed, with some studies suggesting increased risk for social maladjustment while others have not (Kent, 2003). Kent conducted a study in New Zealand of 52 adolescents who were designated as HOH, aged 11-15. HOH status was determined utilizing government records from a community screening program for hearing loss. All HOH students had attended mainstream schooling throughout their school careers. The purpose of the study was to compare the two groups on a self-report survey based on the World Health Organization Health Behaviors of School Age Children. The survey assessed students’ perceptions about school, being bullied or bullying others and about several health-related behaviours such as smoking and drinking.

Overall, there were few significant differences between the designated HOH students and their normally hearing peers on health related behaviours. HOH students did report enjoying school significantly more than their peers,
and this effect was especially pronounced among males. Despite this positive finding, HOH students reported feeling significantly lonelier than their classmates. It may be that HOH students do not often get together with peers outside of school hours and thus school is valued as an opportunity to be with peers. On the question asking whether the respondent had a disability, the majority of HOH students (59%) did not “self-identify” themselves as hard of hearing. The 41% of HOH students who did self-identify, however, reported statistically greater levels of loneliness and peer victimization than all other students. Kent (2003) speculated that those adolescents with more severe hearing loss were less able to hide it from peers, and were therefore more vulnerable to peer victimization.

**Children with learning disabilities**

In contrast to physical disabilities, there is a larger body of research assessing social functioning and bullying and victimization problems among children with learning disabilities (LD). Mishna (2003) reviewed this literature and found converging evidence that, compared to children without LD, children with LD were at greater risk to be bullied, and were characterized as less socially skilled, less cooperative, more shy, and having fewer friends. Many children with LD also have attention problems and are described as impulsive, aggressive, and emotionally immature (Mishna, 2003). There is a significant rate of overlap between LD and Attention Deficit Hyperactivity Disorder (ADHD), with 22% of children with LD reported to have comorbid ADHD (Root & Resnick, 2003). It should be noted that children with LD represent a heterogeneous population with a variety of behavioural profiles. In a meta-analysis of research assessing social skills, Kavale and Forness (1996) found that about 75% of students with learning disabilities have lower levels of social competence than comparison children, as assessed by teachers, peers, and themselves.

Mishna (2003) reviewed three hypothesized mechanisms to account for the lower levels of social competence found among children with LD. The first is that the neuropsychological deficit that underlies the learning disability also underlies such social information processing tasks as the ability to “read” and accurately interpret facial expression and nonverbal as well as verbal communication (Pearl & Bay, 1999). A second mechanism is that the learning disability itself causes poor self-esteem and feelings of frustration at school, which contribute to the child’s tendency to either withdraw from peers or behave inappropriately (Forness & Kavale, 1996; Pearl & Bay, 1999). A third potential mechanism is that isolating children with LD from their classmates (either in a
special class or through withdrawal to a resource classroom) diminishes their opportunities for socialization with typically developing peers (Forness & Kavale, 1996; Lewandowski & Barlow, 2000). It is likely that all three mechanisms interact with each other (Kavale & Forness, 1995). Because academic success is so pervasively valued within the school context, the social model of disability also highlights the role stigma plays. Children as young as grade one can detect differential treatment by teachers that favour the “smart students,” which sets up distinct subcultures within the classroom defined by academic ability (Weinstein, Gregory, & Strambler, 2004). Through social modeling, students are likely not only to pick up on their teachers’ negative attitudes toward children with LD, but to also internalize these attitudes.

Although it is clear that children with LD are at increased risk for being bullied, the evidence about whether they are also at increased risk for bullying others is less definitive (Kaukiainen et al., 2002; Mishna, 2003). Kaukiainen and colleagues conducted a school-based study of self-concept, social intelligence, and sociometric status among 141 grade 5 children from four classrooms in Finland (28 with LD and 111 without). Social intelligence was examined using a peer rating procedure in which children rated same-sex classmates on several items that measured the ability to correctly read and interpret nonverbal cues and flexibly adjust behaviour to accomplish social goals. Bullying and victim status was assessed through peer nomination. Children with high ratings for social intelligence tended to have high academic skills (a significant positive correlation) and low victimization ratings (a significant negative correlation). Children with LD were rated by their peers as low on social skills and significantly higher on bullying behaviour (21.4% of children with LD were nominated as bullies, vs. 6.3% of children without LD). Bullying behaviour was associated with high self-concept only among boys without LD. Thus, two distinct patterns of children who bully emerged: those who are socially skilled with high self-concept, and those lacking social skills. Although LD status was not significantly associated with victimization (10.7% of children with LD vs. 6.3% of children without LD), a group of children with LD were identified as involved in both bullying others and being victimized by peers. These children were socially unskilled and tended to exhibit aggression and impulsive behaviour.

Nabuzoka (2003) conducted a study in Great Britain, which sheds light on the relationship between peer sociometric data and teacher ratings of the social status of children with and without LD. Sociometric data were collected on 55 students (15 with LD and 40 non-LD) selected on the basis that these children had been in the same integrated classrooms the year before and knew each other well. Consistent with the literature, students with LD were perceived
by teachers and peers as significantly less cooperative, with fewer leadership qualities, shyer, and more victimized than non-LD students. Teachers and peers tended to agree on characteristics associated with the children who were nominated as bullies: "disruptive" and "fight-starters." They did not agree about the characteristics of victimized children, however. Surprisingly, teachers associated "victim" status with starting fights, being disruptive and un-cooperative. Peers, on the other hand, associated "victim" status with shyness and seeking help. It appears that peers were able to distinguish the characteristics of children who bullied others frequently from those who were victimized frequently, whereas teachers tended to blur the distinction and tended to see children who were frequently involved in negative peer interactions as being responsible due to their own negative behaviour. The authors suggest that because peers have more opportunities to observe the intricacies of social behaviour, sociometric data provided by peers are especially useful in understanding peer victimization among students with LD.

A recent Canadian study compared 230 adolescents with LD, 92 adolescents with comorbid LD/ADHD, and 322 students without LD or ADHD, matched for age, sex, and school (McNamara, Willoughby, Chalmers, & YLC-CURA, 2005). Students’ perceptions about a large range of psychosocial variables were assessed through surveys administered at school, including loneliness, friendships, and experiences of being victimized. The direct victimization scale comprised being pushed or shoved, sworn at, called names, and teased and ridiculed. The indirect victimization scale comprised receiving hurtful unsigned notes, being excluded, having rumors and untrue stories about them circulated, and having another student dare someone to hurt them. There was a significant and concerning difference among the groups. Adolescents with comorbid LD and ADHD reported the highest levels of direct and indirect victimization, which was statistically significantly greater than the levels reported by adolescents with LD and without LD. In turn, students with LD reported statistically significantly greater levels of direct and indirect victimization than by adolescents with neither LD nor ADHD.

Children with intellectual disabilities

There is a paucity of data concerning bullying and victimization specifically among children and youth with intellectual disabilities (ID) (mental retardation or developmental disability) (Horner-Johnson & Drum, 2006). Horner-Johnson and Drum (2006) recently conducted a review article in which they defined maltreatment to include verbal abuse, theft and other forms of financial mistreatment, neglect, physical, emotional and sexual abuse.
Children, youth and adults with intellectual disabilities were found to face disturbingly high rates of maltreatment in all its forms. Indeed, rates of all forms of maltreatment for people with ID were significantly higher than rates for people without disabilities. The authors conclude that more research is urgently needed to define the scope of the problem and to allocate resources to address it.

Children with emotional disabilities

We have included the less used category of emotional disabilities in our discussion to highlight the fact that 14% of Canadian children have mental health conditions, which affect their experiences in school (Health Council of Canada, 2006). The most prevalent conditions are: anxiety disorder 6.4%, attention-deficit hyperactivity disorder (ADHD) 4.8%, conduct disorder 4.2%, and any type of depressive disorder 3.5% (Health Council of Canada, 2006). In comparison to physical and learning disabilities, school personnel are not as likely to be aware of children’s mental health diagnoses due to students’ right to confidentiality (with the exception of ADHD). Nonetheless, knowledge of the prevalence of these conditions can sensitize educators to recognize that the difficult and challenging behaviours they encounter in their students reflect the students’ inner struggles with issues such as anxiety, impulse control, emotional and behavioural regulation (i.e., self-control), or feelings of hopelessness and helplessness.

Currently there is a dearth of research assessing the links between bullying and victimization problems and mental health disorders. One notable exception is an epidemiological study conducted in Finland by Kumpulainen, Rasanen, and Puura (2001). In Stage 1 of this research, a representative random sample of all children born in Finland in 1981 were screened for mental health problems at the age of eight, by having each child, a parent, and a teacher complete a questionnaire. Thus a child could screen negative on all questionnaires (self, parent, teacher) or could screen positive on one, two, or three. In Stage II a random sample comprising 420 children was selected to represent each of the four screening categories (negative, positive on one, two, or three questionnaires). Face-to-face diagnostic interviews were conducted with each of these selected children and separately with a parent. Children were given a psychiatric diagnosis if warranted, and their involvement in bullying problems was categorized as “not involved,” “bully,” “victim,” or “bully/victim.”

Among the children who were not involved in bullying, 22% met criteria for a psychiatric diagnosis. In contrast, 71% of children classified as ‘bullies’
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met criteria for a psychiatric disorder, which was: ADHD 29.2%, Oppositional Defiant Disorder or Conduct Disorder 12.5%, Depression 12.5%, and Other 16.6%. Fifty percent of children classified as ‘victims’ met criteria for a psychiatric disorder, which was: ADHD 14.4%, Depression 9.6%, Anxiety 8.7%, and Other 13.3%. Sixty-seven percent of ‘bully/victims’ met criteria for a psychiatric disorder, which was: Oppositional Defiant Disorder or Conduct Disorder 21.5%, ADHD 17.7%, Depression 17.7%, and Other 10.2%. The authors concluded that school staff and parents should be aware of the significant risk for mental health disorder if a child has frequent and severe involvement in bullying, and that mechanisms for referral to mental health services should be strengthened between schools and service providers.

It is apparent that ADHD stands out as a risk factor for bullying as well as victimization and bully/victim status (Kumpulainen et al., 2001). A qualitative Canadian study of four boys, aged 11-13, with ADHD poignantly illustrates their negative experiences within the peer group (Shea & Wiener, 2003). Through interviews with the boys, their parents, and their teachers, Shea and Wiener found that these boys were chronically excluded by their peers and repeatedly victimized and ridiculed. The boys felt like social exiles, which led to severe psychological and emotional distress. Parents and teachers perceived the boys to be emotionally volatile and immature with poor social skills and poor insight into their social problems. This study highlights how the impulsivity and behavioural disinhibition that are neuropsychological correlates of ADHD (Root & Resnick, 2003) place children at risk for chronic social exclusion and ridicule, which in turn may fuel reactive aggression in the child.

Preventing Bullying Problems among Children and Youth with Exceptionalities

The whole school approach

Universal bullying prevention programs targeted to the whole school have long been advocated to reduce school bullying and have been found to be effective (Olweus, 1991; Pepler, 2006; Smith, Pepler, & Rigby, 2004). Although a detailed discussion of whole school bullying prevention programs is beyond the scope of this article, important components of such programs will be outlined. The reader is referred to the Ontario Safe School Action Team document, Shaping Safer Schools, 2005: <www.edu.gov.on.ca/eng/healthysafeschools/actionTeam/shaping.pdf>. Effective school-based bullying prevention programs are implemented in conjunction with formal bullying policies which are communicated to all
members of the school community, including parents, students, administrators, teachers and adjunct school staff members (such as office personnel, bus drivers and lunch and playground supervisors). School administrators are critical in leading bullying prevention initiatives and ensuring that the whole school community is educated about bullying. Education about bullying includes exploring the power imbalances that define bullying, the rights of all students to feel safe and included, the many forms of bullying, (e.g., physical, verbal, social), gender differences in bullying, and the responsibilities of bystanders to shift positive attention away from those who are bullying and to support those who are victimized. Administrators also ensure that all members of the school community know how to report bullying and know how to respond to bullying problems. Adult members of the school community communicate to students and parents their readiness to take reports of bullying seriously and their commitment to solving bullying-related problems.

Effective bullying prevention programs are ongoing and are seamlessly integrated into the formal and informal curriculum throughout the year. This means that there are formal classroom discussions about bullying at the beginning of the school year, and frequent formal and informal re-visiting of these issues to reinforce and broaden students’ understanding throughout the school year. Maintaining a positive social climate must be an ongoing effort and does not result from a single classroom discussion or school-wide assembly. Bullying prevention programs should begin early in a child’s school career and must be attuned to children’s needs and capacities that vary by age, gender, skills, and background. For example, children as young as 4½ years of age tend to use gender stereotypes to justify excluding a peer from play, but can demonstrate a well-developed sense of fairness and the capacity to use moral reasoning when adults provide prompts to respond inclusively (Killen, et al., 2001). As children develop, their understanding of bullying can be broadened and deepened by introducing such concepts as human rights (to be safe and have one’s dignity respected); responsibilities (to respect oneself and others and protect those who are vulnerable); positive versus negative use of power; strategies for assertive communication and conflict resolution; the harmful impacts of stereotyping and bias; and the promotion of equity, diversity, and social justice. When all the components of a whole school bullying prevention program are in place and awareness of bullying is pervasive throughout the school community, bullying problems can be identified and addressed early and interventions are likely to be more effective (Olweus, 1994; Pepler, 2006; Smith, Pepler, & Rigby, 2004).
The development of prejudice

The goal of mainstreaming children with exceptionalities is to enhance their social development and educational opportunities (Kent, 2003), but without careful planning and attention to providing an inclusive, accepting social climate within a school, children with exceptionalities are vulnerable to being rejected, excluded and bullied. Understanding social developmental processes that give rise to prejudice and stereotyping can provide important insights for planning strategies to foster inclusive social climates for children with exceptionalities (Banks, 2006; Cameron & Rutland, 2006). According to Roberts and Smith (1999) mainstream children’s attitudes towards peers with disabilities depend upon the degree of knowledge they have about the disability, and their perceptions of parents’ and teachers’ expectations concerning disability and inclusion. Often adults feel it is inappropriate to talk directly about exceptionality and difference; however, this silence about the obvious may create an aura of secrecy and shame around the issue of exceptionality. Adults and teachers’ attitudes, whether positive, negative, or ambivalent may be inadvertently communicated through silence, or subtle nonverbal cues (Katz, 2003; Weinstein, Gregory & Strambler, 2004).

Looking at research that examines the way young children develop race bias can be instructive. There is a common misconception that children are born “colour blind.” Katz (2003) conducted a program of longitudinal research in which she investigated the developmental forerunners of racial attitudes in White and Black children aged six months to six years. By six months of age, infants reliably discriminated black and white faces, as evidenced from “habituation” experimental methodology which capitalizes on the fact that infants look longer at stimuli that they perceive to be new or different, and look more briefly at stimuli that they perceive to be same or familiar. By 30 months of age, children are capable of sorting dolls and pictures by race. Between three and four years, children start to demonstrate a preference for dolls and playmates of their own race, demonstrating “in-group” favoritism. Katz’s developmental findings support the theoretical work of Gordon Allport, who in 1954 developed the notion of “social categorization” which is now recognized as a fundamental human social cognitive process (Katz, 2003).

Katz also found that the majority of both White and Black parents in her sample studiously avoided talking about race. Some parents, however, unconsciously modeled in-group preferences when playing with their children by focusing their child’s attention on same-race dolls and pictures. Katz assessed race bias when the children in her study were six years of age, and found varying levels of bias in the sample of children, despite the fact that the parents
in her sample valued racial diversity. Among the minority of families that did discuss race with their children, children’s level of bias correlated with their parents. Predictors of low levels of bias in children when they were six years of age were: watching children’s TV (specifically Sesame Street and similar programs that depicted racial diversity), living in integrated neighbourhoods, socializing within an integrated peer group, and having parents who both valued diversity and talked with their children about race. Katz concluded that the development of race bias is multi-determined; however, the most significant way that parents influence the development of race bias is by not doing enough to inoculate their children against it.

The relevance of this program of research to the study of children with exceptionalities is that educators often make the same mistake, believing that children are “exceptionality blind” and that it is, therefore, preferable not to talk openly about exceptionality. As the work of Katz (2003) illustrated, very young children are indeed sensitive to differences between people and have a human tendency to categorize people into “same as” and “different than” oneself. Moreover, children have a tendency to prefer the “same as me” category and to develop bias towards the “different than me.” While physical disabilities may be salient and easy for very young children to notice, children of early elementary school age rapidly learn to socially categorize children on the basis of behaviour problems and academic achievement (Gest, Domotrovich, & Welsh, 2006). Children with exceptionalities, therefore, may be at heightened risk for marginalization and victimization because of being perceived by peers as “different than me” and this risk may be amplified if the exceptionality entails poor behavioural control and/or poor academic achievement. Children choose friends on the basis of perceived similarity, a process that is accentuated as children approach adolescence (Cairns & Cairns, 1994). In order to promote inclusiveness and respect for diversity, educators must actively teach about exceptionalities and model the ability to see the whole child whose exceptionality is but one aspect of a unique and multifaceted identity. Educating children to reduce stereotyping and bias can be likened to educating children to read and write. Left to their own devices, few children would actually master these skills; however, with effective education universal literacy can be achieved.

Talking to students about exceptionalities

Talking to children frankly and respectfully about differences and disabilities is a healthy approach. Helping children to develop positive attitudes about diversity when they are young, and nurturing such attitudes throughout
development helps to create Canadian citizens who are able to contribute to a positive social climate in the classroom and the school, and eventually in the community and workplace. Teachers may feel unprepared and find it anxiety provoking to discuss disabilities (whether physical, intellectual, learning or emotional) with their students. They may also be concerned about how to have conversations with children and youth in a way that doesn’t embarrass and further marginalize the child with the exceptionality. We suggest that teachers invite an older student or an adult spokesperson with a disability to address the class about the disability and its social impact (including experiences with bullying, if relevant). Public health nurses or spokespeople from disability organizations also have knowledge and expertise to share with the classroom about specific exceptionalities. It is essential to help students understand what they can do to support a child with exceptionalities and what they might be inadvertently doing that could make the exceptional child’s experiences more difficult.

In addition or alternatively, teachers may choose to have a “private” classroom discussion. Planning such a discussion beforehand with the child or youth and the parents can diminish the teacher’s and the child’s anxiety. Ascertaining whether the student would prefer to explain the exceptionality to the class or have the teacher do it, what information the student wants to share, and whether the child would feel comfortable receiving assistance from classmates on an ongoing basis. Including the child in planning is respectful and empowering.

In a classroom discussion, we recommend that teachers frame the discussion by first highlighting the commonalities between the student and classmates, and only then move to a straightforward discussion of the exceptionality. The teacher can invite classroom members to participate in the discussion and ask questions. It is critical that the teacher be ready to use “teachable moments” to guide students in open, tactful, and respectful communication. Teachers should include genuine positive statements about the strengths and talents possessed by the student with the exceptionality. The discussion should be ended with a clear statement of positive expectation that all members of the classroom will be respectful, helpful and caring to one another. In a discussion with grade one students about a classmate who has hemiplegia, for example, a classroom teacher might start the discussion by talking about the child’s brothers and sisters, the child’s favorite activities, foods, books, and TV shows, followed by other children’s siblings and favorite things, thus highlighting the commonalities. Then the teacher can explain the physical disability using simple but straightforward terms, saying something like “Mary has trouble moving her right arm and right leg and this is called hemiplegia. This happened...
when Mary was first born. Mary can do just about everything other children her age can do, but it takes her longer. Children in the class can help Mary by....” As the discussion progresses, the teacher can include genuine and positive comments and comments to remind students of the ways Mary can help them, such as “I am so glad to know Mary because of her sunny smile, how she helps other students with reading and the way that Mary loves to sing.” To communicate positive expectations to the class, the teacher may comment, “I am counting on all of you to help Mary if she asks for help in the classroom and on the playground at recess.”

**Optimal conditions for reducing prejudice**

Allport (1954) proposed the “direct contact hypothesis” which states that face-to-face contact between members of two groups can reduce intergroup prejudice and improve intergroup relations if the contact is carefully structured so that the following four “optimal conditions” are met: (a) equal status of participants; (b) sanctioned by authority; (c) cooperative rather than competitive alliances; and (d) common goals. The contact hypothesis has been supported by over half a century of extensive research among members of different racial and ethnic groups, as well as between people with and without disabilities, as evidenced by a recent meta-analysis (Pettigrew & Tropp, 2006). These four conditions have clear relevance for helping to reduce peer group prejudice, which gives rise to exclusion, rejection and bullying of children with exceptionalities.

It is essential and an issue of basic rights for school administrators and teachers to ensure equal status within the school community of children and youth with exceptionalities. Often children who do not achieve academic or athletic excellence are not given equal opportunity to be recognized, validated and supported. Research has consistently shown that high academic achievers are exposed to more interesting and challenging learning material, offered more opportunities for autonomy and leadership, and receive more positive attention from teachers and administrators (Weinstein, Gregory, & Strambler, 2004). Educators are encouraged to recognize and reward children and youth for other strengths such as caring behaviours, perseverance, honesty, courage, and originality. It is helpful for educators to think deeply and reflect carefully about their own expectations of and responses to students who present behavioural challenges and who learn differently. As stated earlier, even young children pick up on subtle nonverbal cues of negative adult responses and self-fulfilling prophecies (Weinstein et al., 2004). Teachers should endeavor to use equitable practices when choosing children for all leadership roles (even those that seem
inconsequential), ranging from passing out papers or cleaning the blackboard to making announcements at a school assembly or representing the class at a presentation for parents.

The second optimal condition described by Allport (1954) concerns sanction by authority, in other words, the degree to which authorities officially value the inclusion of outgroup members. Sanctifying the integration of children with exceptionalities in school is nominally the case across Canada. There are systemic inconsistencies in policy, however, such that authorities do not allocate financial and staffing resources adequately to meet the needs of children with exceptionalities (Canadian Council on Social Development, 2001). Thus, in practice, official sanction is uneven and inconsistent. Many classroom teachers experience their students with exceptionalities as burdensome. These perceptions likely arise from systemic and institutional factors rather than from a view of the students’ disabilities. These systemic factors include large class size and lack of support from highly qualified personnel such as special education teachers, psychologists, speech and language pathologists, behavioural specialists, occupational therapists and others. Moreover, physical barriers in many schools make it difficult for children with physical disabilities to participate fully in all aspects of school life.

The third optimal condition discussed by Allport (1954) concerns fostering cooperation rather than competition between the two contact groups. Researchers have consistently found that fostering cooperation and collaborative learning is more effective in promoting academic accomplishment than competition for children who belong to ethnic minorities (Weinstein, Gregory & Strambler, 2004), which we suggest is also the case for children and youth with exceptionalities. An atmosphere of competition may motivate able students, but is likely to create anxiety and feelings of hopelessness in students with learning or other disabilities who (accurately) perceive they cannot win (Weinstein, Gregory & Strambler, 2004). Carefully structured collaborative learning opportunities allow the diverse strengths and talents of each group member to be appreciated by all. Measuring success on the basis of individual progress on divergent tasks and tests allows each child to experience a sense of personal agency and success.

The final optimal condition concerns creating over-arching goals and a common identity that subordinates the in-group and out-group identities. In the case of schools, this means creating a sense of belonging to the school community and to the classroom. To create a sense of classroom loyalty and caring, teachers of younger students guide students at the beginning of the year to generate their own classroom rules about caring for each other and not
bullying others. Older students can participate in a classroom 'pledge' ceremony in which all members of the classroom take an oath to refrain from bullying and to respect one another. Successful schools have school celebrations and school traditions that unite students across grades and classrooms. For example, many Kindergarten through Grade 8 schools provide leadership opportunities for senior students by having them organize and supervise structured activities for younger students during recess. Middle and secondary schools can foster a broad range of collaborative activity clubs and interest groups, along with traditional competitive and noncompetitive athletic teams. This allows diverse opportunities for students to interact and experience belonging and common goals. Such practices develop students’ relationship skills as they socialize in a structured, supportive atmosphere.

We use the metaphor of scaffolding, introduced by Bruner (1971) and Vgotsky (1986) to convey the adult’s role in providing temporary structure and support to allow children to rise above their normal level of performance (Pepler, 2006). When applied to victimization problems, adult scaffolding can allow children to acquire and rehearse essential relationship skills such as self-calming strategies, ignoring provocation, identifying and joining caring peers, problem solving, and communicating assertively. Adult scaffolding can enable children and youth involved in bullying to take the perspective of another, develop the capacity for empathy, appreciate that others have rights, control anger, find new ways to excel and engender admiration and attention, communicate honestly, and experience gratification through helping others. The adult scaffolding must be individually constructed for the unique strengths and weaknesses of the particular child or youth – one size does not fit all. Children and youth with exceptionalities who are experiencing problems with bullying or victimization require adult scaffolding to develop relationship skills. The acquisition of these skills will be attained more quickly if the scaffolding is readily available when needed, left in place as long as needed, and consistently applied by adults at school and at home. Thus, communication and teamwork among school staff and between home and school is vitally important.

When a bullying problem comes to the attention of a teacher or educator, through direct observation or because a peer or a parent reports the problem, it is the adult’s responsibility to respond in a way that provides protection and
ensures the dignity of the child who has been victimized. In our experience, some children and youth with exceptionalities downplay or minimize victimization experiences, commenting, “it's not that bad,” “I am used to it,” or “I don’t really mind.” Rather than finding this reassuring, such statements may indicate that the youth cannot express the pain because it feels potentially overwhelming, or the youth cannot appreciate the significance of the violation of his or her rights, or has come to prefer negative attention from peers over being ignored. In any case, the adult must affirm concern, and scaffold the youth’s understanding that he or she is entitled to respect from others and scaffold the youth’s ability to discriminate healthy from abusive relationships. The youth needs support to find new ways to connect with peers, such as joining a structured group or interest club.

Some children and youth with exceptionalities may be able to openly discuss the experience of victimization. It is helpful to listen to the child or youth tell the painful story, and this attentive listening can be therapeutic. Scaffolding the child or youth’s ability to create a coherent narrative, with a beginning, middle and end can help the child or youth make sense of the experience, and sharing the story with a caring listener can bring considerable relief. The adult should reassure the child or youth that he or she does not have to face the problem alone and does not have to feel ashamed, and that a solution can be found. The adult should carefully assess the particulars of the situation: for example, ascertain where and when the bullying is taking place so that an appropriate safety plan can be developed. It is important to scaffold the child’s ability to problem solve by encouraging the child or youth to brainstorm as many strategies as possible, and together evaluate and choose the best strategies for implementation. Common effective strategies include helping the child to identify a helpful peer or an older child who could “buddy” with the child, reaching out to other peers, and staying close to the playground supervisors at recess. It is imperative that the adult remains in close touch with the child, in an unobtrusive way to avoid embarrassment, to find out how the strategies are working.

In our experience children and youth who consistently bully others tend to minimize the behaviour, see it as “a joke,” and appear indifferent or callous to the distress they are causing others. It is vital for children and youth who bully others to be aware that an adult who knows about the situation will remain in touch with the child who is victimized, and that any further bullying behaviour will be known to the adults responsible. We recommend involving other children and youth who may be joining in the bullying or who are providing positive attention to the child who is leading the bullying. The goal is to scaffold all involved children’s capacities to place themselves in the shoes of
the child who is victimized, thereby changing the dynamics within the peer group so that the bullying behaviour no longer engenders attention, tolerance, or admiration. Consequences must be appropriate to the developmental capacities of the children and youth. We recommend formative consequences: those that foster learning about the negative use of power, oppression and injustice, morality and making amends. Since these are universal themes that are prevalent in literature and film, news stories, and history textbooks, these various media can be utilized to promote learning. Students may be required to read an article or story, which they can discuss orally or in writing. The adults who are intervening should adopt a calm but firm attitude in order to model respect and emotional containment, and to scaffold the child or youth’s ability to take responsibility without the need to save face or retaliate.

A focus on scaffolding for individual children is necessary, but not sufficient because the experiences of disability arise from interactions within an exceptional child’s social context (Antle, 2004). To enhance social acceptance and inclusion, it is essential that adults create social contexts that promote positive peer interactions for exceptional children and ensure that there are not situations in which negative interactions can unfold. We have identified this strategy as “social architecture” (Pepler, 2006, Pepler & Craig, in press). To promote positive relationships and reduce the potential for bullying, adults have the specific responsibility of being aware of the unfolding social dynamics within children’s groups and constantly recreating groupings that promote the four key elements to promote inclusion identified by Allport (1954): equal status, sanctioned by authority, cooperative versus competitive alliances, and common goals.

Longitudinal research conducted with whole school populations reveals that there is a relatively small subset of children and youth (ranging from 5 to 20%) who experience frequent and chronic problems with bullying, victimization, or both during their school careers (Craig, Jiang, Pepler, & Connolly, 2006; Pepler, Jiang, Craig, & Connolly, 2006). Children and youth with exceptionalities are likely over-represented within this subset of children, although more research is needed to confirm this.

From a developmental perspective, we are concerned about the repeated experiences of victimization that children and youth with exceptionalities endure. A child who is repeatedly victimized may lose confidence both in the self and in others (Salmivalli et al., 2005), particularly if adults do not intervene and provide protection and scaffolding. Educators are in a unique position to identify students with chronic histories of involvement in bullying and victimization. These students require individual attention to assess the frequency,
history, and severity of the victimization and/or bullying, and the pervasiveness of the problem throughout the child's relationships with peers and with parents and siblings (Craig & Pepler, 2003). Consistent with Kumpulainen, Räsänen, and Puura (2001) and Kaltiala-Heino and colleagues (1999), we recommend that these children and their families be referred to mental health practitioners for support. Collaborative partnerships and teamwork between schools and community mental health providers must ensure that the individual-developmental and systemic-ecological needs of the child are addressed. Evidence-based individual, family, and/or group psychotherapy and case management approaches can provide the more intensive scaffolding of the relationship skills that children and youth who are chronically victimized may lack (Mishna, 1996a, 1996b, 2003; Pepler, 2006). There is wide recognition that evidence-based treatments for aggressive behaviour, including parent training for younger children and problem solving skills training for older children and youth combined with support for parents are effective interventions (Kazdin & Whitley, 2003). Treatments offered early in development to reduce aggressive behaviour are more effective than those that are offered later in development (Beauchaine, Webster-Stratton and Reid, 2005).

Conclusion

Research is beginning to show what parents of children with special needs have long understood: these children are often on the receiving end of bullying by peers, they may become involved in bullying others, and they need support to build healthy peer relationships. To address the relationship problems of bullying for exceptional children and youth, we need to find relationship solutions. These solutions may focus on developing relationship skills and understanding within individual children, but they must also focus on ensuring that exceptional children are fully included and not marginalized through normal peer processes.

We now have an opportunity to address these problems collectively within Canada. The authors of this paper are involved in establishing PREVNet (Promoting Relationships and Eliminating Violence) – a network of Canadian researchers and child/youth-focused national organizations with the vision of stopping bullying in Canada. PREVNet is funded through the Networks of Centres of Excellence – New Initiative program. In its first stage, our goal is to build a network to promote change through four strategy pillars: Education and Training, Assessment and Evaluation, Prevention and Intervention, and Policy and Advocacy. Within PREVNet, we have begun to work with some national
organizations with a focus on exceptional children and youth and are eager to include others in efforts to promote safe and healthy relationships for all Canadian children and youth. As a foundation for PREVNet, we have developed three key messages:

- Bullying is wrong and hurtful
- Bullying is a relationship problem
- Promoting relationships and eliminating violence are everyone’s responsibility.

For in depth discussion of these key messages, please visit our website: <www.prevnet.ca>.

As we move forward and consider mechanisms to improve professional practice to enhance the relationships and social experiences of children with exceptionalities, we are seeking to identify principles that might guide practice regarding inclusion and support of exceptional children. In addition to the PREVNet key messages that apply to all children and youth, several principles are suggested by this review of bullying problems experienced by exceptional children.

Based on the social model of disability (Antle, 2004), it is essential to promote positive interactions to enable children with exceptionalities to achieve optimal development and experience inclusion within the peer context. Three principles arise from this model:

- Exceptional children require positive validation of their strengths.
- Exceptional children require scaffolding to support their development and to enhance their ability to cope with their weaknesses.
- Exceptional children require social architecture so that they are constantly included in positive peer experiences wherever they live, work, and play.

Research reviewed in this paper indicates that active adult direction is essential to promote positive peer relationships for exceptional children. This support can only be provided if the adults themselves are informed and open in discussing diversity related to disability. Therefore, we can suggest guiding principles for children who comprise the social context for exceptional children.
• Peers require adequate knowledge of an exceptionality to be sensitive and responsive to the needs of an exceptional child.

• Peers require adults to be clear about the equal role and value of children with exceptionalities.

• Peers require adults to establish clear expectations that exceptional children are to be included and that bullying is unacceptable and will consistently be addressed.

To conclude, we leave the reader with some questions to ask that will highlight critical issues related to a child's exceptionalities and provide direction to the need for scaffolding and social architecture to promote optimal development and inclusion: What are the strengths and weaknesses of the child, what supports are required, and who can provide them? Do the significant adults in the child’s life also need supportive scaffolding so that they can become attuned to the child’s needs and anticipate and provide the required support? What are the dynamics in this child’s relationships within the family, peer group, classroom, and community? How does the child relate to others; how do others relate to the child? How can this child’s social contexts be reconstructed to minimize the opportunities for negative interactions and to promote positive interactions with other children and adults? Through PREVNet, we are beginning to raise awareness of bullying as a relationship problem. By supporting the development of relationship capacity for all children and adolescents and by providing social contexts that promote healthy relationships, we hope to lay a collective foundation for healthy adaptation and positive relationships across the lifespan.
References


Bullying and Victimization among Students with Exceptionalities


Authors' Note

We would like to dedicate this article to the memory of Dr. Beverley Antle, for her commitment to treatment and research with children who have exceptionalities. She was an Academic and Clinical Specialist in the Department of Social Work and Director of the PKU (Phenylketonuria) Program in the Division of Clinical and Metabolic Genetics at the Hospital for Sick Children. She was an Adjunct Associate Professor in the Faculty of Social Work, University of Toronto. Dr. Antle had a leadership role in facilitating psychosocial research aimed at improving the well-being and quality of life for young people with PKU (Phenylketonuria) and other chronic health conditions. Her areas of interest and expertise included: improving patient and family participation in treatment, fostering successful transitions for young people with chronic health conditions and physical disabilities, developing professional interventions to support parents of young people with chronic and disabling conditions, and bioethics and the complexity of treatment decision-making.

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