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CHILD PSYCHIATRY

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Editor-in-Chief

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IN THIS ISSUE

Problematic Technology

Learning objectives for this issue:

1. Explain characteristics, diagnosis, and treatment of video game addiction. **2.** Describe cyberbullying. **3.** Detail problematic Internet usage. **4.** Understand some of the current findings in the literature regarding psychiatric treatment.

Video Game Addiction

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Dr. Patel has disclosed that he has no relevant relationships or financial interests in any commercial company pertaining to this educational activity.

Video games have come a long way since Pac Man and Tetris. Games today simulate reality in massive user-generated worlds. Players chat by voice or text with people around the globe. Virtual characters work for gold, get married, become sick, and even host religious gatherings. Psychologically, games allow players to avoid real life while engaging and even succeeding in a semi-real fantasy world.

Video games are pervasive among youth culture. There's not a child psychiatrist out there who doesn't see patients who play games at least sometimes. Learning which type of game your patients are playing is a great way to build rapport. Recently I saw a boy who had huge fights with his parents about turning off his game after school. After learning more, I convinced him to play an older style game (which you can turn off easily) after school, and a more interactive game later, which led to less conflict and better grades.

The online, collaborative aspect of modern games is what makes them so interesting, insidious, and addictive. In the past, kids could spend hours playing a game, press pause to eat dinner, and then return to the game without missing a beat. Because many of today's games are often interactive, if you step away, you might miss something.

Part of the appeal of these games can

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Cyberbullies and Cybervictims: Understanding a Modern Threat

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Dr. James has disclosed that he has no relevant relationships or financial interests in any commercial company pertaining to this educational activity.

As technology advances, so too do the problems that come with it. In 2008, Jessica Logan, 18, of Ohio, committed suicide after sexting (sending a nude photo to her boyfriend) led to the posting of the photo for all to view when they broke up. In 2009, 12-year-old Sarah Lynn Butler hanged herself after numerous derogatory MySpace posts. In 2012, Iowan Kenneth Weishuhn, Jr., 15, was tormented by an anti-gay Facebook page created by his classmates, something that led him to suicide. (You can read their stories, among others, at http://bit.ly/TccPSq.)

There are countless tragedies linked to what is commonly known as cyberbullying. With our growing dependence on technology as a source of socializing comes a new vulnerability to the darker aspects of social behavior.

Bullying was once something that primarily occurred at school or local hang outs for youth. Now it infiltrates our homes 24 hours a day. Cybervictims do not have to act inappropriately, make the wrong friends, be in obviously dangerous environments, or even know their bully. For cyberbullying, the only criterion is that you are connected.

Texting, social networking, e-mail, blogs, and other technological avenues make us all vulnerable to emotional battery and degradation of esteem. Every

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Video Game Addiction

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be explained by the classic *New Yorker* cartoon: "On the Internet, nobody knows you're a dog." Online, kids are able to recreate themselves—or not. The Asian teenager whose parents don't speak English is able to be a talkative warrior. The socially phobic girl might find that she can make friends more easily online than in school, even if she keeps the same personality—or she might prefer to wander the virtual world by herself.

Video Games and Violence

We can't talk about games without discussing violence. The link between video games and violence is unclear. There is a sense that violent video games could desensitize kids to violence, but there is no conclusive evidence that links video games with major violence, partly because major acts of violence are so rare (Ferguson CJ et al, *J Youth Adolescence* 2013;42(1):109–122). However you look at it, video games can be just one of many factors in real world violence.

For medicolegal reasons, if your patient is spending hours playing games, it is worth asking whether they are violent shooting games. If so, then follow up about guns in the house and violent plans, just to make sure that the game isn't a trial run for something sinister.

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This CME/CE activity is intended for psychiatrists, psychiatric nurses, psychologists and other health care professionals with an interest in the diagnosis and treatment of psychiatric disorders.

Gaming Addiction

In terms of understanding and treating video game addiction, the United States is behind Asia. In countries such as South Korea and China, video game addiction is considered to be an urgent public health issue.

Asian awareness of video game addiction stems from two main factors. First, there were a series of high profile deaths connected to gaming, including a couple that took care of a virtual infant while their real infant starved to death, and a man who refused medical attention for shortness of breath because he did not want to stop playing. Second, in Asia, these games are typically played in Internet cafes—in comparison to the United States, where home computer usage is the norm—so video game addicts are more visible in public.

In the US, we tend to treat the comorbid disorders, which are present in about 86% of patients who are addicted to video games (Block JJ, *Am J Psychiatry* 2008;165:206–307). In Asia, therapists tend to screen for Internet addiction as part of the initial assessment, making that a specific treatment focus.

Not aggressively screening for and treating video game addiction is a mistake on our part. Our patients were born with technology integrated into their lives. For many of them, it may not be strange to develop a simulated character at the expense of their own character. Asking whether they play video games with their school friends or only online friends is a good way to find out whether the games are a continuation of offline life or something separate.

Ongoing studies around the world show that heavy users tend to play up to 20 and 30 hours, and sometimes more than 40 hours per week (Haagsma MC et al, *Cyberpsychol Behav Soc Netw* 2012;15(3):162–168). Most video gamers are male, and they often play well into their 20s. Female gamers often play for fewer hours, but have higher depression and social phobia ratings than male players (Wei HT et al, *BMC Psychiatry* 2012;12(1):92).

Say What? Gamer Terms for the Uninitiated

MMORPG (Massively multiplayer online role-playing game): A fantasy game where an individual develops a character and interacts with other players from around the world. These games often involve magic and a fantasy world, and do not have an ending. The goal is to develop your character and interact with other characters. The most famous example is *World of Warcraft,* a game with 10 million online subscribers, half of them in Asia.

FPS (First-person shooter): An action game with a first-person perspective, usually detailed, graphic, and often with realistic military-style weaponry. The best-known FPS game is *Call of Duty,* a game so popular that each year's version earns more than $1 billion, often in less than a month. (Compare that to the most popular movies of all time, which earn about the same amount.) Players go online to play matches where the goal is to kill the other players. They often use an online service such as Xbox Live to play this game online.

Treating Video Game Addiction

Treatment is multifactorial. Most important, we need to recognize that it's worth discussing. Patients have to feel comfortable talking about their excessive gaming habit, which can be difficult when it has to do with things like monsters and magic. In fact, talking about gaming can feel dangerous for patients, because they feel powerful and successful when playing, but that feeling can disappear rapidly when discussing it in an office.

In terms of medication, there is only a small study of 11 patients who took bupropion (Wellbutrin) and played 25% fewer hours of video games (Han DH et al, *Exp Clin Psychopharmacol* 2010;18(4):297–304). Anecdotally, one

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Video Game Addiction

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of my patients had a similar result with Wellbutrin XL 300 mg.

The general approach is to have the patient spend more time in the real world and less time in the virtual world. Finding ways to engage the patient in the offline world is one way to approach this—preferably suggesting things that encourage psychological and social development. This can be as simple as joining a sports team or engaging in physical exercise, or as exotic as sending a patient on an outdoor adventure program (Outward Bound, NOLS, Overland) where computer time is very limited. South Korea has camps dedicated for video game addiction.

A family-wide approach to treatment can be useful, because patients addicted to video games may not have the motivation to change on their own. Use games as rewards for engaging in other activities, have parents keep the power cord, and limit screen time to weekends or evenings only. I tell parents to use a kitchen timer, which keeps the game to under an hour, and puts the blame on an object (the timer) rather than on the parents. Finally, consider making the family vacation "electronic-free," although some families discover the child is not the only member of the family jonesing for a fix.

Cyberbullies and Cybervictims: Understanding a Modern Threat

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person connected is a potential victim, but it is children that are most affected because they are at the crossroads of intense developmental change and self-exploration, and because they are at the forefront of technological socializing.

Epidemiology of Cyberbullying

The epidemiology of cyberbullying and cybervictimization is poorly defined. Reported prevalence is highly variable between studies and country to county. What remains consistent is that cybervictimization appears more prevalent than cyberbullying. In the US, the prevalence of cybervictimization is 9% to 72% and cyberbullying is 4% to 36% (Suzuki K et al, *Int J Adolesc Med Health* 2012;24(1):27–35).

The association with gender is also unclear. Some studies indicate there is no gender difference, while others suggest that more males are cyberbullies and more females are cybervictims or dual bully-victims (Suzuki ibid; Bauman S et al, *J Adolesc* 2013:36(2):341–350). One gender difference that may affect cyberbullying susceptibility is that females tend to engage more in emailing and perhaps other forms of technological communications, while boys tend to spend more time playing online video games. In addition, girls often multitask, allowing them to have a greater exposure to risk.

Regarding age, trends remain vague. Most studies focus on middle and high school. Some of these studies suggest that there is an inverse relationship between age and cyberbullying, while other studies suggest the opposite holds true (Suzuki op cit; Heirman W & Walrave M, *Psicothema* 2012;24(4):614–620).

Cyber Versus Traditional Bullying

Lack of supervision creates an environment for cyberbullying to thrive. It can be carried out discreetly and quickly. Moreover, technology is accessible nearly everywhere and at any time of day. With traditional bullying, the majority of acts occur on the school grounds where supervision is relatively well developed. Aside from texting, cyberbullying tends to occur off school grounds. This creates not only an issue with supervision, but also confusion for victims as to where to bring their problems.

In addition, the qualities of anonymity and broad publicity are available through technology in a way that they are not in the schoolyard. With anonymous bullies, the victim loses the ability to anticipate the act, which lends to a sense of helplessness and constant fear. (Anonymity can be preserved through unrevealing screen names.) Research has shown that among cyberbullies, 84% knew their victims personally, whereas only 31% of cybervictims knew their perpetrators (Ybarra MI & Mitchel KJ, *J Adolesc* 2004:27(3):319–336). Consequently, interactions with others may be compromised by a nagging concern about who the faceless perpetrator might be.

Publicity obviously means more observers, and reduced control over how many people will witness the aggression. Once posted, material remains accessible for long periods of time and by many observers. Dehumanization of others is also easier when one is not in the presence of environmental and social cues that one would experience in traditional bullying, and this could potentially allow for greater escalation of acts with little thought of impact or consequence (Suzuki op cit). One study found that people who cyberbully primarily do so because it is "fun" (38%), for retaliation (25%), or because they have a negative self-image (6%) (Kiriakidis op cit).

Terms to Know

Cyberbully: One who bullies using electronic media (Internet, smart phones, social media)
Cybervictim: One who is victimized via electronic media
Dual bully-victim: One who both bullies and is bullied via electronic media

Identification of Potential Perpetrators and Victims

Cybervictims may fail to come forward in part because policies regarding cyberbullying are often lacking or unenforceable, making efforts to report the abuse appear meaningless. Because it happens "in the ether," it can be hard for victims to know to whom to report. Studies also seem to indicate that adults are often seen as uninformed or impotent to address the cyberbullying.

There are character traits associated with both victims and bullies. Those who are perpetrators of cyberbullying tend to use computers and the Internet

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Q&A With the Expert

Expert Interview

Problematic Use of the Internet and Social Media

Megan Moreno, MD, MPH

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Dr. Moreno has disclosed that he has no relevant relationships or financial interests in any commercial company pertaining to this educational activity.

CCPR: Dr. Moreno, please tell us a little about your background.

Dr. Moreno: I am a pediatrician and adolescent medicine specialist. My primary areas of research are social media and problematic Internet use.

CCPR: What exactly is Internet addiction and where did the idea of it come about?

Dr. Moreno: A lot of the early literature used the term "Internet addiction" as something that was synonymous with other addictive behaviors. In some research they would take a scale, for example, for substance use, and essentially just "white-out" everywhere that said "substance use" and replace it with "Internet addiction." That fascinated me because it didn't seem like a very evidence-based approach, and I wasn't sure whether Internet use was going to function like substance use or like a problematic behavior like gambling. Internet addiction early on was defined as essentially the same thing as a substance use disorder, with qualities like dependency and excessive and compulsive use. In my research, I tried to approach it more as a blank slate and look at what aspects of Internet use would make it problematic.

CCPR: What did you find?

Dr. Moreno: We did a study that will be published in the coming months, where we worked with a large group of college students and adolescent and college health providers, including primary care providers, psychiatrists, and mental health counselors, to define what this is. Not surprisingly, there is a lot of overlap with other addictive behaviors. There is overuse, excessive use, and compulsivity—the idea that when you walk away from your computer you are thinking about it or you can't put your phone down. But there is an interesting angle in that we found risky use was a component, too—the idea that the way you use the Internet matters as well as *how much* you use it.

CCPR: What do you mean by risky use?

Dr. Moreno: Risky Internet use is doing things that you wouldn't do in offline life that now you do online, things like looking at pornography and bullying other people. So if people are using the Internet in a way that introduces them to behaviors that are not part of their offline life, then that gets them ensnared in using the Internet for maladaptive behaviors. We also think of risky behavior in terms of social consequences; by engaging and centering social life within the Internet, adolescents and young adults are not getting offline experiences that are critical for their development. If people are using the internet to the exclusion of making contacts in the offline world, they may fail to build an identity and establish a peer group, which may be to their detriment for the rest of their lives.

CCPR: So does Internet addiction have a withdrawal syndrome?

Dr. Moreno: People have described a feeling of withdrawal even in the short-term acute sense—when they can't get access to their phones for a couple of hours and can't concentrate in class because of it, for example.

CCPR: Is problematic Internet use common?

Dr. Moreno: The prevalence estimates are all over the place. European prevalence estimates are between one and nine percent, Asian prevalence between two and 18 percent, and in the States it is between zero and 26 percent (Moreno MA et al, *Arch Pediatr Adolesc Med* 2011;165(9):797–805). One of the better scales, the Young Internet Addiction Test, has found a prevalence in the 7% to 10% range in the US (see the Young test at http://bit.ly/TE4wA).

CCPR: How do you treat it?

Dr. Moreno: To study this, my research assistant and I took advantage of a naturalistic experiment when I was at the University of Wisconsin in which all women rushing a sorority were required to deactivate their Facebook accounts for the entire length of the rush period. So we studied those women before the period where they shut off their access, and then during, and then after. It was a small pilot study so it really isn't something to take to the bank, but the data suggested that, when the women were not using Facebook, social anxiety decreased, perceived stress decreased, and for some people depressive symptoms decreased. What makes problematic Internet use so fascinating in comparison to things like substance use is that typically the gold standard treatment is abstinence, but it is impossible to get through school and find a job without using the Internet. So treatment is hard.

CCPR: How should we screen for this disorder?

Dr. Moreno: This is difficult because in a systematic review we couldn't find a single screening instrument that had actually gone through validation on its own, although the Young Internet Addiction Test had some nice studies after it was already in use. It is somewhat out of date, though—some of the questions are about things like chat rooms that were quite relevant 10 years ago but really aren't now. My graduate assistant built an evidenced-based screening instrument that has held up very well in different validity tests. [The tool is not yet published.]

CCPR: So this brings us back to the question: Does Internet addiction actually exist?

Dr. Moreno: I am still not sure if it exists. I love doing this work even with a huge dose of skepticism. Can you be addicted to the Internet as a whole, or is it a series of pieces of addiction? For example, is a video game addiction online different from Facebook addiction, and is that different from the compulsive checking of a smartphone?

CCPR: To change gears, talk to us a little bit about Facebook.

Dr. Moreno: The bulk of my work has been in the area of social media. I became interested in this during my adolescent medicine fellowship when I was seeing patients who were referred for something like stomach pains, and I would ask when they started and the patient would say: "It started the day that my best friend put this thing about me on MySpace [a precursor to Facebook] and now my whole life is ruined."

CCPR: So you became interested in the power of what was basically a single website.

Dr. Moreno: Yes. I think that the power of the site to take things that teens maybe always knew and did, but make them so plainly visible, is fascinating. Younger teens will say, "I am trying to be like the popular kids at my school, but on Facebook they all post about drinking; does that mean that I should do that?"

If people are using the Internet to the exclusion of making contacts in the offline world, they may fail to build an identity and establish a peer group, which may be to their detriment for the rest of their lives.

Megan Moreno, MD, MPH

CCPR: And you are particularly interested in its influence on health.

Dr. Moreno: Yes. How does health get displayed within social media by teens; what does it mean to them; how can we use it to interact with them? If you think about the things that influence adolescent health behavior, it is a complex picture with inherent and external or genetic and environmental influences, but two consistent influences are media and peers. Movies, television, and music have been shown to affect adolescents' attitudes and behaviors, particularly about things like sexual behavior and substance use. And peers are also known to greatly influence adolescents' behavior. Facebook has the sexiness of media but it is created by peers. It is a very tailored and potent source of influence.

CCPR: You published a paper on sexual expectations and Facebook. Please tell us about that.

Dr. Moreno: Once we started looking for it, we consistently found that many young women were displaying sexual references in their Facebook profiles. So we wondered how those references were interpreted by peers of the opposite sex. We showed young men examples of references and asked them how those references would influence their intentions towards these women if they met them.

CCPR: And what did you learn?

Dr. Moreno: We found that guys saw these types of references all the time, and that they heighten the males' sexual expectations. So the guys would tell a story about being at a bar, for example, and meeting a girl—looking her up on Facebook, and if they saw these types of references, thinking, this looks like a girl I could probably score with tonight. These references strengthened the idea that the male could "hook up" with the female, but decreased the likelihood that he wanted to date her long term (Moreno MA et al, *J Pediatr Adolesc Gynecol* 2011;24(2):85–89).

CCPR: Is there some good that could come out of this behavior on Facebook?

Dr. Moreno: In the course of our research, we started seeing a lot of people talking about "having a bad day." So we used clinically relevant criteria for depression and started counting references to these criteria on people's profiles, and we consistently found about a quarter of profiles across the college population make one or more mention of a DSM-defined symptom of depression (Moreno MA et al, *Depression Anxiety* 2011;28(6):447–455; Moreno et al, *Journal of Behavioral Health Services & Research,* 2011;published online August 24 2011). So we asked ourselves: What can we do to get these kids some help? So now an area we have some optimism about is using these online disclosures to try to link these kids to clinical care.

CCPR: And how would you do that?

Dr. Moreno: We could, for example, work with a college counseling center to determine the three most common depression keywords on profiles that are linked to positive results on the PHQ-9. Then we create a Facebook advertisement with a link to the counseling center that pops up on their college students' profiles if one of those keywords is present. [Facebook allows advertisers to create ads on the profiles of a very targeted population based on keywords and geography, among other criteria.]

CCPR: Very interesting. Thank you, Dr. Moreno.

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frequently, are savvier with technology, have poor academic performance, and are commonly also cybervictims (Heirman & Walrave op cit). Cyberbullies typically have increased levels of undesirable behaviors, aggression, hyperactivity, and substance abuse. They also often have less social support and have negative views towards school (Suzuki op cit).

Cybervictims miss more school and have poor performance, relationship problems, and inadequate social skills. Insomnia, somatic complaints, strained relationships with loved ones, and social anxiety are often correlated with cybervictimization. Decreased empathy and greater aggression in their relationships with others may be seen. Not surprisingly, those that are traditional victims are also more likely to be cybervictims (Suzuki ibid).

Bully-victims often have poor empathy (Suzuki ibid). Additionally, people who are found to have elevated reactive aggression tend toward

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Research Updates IN PSYCHIATRY

ADHD

Treating ADHD Symptoms in ASD

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Dr. Kahler has disclosed that she has no relevant relationships or financial interests in any commercial company pertaining to this educational activity.

Children with autism spectrum disorders (ASD) frequently have comorbid attention-deficit/hyperactivity disorder (ADHD) symptoms. In fact, it is estimated that these symptoms, including inattention, hyperactivity, and impulsivity, affect 41% to 78% of these children. However, there have been no practice guidelines to aid clinicians in treating ADHD symptoms in children with ASD.

This issue was recently addressed by a group of specialists in the treatment of comorbid conditions in children with ASD, the Autism Speaks Autism Treatment Network Psychopharmacology Committee (ATN-PC), Medication Choice Subcommittee. Drawing on both existing evidence and collective clinical expertise, the ATN-PC aimed to develop practice pathways for evaluating and treating ADHD symptoms in children with ASD.

The group conducted a systematic review of literature published between the years 2000 and 2010 to evaluate the benefits and adverse effects of medications on ADHD symptoms in children with ASD. The medications included stimulants, atomoxetine (Strattera), alpha agonists, and antipsychotics. The search yielded 31 articles appropriate for inclusion. The most randomized controlled trials (RCTs) were found for antipsychotic agents. In these studies, the medications were being studied primarily for the impact on behavioral symptoms and irritability, not ADHD symptoms. However, the benefit for ADHD was a secondary outcome, with improvement reported primarily in hyperactivity. Of the RCTs focusing on ADHD symptoms, the stimulant methylphenidate had the most evidence available.

The ATN-PC developed a symptom evaluation pathway for the treatment of ADHD symptoms in children with ASD. They recommends that once an ASD child with ADHD symptoms has been identified, behavioral, educational, and speech and language supports should first be maximized to target the underlying ASD symptoms. Then, if the ADHD symptoms remain, existing questionnaires and tools to evaluate the ADHD symptoms should be employed, along with a thorough medical evaluation to exclude confounding medical comorbidities. The "medication pathway" then provides guidance for psychopharmacology in cases where the behavioral and other supports are insufficient to control the ADHD symptoms.

In these cases, the ATN-PC recommends beginning with a stimulant, generally methylphenidate, in a short acting form to assess for side effects before switching to a long acting agent. Although stimulant medications have fewer RCTs and a demonstrated efficacy of approximately 50% (compared with 69% in children without ASD), they remain the first choice due to the demonstrated safety profile and decades of use and experience with them. Notably, children with ASD have shown to have lower effect sizes and be more sensitive to medication side effects in general. Thus, antipsychotics, which have more serious side effects, are reserved as a last choice after considering other agents, despite having the most evidence for ASD (Mahajan R et al, *Pediatrics* 2012;130:S125–138).

CCPR's Take: These practice pathways provide much needed guidelines in the treatment of ADHD symptoms in children with ASD. A limitation is the lack of RCTs available for guidance on this topic. The development of these pathways is particularly timely considering the reported change for the DSM-5 to allow for the concurrent diagnoses of ASD and ADHD, which may result in increased identification and treatment of ADHD in children with ASD.

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retaliation, thereby taking the trauma of victimization and perpetrating acts upon their bully or even others. Bully-victims also usually have more experience with traditional bullying and victimization, poor emotional relations with parents, and often associate with peers of poor moral character.

Consequences

As with other forms of bullying, cyberbullying produces an array of consequences, including suicide and, conceivably, homicide. Research indicates that the effects of cyberbullying manifest in many ways. Its victims may feel worry and sense of threat (65%), emotional distress (38%), and indifference (22%) (Suzuki ibid). Cybervictims are at two to three times the risk compared to their peers for problems such as depression and substance abuse. More frequently they also demonstrate delinquent behavior such as increased rates of suspension, detention, and likelihood of carrying weapons. Cybervictims are also twice as likely to attempt suicide. There has also been found to be a direct association between the act of cyberbullying and suicide attempts in males (Bauman op cit).

Prevention and Interventions

Cyberbullying is a real threat to our patients, particularly those in middle school and high school. Poor school performance, difficult relationships, maladaptive behavior, and depressed mood may all be closely associated with exposure to cyberbullying. Since youth tend not to divulge involvement with cyberbullying to adults, catching this through screening and close evaluation may be even more crucial

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CME Post-Test

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Below are the questions for this month's CME post test. This page is intended as a study guide. Please complete the test online at www.TheCarlatChildReport.com. Note: Learning objectives are listed on page 1.

1. According to Ferguson et al, there is no conclusive evidence that links violent video games with major violence (Learning Objective #1).
   [ ] a) True [ ] b) False

2. According to Ybarra et al, what percentage of cybervictims know their bullies personally (LO #2)?
   [ ] a) 95% [ ] b) 84% [ ] c) 31% [ ] d) 5%

3. Research indicates that 65% of cybervictims feel which of the following (Lo #2)?
   [ ] a) Worry and sense of threat [ ] b) Emotional distress
   [ ] c) Indifference [ ] d) Negative views toward school

4. According to the Young Internet Addiction Test, how prevalent is problematic Internet use in the US (LO #3)?
   [ ] a) 1%–9% [ ] b) 2%–18% [ ] c) 11%–25% [ ] d) 7%–10%

5. In the Mahajan R et al study of ADHD symptoms in ASD, what is the approximate demonstrated efficacy of stimulants in children with ASD (LO #4)?
   [ ] a) 25% [ ] b) 50% [ ] c) 69% [ ] d) 88%

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than with traditional bullying. Once patients are identified as cyberbullies and/or cybervictims, mood and risk for depression should be vigilantly monitored in these patients, as should risk of suicidality. Skills deficits should be identified and addressed. For example, cyberbullies could be educated on relational problem solving, anger management, and the impact of their acts, in an effort to induce greater empathy. Education for cybervictims might include social skills, improving comfort in social settings, and increasing assertiveness. Training in cooperation and compromise, comfort in seeking help, and basic skills like problem solving and making decisions could prove to be very beneficial as well (Suzuki op cit; Kiriakidis op cit). Therapeutic techniques such as cognitive behavioral therapy may prove very effective in receptive individuals.

Once individuals are identified as being involved in some capacity with cyberbullying, further exploration is necessary. A thorough evaluation should include questions such as:

- When, how often, and through which means does the cyberbullying occur?
- What are the contents of the attacks, and what is the extent of public exposure?
- Did the individual know the perpetrator?
- How did the victim respond to the attacks and with whom did they share?

Given its strong association, questioning about traditional bullying is highly pertinent as well.

To further help an individual identified as a cyberbully or cybervictim beyond the clinical setting, communication with schools and parents is needed to provide greater awareness and support for the child. Many youth see adults as either indifferent or incapable of addressing this novel problem, driving them to either keep silent or only share with friends (Suzuki op cit; Hinduja S & Patchin J, *J Youth Adolesc* 2013;January 2013 online). Creating a sense that adults are knowledgeable and capable of addressing cyberbullying is needed. This must be backed by hard evidence that adults are part of the solution. Public workshops, school-led events, and government announcements can create understanding of the technology involved, indicate how to identify cyberbullying and victimization, and suggest means to respond to such events.

Changing attitudes toward cyberbullying and perceived social norms is paramount. Cyberbullies often believe

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that attitudes toward their acts are either neutral or positive and that their behavior is acceptable and common (see for example Hinduja & Patchin op cit). By addressing these and other misperceptions, acts may be averted. The opinion of others is critically important to cyberbullies' self-esteem and worth. Peers, teachers, and parents all impact the individual's perception of right and wrong. Social pressure by those who provide significant influence upon individuals has the best potential to effect change.

Cyberbullies may believe that they can carry out their acts without consequence and with pure anonymity. But most actions through technology leave a trace, and dispelling the myth of anonymity will create a better sense of accountability. Sanctions at school have been shown effective in reducing cyberbullying (Hinduja & Patchin op cit), so these along with other means of reprimand should be identified and clearly announced. Cyberbullies need to recognize that their actions may warrant investigation and punishment ranging from interventions at school to prosecution under laws such as the Protection from Harassment Act of 1997 (Kiriakidis op cit). Since people who cyberbully often do not appreciate the ramifications that their behavior has upon their victims, helping expose the consequences may deter some events.

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