Evidence-based, Solution-Focused Care for School Children Experiencing Cyberbullying: Using the Omaha System to Guide and Document Psychiatric nurses Interventions

Abstract

Cyberbullying is a global phenomenon. The experiences of bullied children are the same across cultures and languages, and psychiatric nurses interventions are known to be effective. It is critical to widely disseminate effective interventions to identify and address cyberbullying. Therefore, evidence-based care plans addressing cyberbullying at the individual and community levels were developed using the Omaha System, a terminology that is used internationally to guide and document care. This article presents a case study in which an evidence-based intervention was employed to help a bullied child arrive at a solution, and demonstrates the use of the Omaha System to document evidence-based cyberbullying interventions with individuals and communities.

Introduction

Cyberbullying is a newly identified form of bullying among adolescents (Mc Guinnes 2007) similar to traditional bullying in that it is hurtful, resulting in an imbalance of power and causing psychosocial problems for the victims. This form of bullying poses similar challenges as other forms of bullying but differs because of its faceless nature for which the source cannot always be identified. The consequences of not identifying this form of bullying in a timely manner can result in severe and long-term health problems. It is critical to widely disseminate effective interventions to identify and address cyberbullying. Therefore, evidence-based care plans addressing cyberbullying at the individual and community levels were developed using the Omaha System, a terminology that is used internationally to guide and document care and explained later for clarity of meaning.

In some cases bullied children take their own lives as in the case of a 15 year old girl called Megan who committed suicide because of a comment posted on her *Myspace* profile which read *"the world would be a better place without you".* Initially the cyber bully was thought to be her boyfriend but it later transpired that this so called boyfriend used an online alias Josh but was actually a 47 year old neighbor known to the family (Ruedy 2007).

The sinister nature of this form of bullying demands a more proactive approach for prevention, early identification and intervention. Psychiatric nurses are ideally placed and skilled to work with teachers and parents to support bullied children. This article presents a case study of a young teenager Clara who experienced cyberbullying; and provides a practical breakdown of how this pupil was supported by her psychiatric nurses using validated frameworks.

Background

Cyberbullying is defined as "any communication activity using cyber technology that could be considered harmful to individual or collective well-being" (Bamford 2004 page 1).

Cyberbullying includes the use of email, cell phones, text messages, and other Internet media to threaten, harass, embarrass, or socially exclude (Patchin & Hinduja, 2006;; Mishna, Faye et al. 2009). Both physical and mental health problems can result from cyberbullying, which can affect the health of school children (Sourander et al., 2010; Williams & Godfrey 2011) and subsequently their ability to learn and reach their full potential academically. A study by Beran and Li (2007) about cyberbullying showed that pupils reported feelings of sadness, anxiety, and fear stating that it affected their ability to concentrate on their school work and to attain good marks. About 10-40 % adolescents experience cyberbullying in its various forms (Hinduja & Patchin 2010).

Despite increased awareness of cyberbullying and efforts to deal with this form of abuse it remains a constant threat to health and well-being of school children. Evidence-based interventions are needed to ensure that cyberbullying is detected and addressed. Children who participate in psycho-educational internet safety interventions showed better internet safety knowledge; however, this knowledge did not necessarily translate into safe practices when using online communications (Mishna, Faye et al. 2009). An intervention that has been shown to increase self-efficacy among 12-13 years old school children is the Solution Focus Approach (SFA) (Kvarme et al 2010a). Given the self-demoralization caused by cyberbullying and the covert nature of this type of bullying, empowerment of school children is critical for them to firstly, recognize that they do not have to tolerate the situations and secondly, that help is available for them to cope, and with good resolve to overcome the bullying. Evidence shows that Solution focus approach (SFA) can help victims of bullying (Young 1998, Young & Holdorf, 2003, Fekkes 2005).

Solution Focus Approach

Solution focus approach (SFA) is a system of communication that may be used in the intervention for individuals or groups (DeJong and Berg, 2002). SFA is a future-focused and

goal-oriented approach that utilizes questions designed to identify exceptions and solutions (Smith, 2010; Trepper et al., 2006). SFA assumes that individuals possess the necessary resources to resolve their own problems therefore the individual is encouraged to find the solution that fits their own world-view (Corcoran and Pillai, 2009; DeJong and Berg, 2002).

The first step in SFA conversation is to establish a good relationship between the helper and the child, and the child describes her/his problem. The helper providing the support need to be an active listener, because good communication and co-operation with the child is essential for success. The second step is to develop a clear and realistic goal from the problem which only the child can know, as it is his/her life and experience. The helper may use as an opening question "can you describe an ideal day without the problem?" The third step is to look for exceptions and resources and to use the scale question (from 0 to 10). It is often very difficult for school children or adolescents to put into words just how much their experience hurts but giving them a means to quantify their pain as used in pain charts can give the helper some measure of just how bad the child feels. Allowing the child to indicate on the scale where she/he is at the point of contact and how this relates to his/her preferred goal of where he/she wishes to be helps to start the empowerment process. It may be at this point that the child starts to see that his/her has a choice and the situation in which they find his/her is not insurmountable. There could be exceptional situations when the problem no longer exists or much bigger than anticipated. If the latter is the case, then the fourth step in the process is to help the child to construct small steps towards the goal. This process ends with feedback about the discussion and progress that has been made (DeJong and Berg, 2002).

Evaluation research of this intervention has shown that in about 50% of studies, improvement followed the intervention. The outcome measures included: goal attained, self-esteem, psychosocial adjustment and improved mood (Corcoran and Pillai, 2009). SFA is a

relevant method for nurses as it focuses on health and well-being, and is oriented towards empowering the individual (Bowles et al., 2001; Ferraz and Wellman, 2008).

The SFA has been used to help victims of bullying by employing a "no blame" approach (Young & Holdorf, 2003). "No blame" methods means that the bullying problem is discussed in a non-judgmental way providing support to bullied children. At the same time employing a no-blame culture is important for the sake of the bullies because there is evidence to suggest that bullies are victims themselves (Ma 2001; Unnever 2005) although the relationship between the two is not always easily distinguished (Solberg & Olweus 2003).

In SFA, the solutions were independent of the problem and the focus was on the goal to the situation. Actual questions that were asked of pupils involved in group discussions are; "How would you wish your days at school to be? Are there any pupils who can be supportive and helpful to you"? The focus in SFA is on recourses and what the pupils can do. There is evidence that using a SFA peer support group could help the pupils through a variety of difficulties including victims of bullying (Young 1998, Young & Holdorf, 2003, Fekkes 2005).

SFA is a system of communication and a tool to help victim of bullying while Omaha system is a documentation system for identifying and making a planning care for the victim.

Omaha System

The increasing use of electronic health records (EHRs) provides a new platform for describing evidence-based interventions such as SFA, and generating evaluation data to demonstrate the effectiveness of interventions. One such multidisciplinary standard used in many countries is the Omaha System (Martin 2005, Omaha System 2012).

The Omaha System is a research-based, inductively derived, comprehensive standardized terminology designed to enhance practice, documentation, and information management (Martin & Scheet, 1992; Martin, Norris, & Leak, 1999; Martin, 2005; Monsen,

Foster, Gomez, et al., 2011; Monsen, Nealy, Oftedahl, et al., 2012). During the development of the Omaha System (1975-1993), researchers tested and retested the three components' reliability and validity. In testing reliability, they gave attention to measures of stability or consistency, homogeneity, and equivalence. In testing validity, they gave attention to content, concurrent, construct, and predictive issues. Testing of the three components as a whole provided the basis for revisions and for establishment of reliability and validity of components (Martin & Scheet, 1992). The Omaha System provides appropriate terms related to health promotion, prevention, potential and actual risk, and thus is suitable for bullying assessments at the individual and community level within the context of comprehensive, holistic care (Martin, 2005).

The Omaha System framework suggests that people have problems that can be addressed by health care services, and that outcomes for each problem are measureable. In this model, the terms and definitions of the Omaha System provide structured, uniform ways of describing problems (Problem Classification Scheme), health care services (Intervention Scheme), and outcomes (Problem Rating Scale for Outcomes) (Martin, 2005).

The Problem Classification Scheme describes health concepts in four domains: Environmental, Psychosocial, Physiological, and Health related behaviors. Each concept (called ‘problem’) is identified by its definition and signs/symptoms. Reliability of the Problem Classification Scheme was established during its development using percentage of agreement in field testing by test agency staff and research project staff. (Results showed 78% agreement in Des Moines, 66% in Delaware, and 68% in Dallas. A retest showed 90% agreement in Des Moines, 73% in Delaware, and 77% in Dallas) (Martin & Scheet, 1992).

The health care services are described by the Intervention Scheme. Each intervention relates to a problem, and consists of an action (called ‘category’), an object of the intervention (called ‘target’) and a fourth component (called ‘care description’) which is customizable and

may be used to capture specific information for a population or programme. Reliability of the Intervention Scheme was established during its development in Des Moines, Delaware, and Indianapolis using percentage of agreement between the staff nurse and nurse testers, and between testers. Percentages of agreement ranged from 42.2% to 96.9% with eight of the twelve percentages at or above 80% (Martin & Scheet, 1992).

The patient outcomes are described by the Problem Rating Scale for Outcomes, a five-point Likert-type ordinal scale that also relates to the problem term (Martin 2005, Omaha System, 2013). Reliability and validity of the Problem Rating Scale for Outcomes was described during its development in Omaha, Des Moines, Delaware, and Indianapolis using percentage of agreement scores, coefficient gamma tests, and content validity index scores (Martin, Norris, & Leak, 1999). This simple but yet comprehensive architecture enables a conceptually sound, robust approach to data aggregation and analysis that has been used with sophisticated statistical and data mining techniques and has advanced the state of the science in health informatics research (Omaha System Partnership, 2012).

Omaha System terms enabled experts in cyberbullying and an Omaha System expert to develop evidence-based standardized care plans from the literature for cyberbullying at the individual level (Table 1) (DeJong and Berg, 2002) and the community level (Table 2) (Kowalski, Limber, & Agatston, 2008). These care plans are available on-line at omahasystemmn.org. The following case study describes the problems Clara faced at school and how she was able to ask for and receive help. Following the case study, psychiatric nurses assessments and intervention documentation within the EHR using the Omaha System is described.

Case study

Clara a 12 years old girl presented to the psychiatric nurses office in tears. She complains about headache and difficulties in sleeping. After some time she discloses that

some pupils had sent her messages on the internet and called her nicknames saying that she was ugly. They had created a web page where they wrote messages that they hated her. This web page had been sent to other pupils at school. She felt excluded from her classmates; this targeted hate mail was made worse by the boys in her class harassing her. Clara was afraid to go to school because the boys in her class followed her during break times continuing their malicious behaviour towards her. Clara said that she had no friends and was not able to cope with the situation anymore. She felt unable to tell her parents; she felt totally alone. Ann (the psychiatric nurses) asked Clara if she had any ideas about how she could stop this name calling and isolation, but Clara had none.

The following conversation then took place between Ann, the psychiatric nurses, and Clara:

Ann: *"Can you remember any day that you enjoyed being at school?" What happened that day? Who were you with?"*

Clara*: "Well, I remember one day two weeks ago I enjoyed being at school because that day one of the bullies was absent and Iris, a new girl started in our class. She did not know anyone else, so she asked me if she could join me. That was a really nice day!"*

Ann*: "Are there any other girls you like being with in school?"*

Clara*: "Susan used to be nice to me when Alice (one of the bullies) was not around and Cheryl in the other class can also be nice sometimes."*

Ann*: "Would it be okay with you if I asked some of these girls to come along to a meeting with you in a group? We can then discuss what to do to help you have a better time at school?*

Clara*: "I really would like that!"*

At the first meeting that followed they started with light hearted conversation about themselves to help them get to know each other. Ann started the group session with an

introduction of herself and why they were having the meeting with a overview of what the purpose of the group was and what they could do to help Clara to make life more enjoyable at school. As the girls talked Ann wrote down each suggestion from the group members and they promised to support Clara and follow the suggestions they had each made. The following week they met again to evaluate how these suggestions had affected Clara's situation in school. These group conversations continued for some weeks until Clara said that her days at school were much better and she had made nice friends to socialise with whilst at school. Ann used the Omaha System assessment to identify and document Clara's main needs as illustrated in Figure 1, and documented the signs/symptoms in Clara's EHR.

Individual level interventions (SFA)

To create an environment where the school children feel comfortable talking with adults about cyberbullying and feel confident that meaningful steps will be taken to resolve the situation is important. Research shows that pupils who experience cyberbullying perceived a poorer climate in their school than those who had not experienced cyberbullying (Hinduja & Patchin 2010). It is critical to develop and promote a safe, healthy and respectful school climate where all the school children are included. Clara felt able to go to Ann for help, initially complaining about a headache and being unable to sleep (Table 1, Intervention 1). In the case of Clara the headaches and sleepless nights stemmed from bullying, however the psychiatric nurses could also refer Clara to a nurse practitioners, school nurse or primary care provider to ensure that these symptoms are treated if her symptoms persist. Children like Clara could be at risk therefore, these complaints should not be dismissed lightly or labeled as 'attention seeking' because the opportunity for timely intervention could be lost to the detriment of the child's health and safety (Vernberg et al. 2011). A qualitative study of bullied school children show that the participants thought it was helpful to talk about their feelings with the nurses (Kvarme et al 2010b). Ann listened to Clara and was able to gain her

confidence to enable her to confide in her (a summary of Ann's assessment of Clara is summarized in Table 1, Intervention 2). It is important for the psychiatric nurses to have active listening expertise or counseling skills facilitate this initial contact. Next, Ann and Clara discussed goals to help Clara overcome her problems, and Ann continued with the SFA conversation, involving other pupils in the conversation as appropriate (Table 1, Interventions 3-7). Ann documented this process within Clara's EHR by checking off the interventions and adding brief narrative comments as needed.

Community level interventions addressing cyberbullying

Psychiatric nurses promote safety for pupils at the community level as well as the individual level. To further support Clara and other pupils, Ann documented her activities with school and community groups using interventions from Table 2. Ann worked with teachers and other concerned individuals to teach school policies about cyberbullying (Table 2, Intervention 3) as part of a whole-school anti-cyberbullying programme, and advocate for a zero tolerance policy against cyberbullying (Table 2, Intervention 4). She provided education to other school children about cyberbullying to alert them of its existence and empower them to ensure that others who may be experiencing the same problem but to seek help from their psychiatric nurses or teacher and not suffer silently. In addition, she taught pupils about cyberbullying during class time to clearly demonstrate that the school is aware of cyberbullying, legal consequences, and harm (Table 2, Intervention 6). Ann documented these interventions as part of her community-level work in the psychiatric nurses activity record.

Discussion

Cyberbullying is a global phenomenon and the experiences of victims across all cultures and languages are the same. It therefore important to use a universally recognised tool in helping psychiatric nurses to recognise this problem early, to effectively assess and intervene to help pupils in need. Through the use of the Omaha System, the psychiatric nurses

assessments and interventions were described. Extensive use of the Omaha System has shown it to be a valid tool for identifying and planning care for many complex health related problems internationally (Martin, 2005, Martin & Scheet, 1992). Because it is a holistic and comprehensive conceptual framework for health and health care, it takes into account the individual, family and wider community context rather than looking at this problem in isolation. This results in a broader perspective, and the implementation of evidence-based solutions. In the future, structured data from psychiatric nurses documentation in EHRs using evidence-based care plans will enable evaluation of the effectiveness of psychiatric nurses interventions.

The case study demonstrates how the SFA was employed to help the pupil arrive at a solution which not only helped her cope with the immediate problem but also provided her with social skills which will help her to deal with similar situations in the future and also avoid it reoccurring. It is essential to increase psychiatric nurses awareness of cyberbullying and increase their intervention capacity and skills at all levels. Therefore, community level interventions such as the whole school programmes and other interventions described in Table 2 are essential.

Conclusion

In conclusion, the use of internet to connect to every part of the world as a fast and effective media has many benefits; amongst which is connecting people on all levels of life. However, with these advancements there are the down side one of which is cyberbullying, especially amongst school children. It is timely to implement a structured and universal approach, leveraging the benefits of technology to address this global problem.

References

Agatston, P. W., Kowalski, R., & Limber, S. (2007). Pupils' perspectives on cyber bullying. *Journal of Adolescent Health, 41*(6,Suppl), S59-S60.

Bamford, A., 2004. Cyber-bullying, *AHISA (Association of heads of independent schools of Australia) Pastoral Care National Conference, Melbourne* 2004.

Bauman, S., Rigby, K. and Hoppa, K., (2008). US teachers' and school counsellors' strategies for handling school bullying incidents. *Educational Psychology,* 28 (7), pp. 837-856.

Beran, T. & Li, Q. (2007). Cyber-Harassment: A study of a new method for an old behavior. *Journal of Educational Computing Research, 32* (3) 265 – 277.

Bowles,N., Mackintosh,C., Torn,A., (2001). Nurses' communication skills: an evaluation of the impact of solution-focused communication training. *Journal of Advanced Nursing* (3), -54.

Corcoran, J., Pillai, V. (2009). A review of the research on solution-focused approach therapy. *British Journal of Social Work* 39 (2), 234-242.

DeJong,P., & Berg,I.K., (2002). Interviewing for Solution. Wadsworth Group, Milwaukee, Wisconsin.

Eslea, M., Menesini, E., Morita, Y., O'Moore, M., Mora-Merchan, J.A., (2004)
Pereira, B. and Smith, P.K., 2004. Friendship and loneliness among bullies and victims: Data from seven countries. *Aggressive Behavior,* 30 (1), pp. 71-83.

Fekkes,M., Pijpers,F.I.M., Verloove-Vanhorick,S.P., (2005). Bullying: who does what, when and where? Involvement of children, teachers and parents in bullying behavior. *Health Education Research* 20 (1), 81-91.

Ferraz,H.,& Wellman,N., (2008). The integration of solution-focused brief therapy principles in nursing: A literature review. *Journal of Psychiatric and Mental Health Nursing,* 15 (1), 37-44.

Hinduja & Patchin (2010) Cyberbullying, Identification, prevention, and response Retrieved from http:// www.cyberbullying.us/research.php 20.07.12

Kowalski, R.M., Limber, S.P., & Agatston, P.W. (2008). *Cyber bullying: Bullying in the digital age*. Malden, MA: Blackwell. doi:10.1002/9780470694176

Kvarme L, Eboh W, van der Teijlingen E. (2008) Use of solution focused brief therapy in bullying. *British Journal of Psychiatric nurses*; 3: 346-348.

Kvarme L.G., Helseth S., Haugland S., Luth-Hansen V., Sørum R., Natvig G. K. (2010a) The effect of a solution-focused approach to improve self-efficacy in socially withdrawn school children: a non-randomized controlled trial. *International Journal of Nursing Studies.* 47 (11) 1389-96.

Kvarme L. G., Helseth S., Sæteren B., Natvig G. K (2010b). School children's experiences of being bullied, and how they envisage their dream day. *Scandinavian Journal of Caring Science.*

Martin K S, The Omaha System (2005): A key to practice, documentation, and information management, Reprinted 2nd ed., *Health Connections Press*, Omaha, NE.

Martin, K. S., Norris, J., & Leak, G. K. (1999). Psychometric analysis of the Problem Rating Scale for Outcomes. *Outcomes Management for Nursing Practice, 3,* 20-25.

Martin, K. S., Scheet, N. J. (1992). *The Omaha System: Applications for community health nursing.* Philadelphia: Saunders.

Ma, X.,(2001). Bullying and being bullied: To what extent are bullies also victims? *American Educational Research Journal,* 38 (2), pp. 351-370.

Monsen, K. A., Neely, C., Oftedahl, G., Kerr, M. J., Pietruszewski, P., & Farri, O. (2012). *Feasibility of encoding the institute for clinical systems improvement depression guideline using the Omaha system (in review).* Unpublished manuscript.

Monsen, K. A., & Newsom, E. T. (2011) Feasibility of using the Omaha System to represent public health nurse manager interventions. [Comparative Study]. *Public Health Nursing, 28*(5), 421-428.

Mc Guinnes T. M. (2007) Dispelling the myths of bullying. *Journal of Psychosocial Nursing*, (45) 10, 19-22

Mishna, Faye et al. (2009) Interventions for children, youth, and parents to prevent and reduce cyber abuse, *Campbell Systematic Reviews*, 2, Campbell collaboration, USA.

The Omaha System: Solving the clinical data-information puzzle. Internet. Accessed 20 June 2013. omahasystem.org

Omaha System Partnership for Knowledge Discovery and Health Care Quality. [Internet] Accessed 20 June 2013. omahasystempartnership.org.

Patchin, J. W., & Hinduja, S. (2006). Bullies Move beyond the Schoolyard: A Preliminary Look at Cyberbullying. *Youth Violence and Juvenile Justice*, *4* (2), 148-169

Patchin, J.W. and Hinduja, S., 2010. Cyberbullying and Self-Esteem. *Journal of School Health*, 80 (12) 614-621.

Ruedy, M.C., (2008). Repercussions of a myspace teen suicide: Should anti-cyberbullying laws be created. *North Carolina Journal of Law & Technology,* 9 (2), 323-346.

Smith, S., (2010). A preliminary analysis of narratives on the impact of training in solution-focused therapy expressed by pupils having completed a 6-month training course. *Journal of Psychiatric and Mental Health Nursing* 17 (2), 105-110.

Trepper, T.S., Dolan, Y., McCollum, E.E., & Nelson, T., (2006). Steve de Shazer and the future of solution-focused therapy. *Journal of Marital & Family Therapy* ,32 (2) 133-139.

Sourander, A., Brunsteinklomek, A., Ikonen, M., Lindroos, J., Luntamo, T., Koskelainen, M., Ristkari, T. & Helenius, H., (2010). Psychosocial risk factors associated with cyberbullying among adolescents: a population-based study. *Archives of General Psychiatry*, 67 (7) 720.

Solberg,M.E., & Olweus,D., (2003). Prevalence estimation of school bullying with the Olweus Bully/Victim Questionnaire. *Aggressive Behavior*, 29 (3), 239-268.

Unnever, J. D. (2005). Bullies, aggressive victims, and victims: Are they distinct groups? *Aggressive Behavior*, 31, 153–171.

Vernberg, E.M., Nelson, T.D., Fonagy, P., & Twemlow, S.W. (2011). Victimization, aggression, and visits to the psychiatric nurses for somatic complaints, illnesses, and physical Injuries. *Pediatrics, 127,* 842-848.

Williams S.G & Godfrey A.J (2011) Cyberbullying how can psychiatric- Mental Health Nurses Recognize It? *Journal of Psychosocial Nursing*. (49) 10.

Young S, & Holdorf G. (2003): Using solution focused brief therapy in individual referrals for bullying. *Educational Psychology in Practice,* 19. (4) 271-282

Young, S. (1998): The Support Group Approach to Bullying in Schools. *Educational Psychology in Practice* 14 (1)