Cyberbullying and Its Relationship to Current Symptoms and History of Early Life Trauma:

A Study of Adolescents in an Acute Inpatient Psychiatric Unit

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ABSTRACT

Background: Cyberbullying has received wide media attention and appears to be linked to frequent adverse consequences, with multiple suicides reported. This study examined the prevalence of cyberbullying among adolescent psychiatric inpatients and related it to social media usage, current levels of symptoms, and histories of adverse early life experience.

Methods: Data on the prevalence of social media utilization and cyberbullying victimization were collected from adolescent psychiatric inpatients aged 13 to 17 years from September 2016 to April 2017. Fifty adolescent psychiatric inpatients completed 2 surveys assessing childhood trauma (the Trauma Symptom Checklist for Children and the Childhood Trauma Questionnaire) and the Cyberbullying Questionnaire.

Results: Twenty percent of participants (10/50) had been victimized by cyberbullying. Access to and engagement in social media or Internet-based communication was extremely common, with most participants engaging on a daily basis or more frequently in at least 1 social media activity. Those who had been bullied endorsed significantly higher scores on posttraumatic stress disorder (PTSD), depression, anger, and fantasy dissociation scales than those who were not bullied (all P values $< .05$). Subjects who reported having been victims of cyberbullying endorsed significantly higher levels of lifetime emotional abuse on the Childhood Trauma Questionnaire than those who were not bullied ($P = .013$); however, they did not report a significantly higher level of the other types of trauma (physical abuse, sexual abuse, emotional neglect, or physical neglect). More bullied than nonbullied subjects had clinically and statistically significant elevations in hyperresponse, PTSD, and depression scale scores ($P < .05$).

Conclusions: Being cyberbullied was associated with greater psychiatric symptom severity. Further, histories of emotional abuse were correlated with recent cyberbullying. These data suggest that individuals with histories of childhood trauma also seem vulnerable to continued adverse experiences during adolescence.

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Bullying is increasingly recognized as a major public health issue. Various research-focused definitions of bullying have been advanced, with the US Centers for Disease Control and Prevention (CDC) defining bullying as "when a person or a group shows unwanted aggression toward another person."[1(p1)] As clarified by the US Department of Health and Human Services, the behavior in question must be aggressive[2] and must also involve an imbalance of power (eg, physical strength, popularity, access to embarrassing details about a person) and be repetitive, meaning that it is highly likely to be repeated. As integrated by Olweus and Limber, "There are 3 components to the definition of bullying: (1) It concerns purposeful unwanted negative (aggressive) behavior that (2) typically implies a pattern of behavior that is repeated, and (3) occurs in an interpersonal relationship characterized by an imbalance of power or strength, favoring the perpetrator(s)."[3(p139)]

Adolescents who experience bullying are at greater risk for adverse outcomes, including impairments in both physical well-being and relationships.[4] Victimization by bullying has been associated with lower self-esteem and increased depression.[5] Youth who are victimized by bullying are significantly more likely to need mental health treatment later in life[6] and suffer from mood and anxiety disorders, substance use, posttraumatic stress disorder (PTSD), personality disorders, sleep difficulties,[7] and academic problems.[8,9] The causal direction of these correlations is often unclear in that it is possible that manifesting psychiatric symptoms or having academic problems may also influence the chances of being targeted for bullying.

Regardless how it is defined, studies suggest that bullying is a problem that affects children and adolescents worldwide, with one meta-analysis[10] estimating that 35% of youth are affected by traditional bullying and 15% are affected by cyberbullying. Much lower prevalence estimates were provided by Olweus and Limber,[3] at about 15% and 5%, respectively. However, all evidence suggests that in-person bullying is more common but that cyberbullying is also prevalent. As Olweus and Limber also note, many children who are cyberbullied are also bullied with traditional means as well.

Clinical Points

- There is considerable controversy about how common cyberbullying is and what the correlates, causes, and consequences of cyberbullying are. This study addressed both the prevalence and correlates of cyberbullying in recent inpatient admissions.
- Children with a history of being previously abused are probably more likely to be cyberbullied as well, suggesting that assessments for childhood trauma should also include assessments for cyberbullying and that children who report being cyberbullied should be assessed for history of childhood trauma.

The tremendous penetrance of the Internet into the daily lives of adolescents makes cyberbullying extremely feasible and impactful. In 2015, 92% of teenagers reported going online daily, with 56% using the Internet more than several times a day.[11] Research suggests that many teens spend more than 6 hours a day involved in media,[12] and a troubling proportion of teens meet criteria for "addiction" to Internet and other media use.[13] While interpersonal interactions previously required actual physical proximity, many adolescent relationships now begin on social media platforms and some take place predominantly or exclusively in that arena, with some suggestions that this activity is impacting adversely on positive interpersonal traits such as empathy.[14] It is, therefore, not surprising that bullying, which has always been a regrettable part of the adolescent social landscape, is now found within the cyber world where so many adolescents conduct a large part of their social lives.

Bullying on the Internet has qualities that may make it more potent and harmful than traditional bullying, even if less common. First, messages, images, and pranks can be much more widely disseminated through the Internet than was previously possible. Second, while the physical and verbal attacks of traditional bullying end with the conclusion of the encounter, attacks perpetrated on the Internet can persist indefinitely. Attacks can be conducted in a manner that makes them continuously available to new viewers, and the victim may be reexposed to the attack whenever they become aware of others' having seen these postings. The occurrence of co-rumination has been shown to be associated with psychological problems in children who are peer-victimized,[15] and the Internet makes this possible on an unprecedented scale. Co-rumination is defined by several related behaviors: discussing problems, discussing problems instead of engaging in other activities, discussing the same problem repeatedly, speculation about causes of problems, speculation about consequences of problems, speculation about parts of the problem that are not understood, and focusing on negative feelings. Co-rumination was found to be especially important in children who had been peer-victimized, with the co-occurrence of these two events found to manifest an exponential impact on expression of certain types of depression and PTSD symptoms.[15]

Finally, the face-to-face interactions of traditional bullying ensured that the victims at least knew the perpetrators, while attacks that take place through the Internet can be anonymous or fictional,[16] making it more difficult for prevention strategies to be implemented

If victims of bullying are more likely to experience mental health problems, then adolescents receiving mental health services would logically be more likely to have been victims of either traditional bullying or cyberbullying than their non-patient peers. A study of 353 adolescents seen in an emergency department[17] found that 39% had been victims of cyberbullying, while 47% had been victims of physical abuse. This very high prevalence contrasts to the aforementioned prevalence numbers. There have been substantial variations in the extent of assessment of cyberbullying, and the study[17] used a 2-item question set that clearly could not capture the breadth and frequency of assessment in targeted questionnaires. However, information is more limited concerning the prevalence of cyberbullying among adolescents experiencing more severe problems that lead to inpatient psychiatric care.

Research to date has also not thoroughly addressed the extent to which earlier experiences of emotional, physical, or sexual abuse might sensitize adolescents to the effects of cyberbullying or make them in some way more susceptible. Published data do suggest that some youths who are abused and suffer PTSD symptoms may be at greater risk of being revictimized in the future.[18] Other previously reported risk factors for victimization through cyberbullying include more time online[19] and a history of having been bullied or victimized in other ways.[20] These data raise the possibility that there may be a relationship between a history of abuse, maltreatment, or bullying and the likelihood that one will experience cyberbullying in the future.

There are at least two ways that this history could be operative. First, a history of abuse may sensitize adolescents in a manner that makes them more likely to experience the high volume of hostile messages in the virtual world as personalized and bullying (ie, a hypersensitivity hypothesis). Second, a history of victimization may make an adolescent more likely to act in ways that attract attention of abusive and predatory peers (ie, a vulnerability hypothesis).

The purpose of this study was to find out how commonly adolescents whose mental health issues were of sufficient severity to require inpatient care were victims of cyberbullying; that is, to develop a tentative estimate of prevalence. Second, we wanted to examine the relationship between these recent experiences of cyberbullying and the current expression of internalizing symptoms, externalizing symptoms, and trauma-related symptoms. We also wanted to examine risk factors for being bullied, such as the amount of time spent in social media activities and a history of experiences of abuse or neglect. The general level of maladjustment of hospitalized adolescents would render any differences in these symptoms or other characteristics of the victims and nonvictims even more salient. Through comparison of symptoms in cyberbullied adolescents to those of a cohort of

other adolescents in an inpatient psychiatric unit who have not experienced cyberbullying, tentative conclusions about associations between cyberbullying and severity of mood, anxiety, and trauma-related symptoms may be made.

METHODS

Participants

This questionnaire-based study assessed the correlates of recent experiences of cyberbullying in adolescents aged 13 to 17 years who were admitted to the inpatient psychiatric service at a psychiatric hospital in suburban New York. Adolescents were excluded from this study if they were intellectually disabled or unable to speak English or did not have a parent or adult guardian able and willing to provide informed consent for participation. The University of Miami institutional review board approved this study. This study was conducted from September 2016 to April 2017. Within 7 days of admission, the parents of adolescent patients who met criteria to participate in the study were contacted by telephone. Verbal informed consent was solicited from parents. If verbal consent was obtained, adolescents were contacted by a research assistant who explained the study details to them and requested their assent to participate. Written assent was obtained and signed parental informed consent was documented at the next parent visit.

After parental informed consent and adolescent informed assent were obtained, participants completed 3 questionnaires: a modified Cyberbullying Questionnaire,[21] the Trauma Symptom Checklist for Children [TSCC],[22] and the Childhood Trauma Questionnaire [CTQ].[23]

The Cyberbullying Questionnaire used in this study was a modified version of an instrument developed for use in a study of adolescents at Goldsmiths College at the University of London. Our modified Cyberbullying Questionnaire was updated to reflect social media technologies developed since 2006, including questions regarding access to smart phones and specific social media platforms (eg, Snapchat, instant messaging). This original rating scale has been validated in multiple countries and cultures[24] and has shown high levels of internal consistency, test-retest stability, and convergence with other bullying measures. Questions addressed the frequency of use of various social media platforms, with whom adolescents were communicating, and whether they had been victims of cyberbullying within the last 2 months. Those who denied cyber-victimization did not complete the remainder of the questionnaire, while those who endorsed victimization were asked additional questions about how these messages were transmitted (ie, text messaging, pictures/video clips, Instagram, e-mail, chat rooms, instant messaging, websites, or Facebook). Answers were scored on a 5-point Likert-type scale with scores of 3 or more reflecting occurrence 2 or 3 or more times per month. This frequency criterion was employed to define presence or absence of cyberbullying.

The CTQ is a widely used 28-item self-report questionnaire that asks about experiences of abuse or neglect in childhood. It consists of 5 subscales measuring emotional, physical, or sexual abuse and emotional or physical neglect. It has good internal consistency, and each subscale has items assessing minimization and denial. The CTQ items are scored on a 5-point scale ranging from Never True to Very Often True. It has good reliability and validity in adolescent populations. It requires approximately a 6th-grade reading level.

The TSCC is a 54-item self-report measure for children and adolescents between the ages of 8 and 16 years. Each item has a 4-point frequency scale. Its validity has been studied in adolescents, including those who are hospitalized for psychiatric reasons.[25] It includes scales to detect exaggeration or minimization, anxiety, depression, anger, PTSD symptoms, various forms of dissociation, and trauma-related sexual concerns.

Trained research assistants (ie, advanced doctoral students in clinical psychology) recruited subjects, obtained informed consent, presented questionnaires to the subjects, ensured their understanding of the instructions, and then reviewed the questionnaires to make sure that they were completed correctly. The CTQ and TSCC were manually scored. Subjects' age, sex, and other demographic information were extracted from their medical records. All questionnaires were completed prior to subjects' discharge from inpatient care.

Statistical Analysis

We identified adolescents who had been cyberbullied on the basis of their responses to the Cyberbullying Questionnaire. We then compared frequency of overall social media use and domains of use across the 2 groups of participants with nonparametric tests and then compared the severity as indicated by scores on the TSCC and CTQ with independent-samples *t* tests. Finally, we predicted the 2 domains of TSCC symptoms that were most different across the 2 samples with cyberbullying status and the CTQ variables that also differentiated the groups.

RESULTS

Fifty adolescents completed the study. Demographic information is in Table 1. There were more females than males. Half of the participants were Latino in ethnicity, and 20% were black. A total of 50% of the participants were insured by Medicaid. Discharge diagnoses, grouped into general categories, were mood disorders (n = 30; 60%), conduct problems (n = 10; 20%), and PTSD (n = 10; 20%). There were no diagnostic differences between individuals who were and were not cyberbullied. The vast majority (96% [48/50]) indicated they had access to a cell phone and access to social media networking sites, and engagement in various forms of Internet-based communication was extremely common, with most participants engaged in such communication on a daily basis.

Twenty percent (10/50) reported that they had been a victim of cyberbullying in at least 1 modality within the last 2 months. There were no differences in racial or ethnic

Table 1. Demographic Information for Participants (N = 50)[a]

Variable	Value
Age, mean (SD), y	15.22 (1.89)
Sex	
Male	16 (32)
Female	34 (68)
Racial status	
White	40 (80)
Black	10 (20)
Ethnicity	
Latino	25 (50)
Non-Latino	25 (50)
Insurance	
Medicaid	25 (50)
Commercial	25 (50)
Current grade enrolled	
8	7 (14)
9	16 (32)
10	12 (24)
11	12 (24)
12	3 (6)

[a]Values shown as n (%) unless otherwise noted.

Table 2. Scores[a] on the Trauma Symptom Checklist for Children (TSCC) for Cyberbullied and Non-Bullied Adolescent Inpatients

	Bullied		Not Bullied			
TSCC Domain	Mean	SD	Mean	SD	*t*	*P*
Depression	74.00	15.17	60.68	16.32	2.34	.024
Anger	56.80	7.05	49.20	11.85	2.61	.016
Anxiety	64.40	12.74	56.23	14.59	1.62	.11
Hyperresponse	68.70	20.34	57.93	16.59	1.76	.085
PTSD	66.90	9.23	57.03	12.86	2.79	.012
Dissociation	65.50	11.79	56.98	13.41	1.99	.065
Overt dissociation	65.70	12.82	57.95	14.41	1.66	.116
Fantasy dissociation	60.30	9.39	52.68	11.61	2.18	.04
Underreporting	41.40	9.62	51.05	9.76	3.09	.002

[a]Scores are shown as *t* scores (mean = 50, SD = 10). Clinically significant elevations are present at *t* score > 64.
Abbreviation: PTSD = posttraumatic stress disorder.

Table 3. Scores on the Childhood Trauma Questionnaire (CTQ) for Cyberbullied and Non-Bullied Adolescent Inpatients

	Bullied		Not Bullied			
CTQ Domain	Mean	SD	Mean	SD	*t*	*P*
Emotional abuse	15.70	5.58	11.08	4.91	2.59	.013
Sexual abuse	9.60	7.00	7.55	5.39	1.04	.32
Physical abuse	10.90	5.57	8.33	4.00	1.69	.098
Emotional neglect	12.30	5.01	13.18	5.45	0.496	.65
Physical neglect	8.30	3.09	8.68	3.25	0.33	.74

status or in whether or not the participants were insured by Medicaid. Ninety percent of the bullied individuals (n = 9) were female, whereas 63% of the nonbullied individuals (n = 25) were female, although this difference was not statistically significant.

Cyberbullying victims were engaged in several forms of social media daily or more often: text messaging 80% (8/10), instant messaging 80% (8/10), Facebook 60% (6/10), chat rooms 40% (4/10), Instagram 60% (6/10), and Twitter 40% (4/10). Those who denied a history of cyberbullying were also engaged in social media on a daily basis or more often than that. When the frequency of media usage was compared across the 2 samples, there were no statistically significant differences in the frequency occurrence of overall social media usage, ($\chi^2_5 = 10.48$, $P = .063$), and no individual form of media use was significantly different across the 2 samples.

The modality of cyberbullying in those who met criteria was examined by defining present as occurring within that modality more than 2 or 3 times per month. Using that criterion, 50% (5/10) were bullied by text messages, 50% (5/10) on Facebook, 40% (4/10) by transmitted pictures or videos, 20% (2/10) on Instagram, 20% (2/10) by instant messages, and only 10% (1/10) in chat rooms.

Scores on the TSCC are presented in Table 2. Subjects who reported having been victims of cyberbullying had significantly higher scores on the TSCC PTSD, depression, anger, and fantasy dissociation scales than those who were not bullied. In addition, victims of cyberbullying were significantly less likely to underreport symptoms than those who were not bullied. There were no significant group mean differences in victims of cyberbullying in hyperresponse, anxiety, dissociation, or overt dissociation compared to nonvictims. In terms of clinically significant elevations, the cyberbullied sample as a whole had clinically significant elevations (*t* score > 65) on average for hyperresponse, PTSD, dissociation, and overt dissociation, while scores on none of these scales were elevated on average in the nonbullied sample. When the proportion of individuals who had clinically significant *t* scores was examined across domains, 60% of the cyberbullied adolescents (n = 24) manifested elevations on all 4 scales, while the prevalence for nonbullied individuals was 25% (n = 10) for hyperresponse and PTSD, 23% (n = 9) for dissociation, and 33% (n = 13) for overt dissociation. Chi-square tests revealed significant differences for hyperresponse and PTSD ($\chi^2_1 = 4.50$, $P = .033$) as well as dissociation ($\chi^2_1 = 5.36$, $P = .02$). Differences for overt dissociation were not significant ($\chi^2_1 = 2.57$, $P = .11$).

Table 3 presents data on CTQ scores for the samples. Subjects who reported having been victims of cyberbullying endorsed significantly higher levels of lifetime emotional abuse on the CTQ than those who were not bullied; however, they did not report a significantly higher level of physical abuse, sexual abuse, emotional neglect, or physical neglect. When bullied and nonbullied groups were compared on the dichotomous present/absent classification for the CTQ, the difference was significant, and those subjects who were bullied were more likely to meet clinical criteria for a history of lifetime emotional abuse ($\chi^2_1 = 4.01$, $P < .05$).

In a final analysis, we used cyberbullying status and the severity of emotional abuse to predict the 2 TSCC symptoms that were most different between the bullied and nonbullied cases, depression and PTSD. We performed these analyses in the entire sample of 50 individuals. When we entered both cyberbullying and emotional abuse simultaneously to predict the TSCC variables, we found that both regressions were significant overall. For the prediction of depression, the overall model was significant ($F_{2,47} = 4.02$, $P = .024$), as it was

for PTSD ($F_{2,47}$ = 4.19, P = .021). A stepwise regression model was applied to follow up the 2 simultaneous regressions in order to identify differential prediction of the clinical outcomes across emotional abuse and bullying history. For predicting the severity of depression, only cyberbullying status entered the equation (t_{48} = 2.34, P = .024, R^2 = 0.10). In contrast, for the prediction of PTSD symptoms, only a history of emotional abuse entered the equation (t_{48} = 2.30, P = .021, R^2 = 0.11).

DISCUSSION

This study assessed the prevalence of cyberbullying and its association with adolescent mental health in a psychiatric inpatient population. On the basis of these data, it appears that cyberbullying is not uncommon, with participants reporting a 20% prevalence of victimization. This prevalence of bullying is in the midrange of previous estimates of the occurrence of cyberbullying in the general population and in psychiatric samples. For example, in the initial validation of the Cyberbullying Questionnaire in the United Kingdom in public school students,[21] 20 students, or 22%, had been victims of cyberbullying at least once, and 5, or 6.6%, had experienced being cyberbullied more frequently over the previous couple of months. In our sample, differences in social media contact were not found across cyberbullying victimization status, with both groups having high levels of social media use. While all of the participants in this study were psychiatric inpatients, those who had been bullied had significantly higher scores on PTSD, depression, anger, and dissociation scales than those who were not bullied. Some of the scores on these scales were actually clinically elevated on average in the bullied subsample, and the proportion of subjects with clinical elevations was different across the 2 subsamples for 4 different symptom domains on the TSCC. Finally, there were differences in lifetime histories of emotional abuse between individuals who varied in their cyberbullying victimization status.

These findings suggest, in the context of the limitations described subsequently, that simple quantity of social media contact is not a direct risk factor for being bullied online. The rate of access to the Internet was very high among these adolescents, but not different from those found in the aforementioned previous studies of the general population. Not surprisingly, 86.3% of subjects had access to a cell phone with Internet access, a percentage similar to previous data collected on community samples of teenagers. These numbers are similar to those in previous studies performed for adolescents at large, suggesting that this special subgroup of victims, hospitalized and victimized, are using the same social media platforms as the population as a whole.

Our finding that victims of bullying had more symptoms of PTSD, depression, anger,[26] and dissociation[27] is consistent with past research. Given that both samples were psychiatric inpatients, the elevations in these symptoms are likely to be even more important, and normative information suggested that clinical elevations were more likely to be present in individual cases. Victims of cyberbullying endorsed significantly higher levels of emotional abuse than those who were not bullied, but they did not report a significantly higher level of other types of early life trauma (physical abuse, sexual abuse, emotional neglect, physical neglect). If this relationship is replicated, then there may be some unique consequence of childhood emotional abuse that makes troubled teens more likely to experience or report cyberbullying.

When we compared the importance of recent experiences of cyberbullying and lifetime history of emotional abuse on the 2 symptoms that most greatly differentiated bullied and nonbullied individuals, we found that recent cyberbullying was associated with depression severity and that PTSD symptoms were predicted by lifetime histories of emotional abuse. These findings clearly require replication, but they do suggest that even with overlapping sets of experiences there can be differential prediction of outcomes.

The association between early-life trauma and exposure to bullying has multiple possible origins. It is plausible that early exposure to emotional abuse made these adolescents more likely to expose themselves to situations that led to victimization, possibly by increasing their tendency to engage in interactions with online perpetrators of emotional abuse. This increased frequency of interaction could be due to familiarity effects, habituation to emotionally abusive experiences through repeated exposure, or expression of some behavioral trait that allows perpetrators to identify those individuals most likely to tolerate abuse without terminating the interactions or making a report. One additional area that has been identified as a potential issue is "willingness to share." The extent and personal relevance of media postings can perhaps be a signal to potential bullies that someone is excessively vulnerable to being approached online.[12] Further, it is easy to identify co-ruminators, who may be overly sensitive to negative topics and less able to set aside or ignore negative information sent in their direction online. Cleary, this area is important for further research and identification of the specific characteristics of people who are targeted for cyberbullying and excessively affected by these bullying attempts.

Limitations

The most significant limitations of this study are the small size of the sample and that participants came from only one institution. It is unclear how widely the findings from this study would generalize to larger and more geographically diverse samples. More importantly, it is unclear how specific these findings are to the kinds of adolescents who require inpatient hospitalization versus the broader population of adolescent patients and nonpatients. This sample was also limited by the fact that it did not include early adolescents (ie, 12-year-olds) or late adolescents (ie, 17- to 19-year-olds) and by the fact that the majority of the participants were female. In addition, that only 10 (20%) of these participants reported having been victims of cyberbullying limited the statistical analyses that could be conducted. No formal assessment of

bullying other than cyberbullying was performed. Finally, we do not know the extent to which hospitalizations were directly precipitated by occurrences of cyberbullying.

CONCLUSIONS

These findings suggest that the experience of cyberbullying is not uncommon among adolescents receiving inpatient psychiatric care and, even within the subset of adolescents receiving inpatient mental health services, cyberbullying may be associated with more severe psychiatric symptoms. This experience appears to be related to a past history of emotional abuse earlier during childhood. What remains to be determined is (*a*) the nature of the relationship between cyberbullying and psychiatric symptoms, (*b*) the potentially interactive influence of the history of emotional abuse on that relationship, and (*c*) the presence of these same relationships in less severely symptomatic (eg, outpatient) populations and in the nonpatient population. Given the very widespread use of Internet communications, the apparently high frequency of cyberbullying, and the high frequency of childhood emotional abuse in the general population, answers to these questions are clearly needed.

Clinical Implications

Thorough clinical evaluations of adolescents routinely include a careful review of histories of abuse and neglect and the assessment of possible symptoms including anxiety, depression, and trauma-related symptoms. These data suggest that evaluations of adolescents should also routinely include detailed discussion of their access to and use of social media and the Internet; specific inquiries regarding instances of abuse, persecution, or bullying in these arenas; and a discussion of any reactions they may have experienced as a result of these encounters. Adding these questions to the clinical evaluation of adolescents may bring to light symptoms that may have otherwise been ignored and factors that may be causing or contributing to those symptoms that might then be targeted for specific intervention.

General Implications

Bullying is very common in childhood and adolescence, and bullying through the Internet and social media has the potential for wider and more persistent impacts than in-person bullying. It also seems as if individuals who have been victimized before, particularly through emotional abuse, may be at higher risk. These findings suggest that careful assessments of both bullying experiences and early life trauma should be a part of the clinical assessment of any identified or at-risk children and adolescents. Further, efforts to reduce exposure to cyberbullying through increased care in posting and contacts seem appropriate. Internet use is so common that it cannot reasonably be viewed as a risk factor for being cyberbullied, which seems to involve a combination of risk factors other than Internet access alone. This study did not appear to identify any particularly risky social media platform. Equal consideration should be given to all platforms.

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Additional information: The modified version of the Cyberbullying Questionnaire that was used in this study is available on request from Dr Harvey.

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Editor's Note: We encourage authors to submit papers for consideration as a part of our Focus on Childhood and Adolescent Mental Health section. Please contact Karen D. Wagner, MD, PhD, at kwagner@psychiatrist.com.