Peer Victimization of Children with Hearing Loss

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Approximately one-third of typical school-aged children experience victimization or bullying (*NCES, 2011-336; JAMA.* 2001;285(16):2094). Peer victimization denotes unwanted aggressive behavior(s) by another youth that involves an observed or a perceived power imbalance and can recur multiple times. Certain factors coincide with increased victimization rates, including lower social competence, presence of special needs, and being "different" from the norm (*J Sch Psychol.* 2012*; J Learn Disabil.* 2015; 48(3):239). Children with hearing loss have a higher risk of peer victimization due to differences from the general population physically (e.g., visibility of auditory technology), communicatively (e.g., poorer speech perception, articulation, or language skills), and socially (e.g., difficulty making and maintaining friendships) (*J Sch Psychol.* 2012;50(4):503; *PLoS One.* 2012;7(12): e52174). Our recently published paper examines the prevalence and type of peer victimization experienced by adolescents with and without hearing loss (*Exceptional Children.* 2018;84(3):280).

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BULLYING AMONG YOUTHS

School-aged children in the general population most commonly report teasing, having rumors spread about them, and physical bullying, but gender and social competence affect the rate and type of victimization (NCES, 2011-336). Boys more often experience physical bullying, whereas girls more frequently report social exclusion and having rumors spread about them (*JAMA.* 2001). Children with poorer social skills (e.g., lower quantity and quality of friendships) report higher rates of victimization than those with stronger support systems (*JAMA.* 2001).

Adolescents who do not "fit in" due to cognitive, developmental, emotional, physical, and/or sensory differences experience twice the rate of peer victimization than the general population, and rates increase with chronic or observable conditions (*J Sch Psychol.* 2012; *J Learn Disabil.* 2015; 48(3):239). Adolescents with special needs are most frequently teased, gossiped about, and socially excluded, which diverges from their peers with typical development.

Similar to other children with exceptionalities, children with hearing loss historically have more difficulty making and maintaining friendships (*PLoS One.* 2012). Published rates of peer victimization in children and adolescents with hearing loss vary considerably (17-67%) likely due to differences in participant characteristics (e.g., degree of hearing loss, use of auditory technology, educational setting) and methodology (e.g., parent proxy vs. self-report, ad hoc vs. established instrument; *J Sch Psychol.* 2012; *J Deaf Stud Deaf Educ.* 2011 Spring;16(2):236; *Int J Pediatr Otorhinolaryngol.* 2008 Jul;72(7):1113; *Am Ann Deaf.* 2013 Summer;158(3):334). Despite this variability, research converges on the type of bullying experienced by adolescents with hearing loss, with teasing and social exclusion (e.g., fewer invitations to parties, ignored more by peers) as the most commonly reported issues. These patterns imply adolescents with hearing loss get bullied like children with exceptionalities, but no study has systematically examined the effect of hearing loss on the rate and type of victimization experienced by adolescents.

Our study tackled this issue by administering a well-established survey to adolescents to determine (a) if auditory status affects the prevalence or type of victimization; and (b) if demographic factors (e.g., audiologic characteristics, communication competence, social competence, temperament) differ for bullied versus non-bullied adolescents with hearing loss (*Exceptional Children.* 2018).

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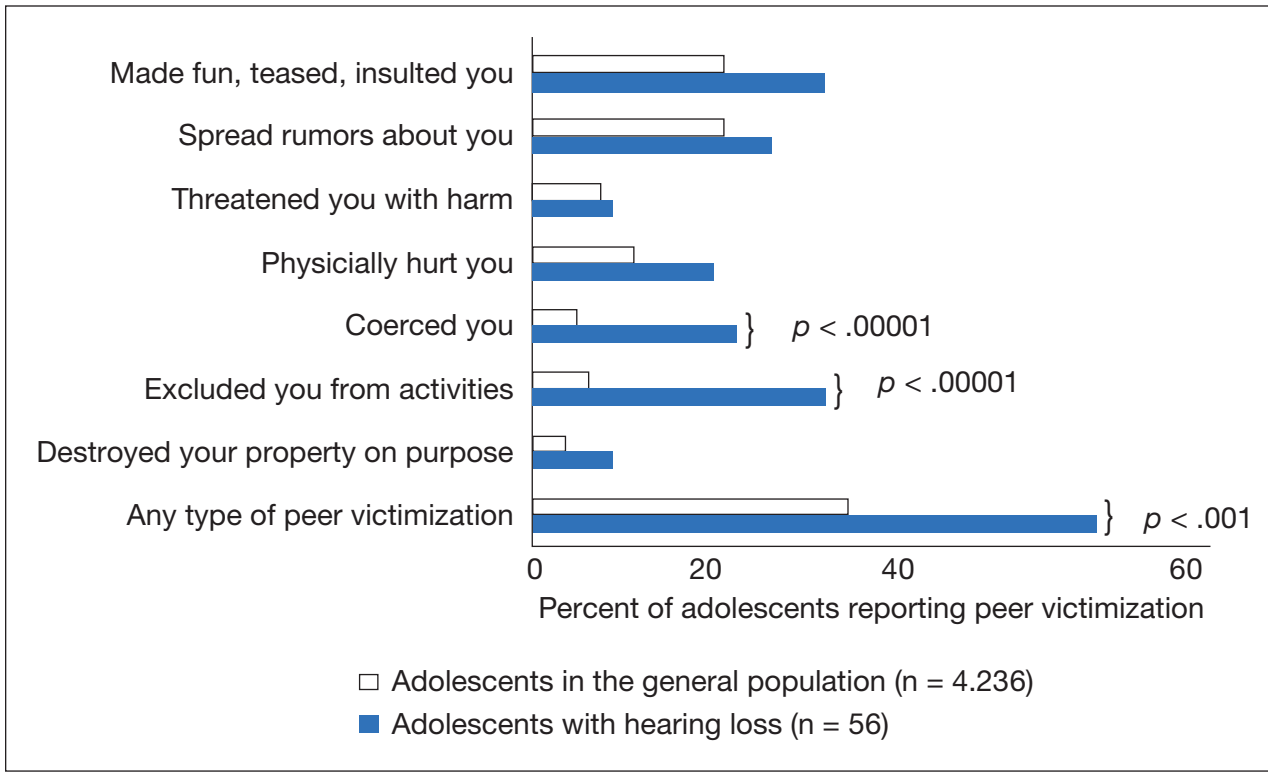

Figure 1. Peer victimization reported by adolescents with and without hearing loss.

STUDY METHODS

Participants included 56 adolescents (ages 12-18 years) with hearing loss, all of whom wore auditory technology (hearing aids or cochlear implants), communicated orally, and participated in mainstream education. Adolescents with hearing loss had a mean age of 14.1 years, mean age at device fitting of 3.3 years, and mean device experience of 10.8 years. Three-fourths wore at least one cochlear implant and one-fourth wore at least one hearing aid. Focusing on adolescents allowed comparison of the prevalence and type of victimization by auditory status to adolescents in the general population (n = 4,326), as reported by DeVoe and Murphy (*NCES,* 2011-336).

Participants completed a series of questionnaires on a tablet or computer. The first questionnaire evaluated self-appraisal of communication competence (i.e., speech perception and speech intelligibility) on a 10-point scale. The second questionnaire explored social competence as a function of quantity of friendships and social engagement (i.e., number of extracurricular activities in which they participated in within the past year). The Early Adolescent Temperament Questionnaire-Revised (EATQ-R) examined performance across four temperament domains (i.e., affiliation, attention, shyness, frustration) and one behavior domain (i.e., depressive mood) likely related to hearing loss and peer victimization (Ellis and Rothbart. Presentation at the Biennial Meeting of the Society for Research in Child Development, 2001). Each participant completed the 2009 National Crime Victimization Survey's School Crime Supplement to assess the occurrence and type of peer victimization. Each participant reported if he/she experienced any of the following: teasing (i.e., being made fun of, called names, insulted), had rumors spread about him/her, received threats with harm, physical harm (i.e., pushed, shoved, tripped, spat on), coercion (i.e., being forced to do something they did not want to do), purposeful exclusion from activities, or property destruction.

STUDY RESULTS

Adolescents with hearing loss who used auditory technology reported significantly higher rates of victimization than adolescents in the general population (50% vs. 28%; Fig. 1). Group differences persisted in the type of victimization experienced. Adolescents in the general population most frequently reported teasing (18.8%), rumors (16.5%), and physical harm (9%). Adolescents with hearing loss similarly reported teasing (25.8%) and rumors (21.1%), but cited social exclusion (26.3%) as the most commonly occurring victimization type. Compared with the general population, adolescents with hearing loss experienced significantly higher rates of coercion (17.5% vs. 3.6%) and social exclusion (26.3% vs. 4.7%).

Men and women experienced peer victimization at similar rates. However, men with hearing loss reported significantly higher rates of coercion (20% vs. 4%) and social exclusion (24% vs. 3.8%) than the general population, and women with hearing loss reported significantly higher rates of social exclusion than the general population (20% vs. 5.7%). The bullied and non-bullied groups did not differ on measures of communication competence, social competence, temperament, or behavior.

Adolescents with hearing loss self-reported twice the rate of peer victimization and more than four times the rates of coercion and social exclusion compared with the published national sample. Our findings mirror previous reports of victimization in adolescents with hearing loss and other exceptionalities relative to the general population (*PLoS One.* 2012; *J Deaf Stud Deaf Educ.* 2011; *Int J Pediatr Otorhinolaryngol.* 2008; *Am Ann Deaf.* 2013). Surprisingly, no personal factors such as audiologic characteristics, communication or social competence, temperament, or behavior differed between the bullied and non-bullied groups.

ADDRESSING VICTIMIZATION

Establishing prevalence is the first step toward addressing peer victimization in adolescents with hearing loss. While current and future research focuses on risk and protective factors contributing to victimization in this population, parents and professionals can act now to increase awareness and improve outcomes. Frequent, open communication between parents and teens not only invokes trust and shared experiences, but may also expedite the awareness of warning signs of bullying, including physical (e.g., changes in sleep or eating patterns), psychological (e.g., withdrawal, anxiety, depression, anger), or behavioral (e.g., irritability, concentration) manifestations.

Hearing health care professionals can incorporate routine screening for bullying via direct questions, as outlined by Squires, et al. (*Audiology Today.* 2013;25(5):18). First, ask the child about friends. A response of "none" or "few friends" deserves additional prompting (Why do you think that is?). Second, inquire if the child avoids going to school and request more information on the assistance the child has accessed. Third, ask the child directly if he or she has experienced bullying. If the child answers "yes," ask follow-up questions and refer the child to school and community resources.

Issues related to peer victimization can also be included on individualized education plans or 504 plans. For example, educational plans can specify informing teachers and classmates about hearing loss. Plans can also include a safe environment statement designating a "home base" where a student can go when feeling unsafe and/or a "safe person" with whom a student can discuss difficult situations. Additionally, education plans could include strategies to reduce vulnerability and improve response to bullying by targeting social pragmatic skills (e.g., taking turns and asking questions; reading facial expressions and body language) via one-on-one instruction, role playing, or social stories. Organizing a social skills group can help children develop social competencies in a supportive environment. Clinicians can also help patients address assertiveness and/or self-advocacy, with specific training to identify and report bullying, say "no" to stop the situation, and request assistance from a trusted source.

Previous research suggests family dynamics represent another factor that could influence peer victimization. Children from families with lower socioeconomic status and parenting styles characterized by abuse or overprotection have higher victimization rates, whereas high-quality, supportive family relationships protect against bullying (*PLoS One.* 2012). Thus, professionals should refer parents and families to appropriate counseling to address family dynamic issues when needed.

Peer victimization demands attention from both parents and health professionals. Increased awareness and routine screening will help identify risk and protective factors for victimization, thereby supporting the development of effective therapeutic intervention to minimize peer victimization and maximize the quality of life of adolescents with hearing loss.