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Appearance-related bullying and skin disorders

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Abstract Bullying encompasses verbal aggression, physical aggression, and social exclusion. It involves "harm-doing" that is carried out repeatedly, over time, and within a relationship, involving a power imbalance between the bully and the bullied. Being bullied may have considerable adverse sequelae, including psychologic or psychiatric harm. Much bullying is appearance-related, and it would be surprising if some individuals with skin disease were not bullied given the high visibility of skin diseases. The limited evidence available does suggest that individuals with skin disease, particularly those with acne, psoriasis, and atopic dermatitis, are often bullied, which can adversely affect them psychologically.
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Introduction

Bullying is a complex construct encompassing elements of verbal aggression, physical aggression, and social exclusion.[1] It is proposed as being aggressive behavior or intentional "harm-doing" that is carried out repeatedly and over time.[1] A defining feature is that it occurs in an interpersonal relationship characterized by an imbalance of power in which the victim finds it difficult to defend himself or herself.[1,2] Distinction can be made between bullying that is "direct," "indirect," and "relational."[1,3,4] Direct bullying involves physical or verbal attacks or aggression. Indirect bullying involves rumor-spreading and gossiping and will often rely on a third party, whereas relational bullying (sometimes considered a subcategory of indirect bullying) involves behaviors such as hurtful manipulation of peer relationships through social exclusion and ignoring.[1,3,4] Bullying is particularly common and problematic among children and adolescents.[2,4-11]

Teasing is often characterized as a specific form of bullying[12] but "can have a milder connotation of verbal and possibly playful aggression." [1] Thus, the construct of teasing may not necessarily meet common definitions of bullying in that it can be "playful" or "pro-social."[13] "Peer victimization" is a further term that is used in connection to, or interchangeably with, bullying and encompasses bullying and teasing,[8] as well as other elements such as harassment. Harassment is similar to bullying, but this term is often used to describe adult or adolescent rather than child behaviors, as in sexual harassment.[14]

A particular variant of bullying, cyberbullying, has been identified. Definitions of cyberbullying are similar to traditional bullying definitions but include "using electronic forms of contact."[15] Cyberbullying can be via text message, e-mail, phone call, and picture or video clip.[16] Research about cyberbullying is still in its early stages,[17] but similar patterns of bullying (and similar patterns of harm arising from this form of bullying) are emerging.[15-17]

Bullying research

Studies of teasing and bullying have often been of bullying in general. Studies of particular circumstances have

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often been of weight-related bullying and teasing, usually in children and adolescents.[8,11,14,18,19]

Teasing and bullying have also been documented in a wide range of medical conditions. Bullying has been shown to be associated with suffering from a chronic medical condition[11,20,21] and with somatic illness.[17] Specific medical conditions in which teasing or bullying of sufferers have been identified include cancer and, particularly, during or after cancer treatment,[22-24] insulin-dependent diabetes mellitus,[25,26] endocrine disorders,[27] congenital heart disease,[28] leukemia,[29] obsessive-compulsive disorder,[30] thalassaemia,[31] Turner syndrome,[32] ophthalmic disorders,[33] learning disabilities,[34] autism spectrum disorders,[34,35] attention deficit hyperactivity disorder,[34,35] specific language impairment,[36] and children with special health care needs.[37]

Bullying in skin diseases

A feature of bullying, both in nonmedical (including weight-related bullying)[8,14,18,38] and in these particular health-related settings[23,24,29,36] is that it is frequently appearance-related. Thus, it would be surprising if bullying were not associated with skin diseases, given the high visibility of skin diseases. Other aspects of skin diseases that render sufferers particularly vulnerable to teasing and bullying are their age distribution and common misconceptions regarding contagion. Many common skin diseases affect children and adolescents—the age groups that are most affected by and most vulnerable to teasing and bullying. Acne and atopic dermatitis are principal examples of skin diseases with high prevalence in children and adolescents and high visibility. Other relatively common skin diseases, such as psoriasis and vitiligo, often have their onset in childhood or adolescence and have significant potential affect on appearance. The appearance of many skin diseases has the potential to invoke misperceptions of being contagious, which also possibly puts the sufferers at risk of teasing and bullying.

Despite this, research examining bullying and teasing of individuals on the basis of their skin disease is relatively sparse. Skin diseases that have been linked to bullying and teasing are atopic dermatitis,[39-42] psoriasis,[40,43] acne,[40,44,45] port wine stains,[46] congenital melanocytic nevi,[47] epidermolysis bullosa,[48] congenital ichthyosis,[49] and hydroa vacciniforme.[50]

Prevalence of bullying in skin diseases

There is limited literature on bullying in skin diseases; therefore, it is difficult to compare the prevalence of bullying in skin disease sufferers with prevalence in other situations. In a schools-based cross-sectional study of Norwegian 15-year-olds,[39] dermatitis was significantly associated with being bullied in boys, with an odds ratio of 1.3 (95% confidence interval, 1.1–1.7), but not in girls. The absolute prevalence of bullying was not reported. Several other studies have, however, reported proportions of participants who have experienced bullying or teasing of various kinds. In a randomized controlled trial of acne treatments,[45] 5.4% of subjects at baseline reported teasing to be the worst aspect of having acne. In a sample of patients with psoriasis recruited from inpatient and outpatient sources in the United States,[51] 27% reported that strangers had made rude or insensitive remarks about their appearance in the past month. A study of congenital melanocytic nevi reported 8% of participants had been bullied.[47]

Elsewhere, the Children's Dermatology Life Quality Index (CDLQI)[52] is a commonly used measure of quality of life in children with skin disease. It consists of 10 items, one of which elicits responses regarding "other people calling you names, teasing, bullying, asking questions or avoiding you" in the past week. In a study that used the CDLQI in children with atopic dermatitis in Hong Kong, 5% reported having been teased or bullied "very much" or "a lot."[41] In primary care in England and Wales, 18% of children with atopic dermatitis reported having been teased or bullied "a little," "very much," or "a lot."[42] In a trial recruiting from specialist practice in the United States,[53] approximately 60% of atopic dermatitis subjects reported having been teased or bullied "a little, very much, or a lot." There were no nondermatitis controls in these studies. In a report of patients with hydroa vacciniforme[50] that used the CDLQI, subject numbers were too small to draw useful conclusions about prevalence of teasing/bullying.

In other studies using the CDLQI, only total CDLQI scores, averages of Likert scale scores on individual items, or "collated groupings,"[52] have been reported. One of these collated groupings is "personal relationships." This consists of CDLQI items 3 and 8—an item asking, "how much has your skin affected your friendships" along with the bullying/teasing item[52]—thus not allowing bullying/teasing-specific inferences.

A major limitation of all these quantitative findings are that they are based on response to a single questionnaire item rather than on results from validated bullying or victimization instruments or scales as are many of the findings from studies in other contexts. Thus, it is difficult to compare prevalence in skin disease with that from studies of bullying in other settings.

The nature of bullying in skin diseases

Alternative approaches have attempted to explore the topic of bullying in more depth. One approach has been to present children with video clips of individual children with and without a (false) facial port wine stain and then assess their attitudes to the children depicted in the videos.[46]

Participants were significantly more likely to think that the children portrayed with port wine stains would attract teasing from their peers.

Three qualitative studies have explored bullying and teasing in patients with skin disease. All used semistructured interviews; one with patients with epidermolysis bullosa,[48] one with patients with congenital ichthyosis,[49] and one with patients with acne, psoriasis, or atopic dermatitis.[40,43,44] Samples in qualitative research are not representative, but these qualitative findings provide in-depth insights into the nature of the bullying and teasing.

In the studies that have been mentioned, teasing and bullying were appearance-based, and in addition to the usual forms of teasing and bullying (mainly verbal but also physical), respondents were upset by the "staring" of strangers at their appearance and "insensate" teasing. Insensate teasing consisted of insensitive or unthinkingly hurtful, rather than deliberately hurtful comments. Teasing and bullying did not correlate well with skin disease severity in these respondents' accounts, especially in epidermolysis bullosa.[48] A feature of teasing related to skin diseases noted in one study[40] was that there was a conspicuous lack of playful or "pro-social" teasing. Teasing was universally negative and hurtful.

One substrate for teasing and bullying in two of these qualitative studies was the lack of knowledge of the teasing and bullying perpetrators concerning the contagious potential of epidermolysis bullosa,[48] psoriasis, and atopic dermatitis.[40] In these studies, there was limited scope to explore a further feature in the general bullying literature—that those bullied may themselves also be perpetrators of bullying.[4] But one respondent noted that on being the subject of contagion-related teasing she had threatened to touch (and thus contaminate) her tormenter.[40]

Psychologic and psychiatric sequelae of bullying

In other settings, bullying and teasing have been associated with mental health morbidity among the target of the bullying. This has included effects on general psychiatric morbidity, depression, anxiety, loneliness, and self esteem,[2,5-11,17,19,21,26,30,39,54-59] psychosomatic complaints,[10,17,21,39,59-62] suicide, suicidality, and self-harm,[63-65] and, in women, psychiatric hospital treatment and use of antipsychotic, antidepressant, and anxiolytic drugs.[66] Health-related quality of life,[5,67] especially psychologic health-related quality of life,[67,68] has also been found to be lower in bullied adolescents.

It is important to recognize that the effects of bullying can be long-lasting, with psychiatric caseness,[55] anxiety or depression, or both,[12,19,56,58,69] body dissatisfaction,[18] poor self-image,[19] and low self-esteem [19] persisting into adulthood. It is also important to recognize that children who are bullied may themselves be involved in bullying behavior as the bully as well as the victim,[66] and that having been bullied is associated with later violence-related behaviors such as carrying a weapon and being involved in fights.[70]

Evidence for the consequences of the teasing and bullying is sparse in studies of bullying in skin diseases despite abundant evidence for the link of skin disease with psychologic and psychiatric morbidity.[71] A history of appearance-related teasing is a predictor of interest in undergoing cosmetic surgery in Norwegian women,[72,73] but other quantitative data are lacking. In a qualitative study,[40] bullying and teasing related to acne, psoriasis, and atopic eczema were causally linked in respondents' accounts with a number of psychologic sequelae: embarrassment, self-esteem, self-image, self-consciousness, and social exclusion. As well as an instrument of social exclusion, bullying in this study was seen as a means of establishing or enforcing power relationships.

In other settings, having a psychologic disorder such as low self-regard[74] or depression[57] has been predictive of being bullied later. In the qualitative acne, psoriasis, and eczema study, respondents felt the direction of causality was solely of bullying causing psychologic morbidity, and not the reverse.

What can clinicians do about bullying in their patients?

The position paper of the Society for Adolescent Medicine on bullying and peer victimization states:

> Health care providers should be familiar with the characteristics of youth that may be involved in bullying, either as aggressors or victims. They need to be sensitive to signs and symptoms of bullying, victimization, their influences and their sequelae.[4]

This advice may be especially pertinent in the case of skin disease where doctors (both family physicians and dermatologists) have been reported as having poor comprehension of the psychologic implications of skin diseases and being insensitive to their patients' emotional suffering.[75] Although good quantitative evidence is not available, the limited qualitative evidence suggests that teasing and bullying are significant problems in patients with skin disease and should be an issue for clinical concern.

The Society for Adolescent Medicine's bullying and peer victimization position paper encourages health care providers to intervene early when bullying or victimization behaviors are noted.[4] As to what should be done to reduce bullying or attenuate its sequelae in patients with skin disease, there is no direct evidence to guide dermatologists, family physicians, or other health care clinicians. Perhaps an obvious response is to improve the skin disease and, hence, skin appearance (given that most bullying and teasing in skin diseases is appearance-related). In clinical trials using tacrolimus for the treatment of atopic dermatitis, one study

reported that the "personal relationships" subscale of the CDLQI (which includes effects on friendships as well as bullying) improved significantly,[53] but in another,[76] the improvement on the CDLQI teasing/bullying item did not reach statistical significance.

In school settings, interventions, including peer-support schemes, have been introduced as a means of reducing bullying and its effects on bullied pupils, although evidence for their efficacy is mixed.[77,78] Again, in dermatologic practice, evidence for such interventions is sparse. In one randomized controlled trial,[79] however, an intervention comprising patient and parent support groups and educational programs significantly improved scores on the "personal relationships" subscale of the CDLQI in children with atopic dermatitis.

At the most basic level, an appreciation of the potential psychologic effect of skin disease and of the possibility of appearance-related bullying contributing to this psychologic morbidity should prompt dermatologists and family physicians to explore these issues with patients.[75] An empathetic approach[75] and, possibly, specialist mental health referral[4] will be required for those patients who have been subject to bullying and teasing.

Conclusions

Bullying and teasing are recognized as major problems in children and adolescents. Despite limited evidence, it is reasonable to conclude that children and adolescents with skin diseases are especially prone to bullying and teasing on the basis of their condition. Dermatologists and other clinicians should be aware of this and of the potential for bullying and teasing to effect their patients' psychological well-being.

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