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BULLYING OF STUDENTS WITH COCHLEAR IMPLANTS

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Abstract

Bullying has become a hot button topic in the media since the recent suicides of children who were victims of relentless bullying. Bullying comes in many shapes and forms, and children who are identified as weaker or quieter than their peers can fall victim to the abuse of schoolyard bullies. Unfortunately, children with communication disorders often fall into the quieter category. Their communication disorder may be a symptom or consequence of a larger disorder that may also cause them to have social skill impairments. Children with poor social skills may not know how to appropriately interact with their peers or may respond incorrectly to their peers' attempts at social interaction. These social impairments can also open children with communication disorders up to an increased chance of being bullied. To get an idea of how comfortable Speech Language Pathologists (SLPs) felt with getting involved in situations where children on their caseload were experiencing different types of bullying. We sent out surveys focusing on different types of bullying, physical, verbal, relational, and cyber, and asked them to rate how comfortable they felt with 14 different strategies. We received 507 of the 1000 surveys back. I chose to focus on the surveys specifically related to children with cochlear implants. After calculating the mean of the responses, we found that SLP's are comfortable with using strategies to prevent further bullying of children on their caseloads.

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Section 1: Bullying Defined

Bullying is not a new addition to schools and playgrounds, but it has recently become the new hot button topic. Recent media attention on bullying cases has led to the topic being discussed just about everywhere. Many people have jumped on this anti-bullying bandwagon. However, they still don't really have a good idea of what exactly bullying is; that there are different types of bullies and bullying, or what the indicators that a child is being bullied are.

Bullying is not just something that occurs after school on the playground where an older, tougher student demands lunch money. It has infected our computers through social media sites and blogs and it serves as a way to pinpoint students with disabilities, such as students with communication disorders and cochlear implants. Bullying is defined as a subtype of aggression (Blood & Blood, 2004). According to Nansel et al., 2001, bullying is a behavior that was purposely meant to hurt or disturb another person in a situation where there was an imbalance of power between two children, and determined that it happens over time (Blood & Blood, 2004)

According to *Bullying and Teasing: No Laughing Matter* (2012), an article published on scholastic.com, bullying affects 20-30% of school age children and can begin as early as preschool (Scholastic, 2012). In addition, Fried & Fried (1996) reported that more than 160,000 children missed school each day because of their fear of being attacked by bullies. Their study also reported that students deal with about 30 put downs per day, or 230 per week (Blood & Blood, 2004).

Bullying happens regardless of socio-economic status, race, ethnicity, and culture (Scholastic, 2012). Targets of bullies are often smaller, quieter children who may not have the social skills or self esteem to stand up for themselves. These children make easier targets for bullies because they are considered to be weaker than their peers (Scholastic, 2012).

All children may not suffer from the same types of bullying. It takes many shapes and forms, all of which can be incredibly hurtful. Bullying can be verbal, which involves name-calling or insults (Scholastic, 2012). An example of this type of bullying would be one child calling another a “loser”, or telling him/her that s/he is “stupid”. According to bullyingstatistics.org (2009), this is a type of bullying most commonly used by girls (Bullying Statistics, 2009). Girls use the subtlety of their words to hurt and demean someone else because it is not as noticeable as physical bullying. However, verbal bullying can be just as damaging. Instead of a black eye, broken nose, or bruises, children who experience this type of bullying can experience low self-esteem as well as depression (Bullying Statistics, 2009).

A different type of bullying that stems from verbal bullying is indirect bullying. This is a type of bullying also more commonly used by girls, and accounts for 18% of bullying. Indirect bullying involves what is said about a person behind that person’s back through gossip or spreading rumors (Bullying Statistics, 2009). Cyber bullying, or using social media sites, text messages, email, websites, or other online forums to harass, post rumors, or mock another person also falls under the umbrella of indirect bullying (Bullying Statistics, 2009). Social alienation is another branch under the umbrella and can include actions such as excluding a child from a group because the other students are

angry with him/her, or because s/he is different from the other students (Bullying Statistics, 2009).

Physical bullying is the type that most people are familiar with. It can include behaviors such as hitting, kicking, spitting, slapping, and can even include damaging another person's property or stealing from another person (Bullying Statistics, 2009). Physical altercations happen occasionally in school settings, so specific requirements have been established to distinguish between these altercations and true physical bullying. In order for a child to be a victim of physical bullying, the altercations must have happened repeatedly in a situation where there was an uneven balance of power, with the balance leaning in the bully's favor. There must also have been intent to embarrass or demean the victim (Bullying Statistics, 2009).

While verbal and indirect bullying are more likely to occur with girls, boys are more likely to be victims of physical bullying. This type of bullying is more likely to begin in middle school, where puberty hits and some students begin to stand out as smaller and weaker than other students (Bullying Statistics, 2009). Warning signs that a child is being physically bullied can include coming home with unexplained cuts or bruises, wanting to take different or out of the way routes to and from school, asking for rides to school and trying to avoid the bus, complaining of illness before school or school activities, and frequently losing or forgetting items that they took to school with them that day (Bullying Statistics, 2009). The effects of physical bullying can be similar to those of indirect or verbal bullying. Children may suffer not only from physical marks but also from low self-esteem, depression, and in some cases, violent behavior (Bullying Statistics, 2009).

Children who are the victims of bullying do not just have to accept their circumstances and allow the bullying to continue. There are ways to stop the bullying in a positive way, without having the child resort to bullying actions themselves. One of the ways to counteract the bully's mean words or actions is to show the child how much s/he is loved. Ensure that they have an adult to go to when they need to talk, and make sure that the child knows that the bullying is not his or her fault. Involving school administrators is also a way to end the bullying. Once school authorities are aware of the problem, they can find ways to step up supervision in areas where the bullying typically occurs, or deal with the bully directly (Bullying Statistics, 2009). Travelling in groups is also an effective way to stop bullying. Being with trusted friends and having a good support system are ways to show the bullies that what they're doing isn't affecting the child (Bullying Statistics, 2009).

Children should try to avoid the bully as much as possible, but there are also methods children can employ when dealing with the bully face to face. Children should be taught to be assertive, so that they can stand up for themselves and tell the bully to stop. In these types of situations, role playing can help the child gain the courage necessary to stand up to the bully (Bullying Statistics, 2009).

Bullying is a difficult thing for children to deal with, but with a good support system, and good friends, the child's self esteem will not be as heavily affected, as it would be in a situation where s/he is facing the bully alone. One day we will be writing about bullying in the past tense, but until then, it is incredibly important to understand bullying and the effects it has on children.

Section 2: Affects of Bullying on Children with Communication Disorders

Children with communication disorders come in all shapes and sizes. Some may be autistic, some may stutter, and some may have a disorder or disability, such as autism or specific language impairment. They work everyday to overcome issues that may come with their communication disorders and, just like every other child, have the right to go to school, learn, and create bonds with their classmates. However, unlike every other child, they may become the target of bullying because they have a difference that causes them to stand out. Many of the suggestions given to fight bullies include words: tell a parent or a teacher; tell the bully to stop; ask your friends to stand up for you. These actions, which might seem simple to a typically developing student, may be incredible challenges for students with communication disorders. S/he may not be able to tell a bully to leave him/her alone without stuttering or being able to find the appropriate words, giving the bully more ammunition with which to create hurtful comments or names.

“Bullies often focus on smaller, or weaker children with poor social skills or communication skills”, says Dr. Gordon Blood, in an article posted by Penn State University’s College of Health and Human Development (2012). The signs bullies look for can also be symptoms of children with different disorders, such as stuttering or autism.

Children who stutter are often singled out and abused by bullies. According to ASHA, the American Speech and Hearing Association, a stutter can affect the fluency of speech. It can be something like adding an “um”, or a pause to speech, which is called a dysfluency (ASHA, 2010). Everyone experiences these dysfluencies every now and then,

such as when speaking in front of a large group, but dysfluencies can cause a problem when too many are produced. Large amounts of dysfluencies can disrupt a stutterer's every day life, and can happen while the stutterer is trying to talk on the phone, order food in a restaurant, or even when having conversations with friends and family (ASHA, 2010). As a result of their dysfluencies, stutterers may stop participating in activities where they experience dysfluencies or may avoid speaking in conversations (ASHA, 2010). Large amounts of dysfluencies are highly noticeable and can cause bullying from other students.

Langevin, Bortnick, Hammer, and Weibe (1998) surveyed 28 students who stutter, 14 males and 7 females. The results of the survey showed that 59% of the students were teased about their stutter, and 56% of that 59% reported that a serious bullying incident occurred once a week (Langevin, et al. 1998). The research found that 81% of the children said that they were upset by the bullying, and 31% of those 81% said that they were upset all of the time. Out of the 28 children, only 5 had never been teased about their stuttering.

The study also indicated that the majority of the bullying happened outside or inside of the classroom and that the bullies imitated their stutter (Langevin, et al. 1998). While the amount of bullying of the children who stuttered mildly or moderately differed depending on the child, all of the children who stuttered severely were mocked for their stutter (Langevin, et al. 1998).

According to a study by Blood and Blood (2004), data obtained from 53 students who do not stutter and 53 students who do stutter demonstrated that 43% of the students

who did stutter had experienced bullying as recently as the past week, while only 11% of the students who did not stutter experienced bullying. The study found that bullying wasn't the only problem for the students who stutter. They also suffered from lower self esteem and lower perceived communication abilities than their non-stuttering counterparts (Blood and Blood 2004).

Low self-esteem is not the only issue plaguing these students. Studies conducted by Blood and Blood (2007) and Blood, Blood, Boyle, & Nalesnik (2010) show that 63% of students who stutter are also more likely to score one standard deviation above the mean on the Revised Children's Manifest Anxiety Scale, compared to 6% of their non-stuttering classmates. This data lead Blood and Blood (2007) to hypothesize that the cause of this increased anxiety could be caused by higher rates of bullying of children who stutter.

Children who stutter are not the only children with communication disorders that experience bullying from their peers. Children with autism or Asperger Syndrome are also prone to bullying from their peers because of communication or social differences. According to Autism Speaks, an organization that promotes research, support, and understanding of people and families of people with autism, autism is a general term for a spectrum of disorders, all of which are characterized by deficits in social interaction, verbal and nonverbal communication, and repetitive behaviors. The severity of the deficits can occur in varying degrees depending on a student's placement on the spectrum (Autism Speaks, 2005-2012). Those with autism may also experience deficits in intellectual ability, motor coordination, and have difficulty with sleeping and gastrointestinal issues (Autism Speaks, 2005-2012).

In a study of bullying rates of students with autism conducted by Montes & Halterman (2007), 44% of children were bullied (Kowalski & Fedina, 2011). In addition to that study, another done on students with Asperger Syndrome by Little (2002) showed that 75% of children had experienced bullying. Evidence from these studies suggests that these rates may be higher because in addition to having difficulties with communication, children on the autism spectrum also have difficulty with social interactions. These children do not have the ability to read social cues and therefore may respond inappropriately to different social interactions (Kowalski & Fedina, 2011). In addition to these social difficulties, children on the autism spectrum also have high sensitivities to different auditory or tactile sensations, such as bright lights and loud noises and can be determined to stick to a particular routine. These characteristics can also lead to higher rates of bullying (Kowalski & Fedina, 2011).

One particular type of bullying that children with autism or an autism spectrum disorder are experiencing is cyber bullying. Roughly 50% of victims say that they don't know whom was cyber bullying them and that anonymity can be appealing to potential bullies. They have the ability to say things online or in a text that they would never say to the victim's face (Kowalski & Fedina, 2011). The anonymity can also make it difficult to punish bullies. Cyber bullying can be particularly difficult because the victim is exposed to it all of the time. Unlike traditional bullying, where the abuse will end when recess or school is over, cyber bullying can continue once the student is home (Kowalski & Fedina, 2011).

These are only two examples of how students with communication disorders can be prone to higher rates of bullying. Standing out or being different from peers can be

difficult in a school setting and can bring about bullying because other students do not understand why the student speaks or behaves the way that s/he does.

Section 3: Children with Cochlear Implants

When babies are born, parents have wild dreams of what their tiny bundles will accomplish as they grow. Will they become astronauts, doctors, or presidents? Will they get married in a beautiful wedding with mothers crying in the front row? Finding out your baby has a hearing loss can shatter those fantasies and replace them with questions: How will I talk to my baby? Will my baby go to college? How is my baby going to get a job? Today we understand that children with hearing losses can do everything that hearing children can, and more. They may just have to take a different path to get there.

One of those paths may include receiving a cochlear implant to improve hearing and communication. A cochlear implant works by bypassing the damaged part of the ear and directly stimulating the auditory nerve (ASHA, 2012). The implant consists of two portions: an outside portion that sits behind the ear and looks similar to a hearing aid and an internal portion which is placed under the skin through a surgical procedure, typically between 2 and 6 years of age (NIDCD, 2011). There are four parts to a cochlear implant and each part plays a significant role in allowing the patient to hear. The first part of the implant is the microphone that collects sound from the patient's environment. The sound is then sent to the second part, or the speech processor. The speech processor selects the sounds and arranges them. Once the speech processor has arranged them, the sounds are changed into electrical impulses by the transmitter and receiver/stimulator (NIDCD, 2011). The electrical impulses are then sent to the internal portion of the implant, where

they are collected by the electrode array and sent to the appropriate areas of the auditory nerve (ASHA, 2012).

Cochlear implants are becoming a popular choice for children and adults who are deaf or severely hard of hearing. In December 2010, the United States Food and Drug Administration (FDA) reported that 219,000 people worldwide had received implants. That number includes 42,600 adults and 28,400 children in the United States (NIDCD, 2011).

However, even if it seems as if this is the solution many families are choosing for their children with hearing loss, it is important to know the risks of surgery. Any kind of surgery poses risks, and cochlear implant surgery is no exception. The surgery is usually an outpatient one and patients can return to school or work in about a week. The surgery typically lasts about two hours and is performed under general anesthesia (University of Miami School of Medicine, 2009). An indentation is made in the mastoid bone where the internal portion of the implant will sit (University of Miami School of Medicine, 2009). This indentation will hold the implant in place and protect it from damage. After this indentation is made the surgeon will drill through the mastoid bone so that the electrode array can be connected to the cochlea (University of Miami School of Medicine, 2009).

Receiving a cochlear implant is not an easy fix to a hearing loss. Patients who receive implants also receive post-implantation therapy to help them learn speech skills (ASHA, 2012). There are also other factors that can affect how well a patient hears and uses speech after receiving an implant. These factors are related to the patient's age at

implantation, whether or not the patient had language skills at the time of the hearing loss, and the motivation of the patient and the patient's family (ASHA, 2012).

Patient motivation is vital for the cochlear implant use to be successful. Post-implantation rehabilitation usually includes multiple visits to an audiologist and doctors to ensure that the incision is healing properly but also to turn on the implant, make sure it is not too loud or too soft and adjust the implant if necessary. After those initial visits, patients will most likely have appointments once a year to ensure that everything is working properly (ASHA, 2012). Therapy after the implant has been turned on and adjusted can also be very time consuming. Patients who have never had any type of hearing must start from scratch. They must learn to identify the differences between speech, a door closing, and the television because they've never heard any of those sounds before. Even patients who have had some hearing must put in a lot of time and energy. They will learn how to listen, improve their speech and possibly speech-read, and handle their communication responsibilities (ASHA, 2012).

Receiving a cochlear implant is a life changing decision that must not be taken lightly. Patients must be aware of the risks and dedication to recovery and treatment they must be willing to make in order to have a successful journey.

Section 4: Methodology

Purpose of the Study

The previous review of the literature highlights the critical role school personnel play in identifying, intervening, and preventing bullying episodes in the schools. This study is part of a larger scale investigation examining the perceptions, definitions,

knowledge, attitudes and need for training speech-language pathologists (SLPs) about bullying in students with communication disabilities. These studies will add new knowledge about bullying from the perspectives of SLPs' in the schools, especially in relation to the students with communication disorders. The purpose of this study was to explore SLPs' perceptions of possible intervention strategies they thought appropriate based on information provided in eight vignettes describing episodes of bullying in students with cochlear implants. According to the American Speech-Language-Hearing Association (2010) Schools Survey report: SLP caseload characteristics trends 1995-2010, 46% of school-based SLPs provide intervention services to students with hearing disorders. The current paper discusses data collected by Gordon Blood and Ingrid Blood. Questions were adapted to collect data on what kind of strategies Speech Language Pathologists use in different situations for children with different types of communication disorders. The strategies used for children with autism, for example, may be different from the strategies used for children with a stutter. The specific surveys I chose to look at were specific to situations and strategies that would be best for students with cochlear implants.

Method

The methods and procedures for this study are similar to methods and procedures used in earlier published work (Blood et al., 2010; Blood et al., 2011). A brief study is provided, and readers looking for more specific descriptions are directed to those studies. The surveys have received Institutional Review Board approval and began with a short description of the study and of the informed consent process.

A random, proportional, stratified, probability sampling technique for mail surveys was used for this study, as recommended by Babbie, (2006, 2007) and Dillman, Christian, and Smyth (2008) (Babbie, 2006, 2007; Dillman, Christian, & Smyth, 2008; Fink, 2008). For a nominal fee, the names of one thousand potential participants from the American Speech-Hearing Association (ASHA) were obtained. Those one thousand names were on ASHA's Speech-Language-Hearing Mailing Lists of certified Speech Language Pathologists (SLPs) who are working in public schools in the United States.

The survey was made up of five different sections. The first section was made up of informed consent, information forms, demographic items, and SLP practice-related items. The second section consisted of multiple vignettes that were followed by questions. After the initial bulk mailing, follow up surveys were sent at 2, 4, and 8 weeks. 507 responses were received from SLPs (this is a return rate of 50.7%). Thirty two of the responses (6.3%) were found to be unusable because the surveys were incomplete, addresses were incorrect, surveys were undeliverable, or surveys had been completed incorrectly. This left a total of 475 responses, which is a 47.5% response rate for the sample.

Participants in the study included 452 (95.2%) female and 23 (4.8%) male ASHA certified SLPs. Four hundred forty five participants (93.7%) were white, non-Hispanic, 15 (3.2%) were Hispanic American, with a mean age of 42.9 (S.D = 11.1) with a range from 26-67 years. The mean caseload for the SLPs was 51.3 with a range from 19 to 88 children. The mean number of children with cochlear implants on their caseloads was 1.1 (S.D = 0.4) children with a range from 1-4 children. Three hundred and sixty five (76.8%) did not currently have children with cochlear implants on their caseloads. The

average number of years the SLPs had been working was 16.6 years (S.D = 10.3) and have been at their current position ranging from 1 to 44 years.

Stimuli - Vignettes

The research methodology used vignettes to determine perceptions of bullying. Numerous researchers have used this type of methodology in previous studies (Bauman & Del Rio, 2005, 2006; Blood, Boyle, Blood, & Naselnik, 2010; Blood, Robins, Blood, Boyle, & Finke, 2011; Boyle, Blood & Blood, 2009; Crothers & Kolbert, 2004; Kochenderfer-Ladd & Pelletier, 2008; Nicolaidis et al., 2002; Yoon, 2004; Yoon & Kerber, 2003). Eight vignettes were developed for this study. Four of the vignettes described bullying episodes (physical, verbal, relational, and cyber bullying) where the actual event was not observed by the SLP, but were related to the SLP by the victim. The final four vignettes depicted bullying events where the SLP directly observed a child on their caseload being victimized. Each vignette included a specific reference that classified the child as a child with a cochlear implant.

The eight vignettes included the following:

1. **Verbal Bullying not observed:** An 11 year old student who has a cochlear implant tells you during a therapy session about being called a “weirdo boy, freak” by another classmate who then starts mimicking some gibberish language. He explains that it happens every day and now he just walks away and sits by himself. You did not see the event. As an SLP working in the schools, do you think you would...

2. **Physical Bullying not observed:** An 11 year old student who has a cochlear implant tells you during therapy that another child in his class keeps kicking his chair and kicks him when they are in their reading group. He tells you that he asked the classmate to stop and the other student tells him to “shut up and take it”. You did not see the event. As an SLP working in the schools, do you think you would...
3. **Cyber Bullying not observed:** An 11 year old student who has a cochlear implant tells you that another child keeps sending e-mails, instant messaging and texts to other classmates saying he can’t talk and does weird things all of the time. He doesn’t know why the other student is doing these things. You did not see the event. As an SLP working in the schools, do you think you would...
4. **Relational Bullying not observed:** An 11 year old student who has a cochlear implant tells you during therapy that another child starts calling him “metal head”, and then a number of the students start mocking his speech and laughing. You did not see the event. As an SLP working in the schools, do you think you would...
5. **Verbal Bullying observed by the SLP:** You are walking down the hall and see an 11 year old student who has a cochlear implant who is on your caseload being called “weirdo boy, freak” and then start mimicking some gibberish language by another classmate. He just walks away and sits down by himself. As an SLP working in the schools, do you think you would...

6. **Physical Bullying observed by the SLP:** You are observing for a colleague and see an 11 year old student who has a cochlear implant who is on your caseload being kicked and having his chair kicked during a reading group. You observe the student with the cochlear implant ask the other student to stop and the other student tells him to “shut up and take it”. As an SLP working in the schools, do you think you would...
7. **Cyber Bullying observed by the SLP:** An 11 year old student who has a cochlear implant on your caseload shows you copies of emails and text messages that another student keeps sending other classmates saying he can't talk like other kids and does weird things all of the time. He explains that know why the other student is doing these things. As an SLP working in the schools, do you think you would...
8. **Relational Bullying observed by the SLP:** You see an 11 year old student who has a cochlear implant leaving your therapy room and another child room and another child starts calling him “metal head”, and then a number of the students start mocking his speech and laughing and yelling he can't hang around with them. As an SLP working in the schools, do you think you would...

Survey Items

The second section of the survey asked SLPs to respond to 14 potential intervention strategies SLPs working in a school setting may use when responding to bullying. The strategies were chosen based on their use in previous published studies (Bauman & Del Rio, 2005, 2006; Craig et al., 2000; Crothers & Kolbert, 2004;

Kochenderfer-Ladd & Pelletier, 2008; Nicolaides et al., 2002; Swearer & Cary, 2003; Yoon, 2004; Yoon & Kerber, 2003). The SLPs responded to the open-ended statement “As an SLP working in the schools do you think you would...” after reading each vignette. The open ended question was followed by 14 strategies. The strategies included:

1. Report the bullying to other educational personnel;
2. Refer the victim to the school counseling staff for help;
3. Talk with the student with the cochlear implant and try to calm him down;
4. Talk with the student with the cochlear implant and offer to protect him from this happening again;
5. Educate the student with the cochlear implant to report when events occur;
6. Talk with onlookers about their responsibility;
7. Help onlookers take a more active role to support victims;
8. Work with other school personnel;
9. Work with parents of victims;
10. Work with parents of bullies;
11. Educate the student with the cochlear implant to be more assertive;
12. Teach the student with the cochlear implant to pretend not to be bothered;
13. Educate the student with the cochlear implant to blend in better; and
14. Educate the student with the cochlear implant to ignore the child.

The strategies were rated using a three-point scale. Participants were instructed to check Definitely YES (scored 1), SOMETIMES (scored 2), or Definitely NO (scored 3) next to the potential strategy. The 14 strategies were reviewed by 25 randomly selected

school-based SLPs to validate the strategies for the study. The final list of strategies came out of this process with an agreement rate of 92% the selection, likelihood of use, and wording amongst the SLPs.

Procedures

25 forms of the survey were developed. Each survey varied the order of the types of bullying (physical, verbal, relational, and cyber). The 4 non observed vignettes were placed first, and the 4 randomized observed (physical, verbal, relational, and cyber) vignettes were last.

SLPs were asked to read the first vignette, then read and respond to the 14-item strategy list using the three-point scale. Once the first vignette had been successfully completed, the second vignette was presented, read, reviewed, and completed. This procedure was then continued for the third, fourth, fifth, sixth, seventh, and eight vignettes.

Section 5: Results and Research Conclusions

Results

Group mean responses of the Speech Language Pathologists (SLPs) were calculated for the 14 strategies for physical, verbal, relational and cyber bullying.

Group means for the strategy “Report the bullying to other educational personnel” were: Physical 2.8, Verbal 2.8, Relational 2.8, Cyber 2.8.

Group means for the strategy “Refer the victim to the school counseling staff for help” were: Physical 2.8, Verbal 2.8, Relational 2.7, Cyber 2.8.

Group means for the strategy “Talk with the student with the cochlear implant and try to calm him down” were: Physical 2.9, Verbal 2.9, Relational 2.8, Cyber 2.9.

Group means for the strategy “Talk with the student with the cochlear implant and offer to protect him from this happening again” were: Physical 2.7, Verbal 2.7, Relational 2.7, Cyber 2.7.

Group means for the strategy “Educate the student with the cochlear implant to report when events occur” were: Physical 2.8, Verbal 2.6, Relational 2.7, Cyber 2.7.

Group means for the strategy “Talk with onlookers about their responsibility” were: Physical 2.7, Verbal 2.6, Relational 2.8, Cyber 2.5.

Group means for the strategy “Help onlookers take a more active role to support victims” were: Physical 2.7, Verbal 2.5, Relational 2.4, Cyber 2.4.

Group means for the strategy “Work with other school personnel” were: Physical 2.0, Verbal 1.9, Relational 1.8, Cyber 1.9.

Group means for the strategy “Work with parents of victims” were: Physical 2.8, Verbal 2.7, Relational 2.7, Cyber 2.6.

Group means for the strategy “Work with parents of bullies” were: Physical 2.7, Verbal 2.6, Relational 2.7, Cyber 2.8

Group means for the strategy “Educate the student with the cochlear implant to be more assertive” were: Physical 1.8, Verbal 2.4, Relational 2.5, Cyber 2.6.

Group means for the strategy “Teach the student with the cochlear implant to pretend not to be bothered” were: Physical 1.4, Verbal 2.3, Relational 2.4, Cyber 2.3.

Group means for the strategy “Educate the student with the cochlear implant to blend in better” were: Physical 1.4, Verbal 1.7, Relational 1.7, Cyber 1.7.

Group means for the strategy “Educate the student with the cochlear implant to ignore the child” were: Physical 1.2, Verbal 1.4, Relational 1.5, Cyber 1.6.

Discussion

The mean responses ranged from 2.9 to 1.2 and didn’t drastically change depending on what type of bullying was presented in the vignette meaning that SLPs were just as likely to intervene with a strategy no matter if the child was being physically, verbally, relationally, or cyber bullied. The most popular strategy was “talk with the student with the cochlear implant and try to calm him down” receiving a 2.8 mean response in all four bullying categories. The least popular strategy was “teach the student with the cochlear implant to pretend not to be bothered”. The mean responses also showed that the SLPs were more likely to utilize strategies that allowed them to interact with the victim such as working with the victim’s family and were less likely to utilize strategies that would require them to interact with the bully such as working with the bully’s family.

Conclusions

It was excellent to find that SLPs recognize and embrace their role in bullying prevention. With so many children experiencing the affects of bullying it is important

that professionals such as SLPs know what to do when they experience a situation where one of the children on their caseloads is being bullied. One interesting thing that I noted about the data was that strategies that involved the SLP getting directly involved in the situation, such as working with other school personnel, and working with the bully's and the victim's families, had higher mean responses in the physical bullying category than in the other three categories. This demonstrates that SLPs feel more comfortable getting directly involved when one of their clients is being physically harmed than if their client was being called names.

The data also demonstrates higher mean responses for strategies that are directly related to dealing with the victim, such as teaching the victim to report incidents. This makes sense to me because the SLP may know the victim better than the bully and will better know the victim's personality and what strategies will work best for that individual. This is especially true if the bully is not on the SLP's caseload. For the strategy "working with the victim's family" mean responses ranged from 2.8 to 2.6 as opposed to working with the bully's family which ranged from 2.0 to 1.8. It's possible that SLP's are also more comfortable working with parents they've dealt with before.

The mean response rates demonstrated that all of the SLPs felt comfortable intervening to protect and help their clients no matter what type of bullying the child was experiencing. With more professionals taking on active roles in bullying prevention, it is my belief that the day will soon come where the topic of bullying is discussed in the past tense and not the present.

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