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REVIEW ARTICLE

Bullying among today's youth: The important role of the primary care physician

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Bullying is a prevalent public health problem that often involves physical, verbal, and psychological forms of aggression. Approximately, 33% of students experienced bullying during the 2007-2008 school year and 25% of school administrators reported bullying as a daily occurrence. Bullying among youth is associated with short-term and long-term psychosocial sequelae. These include psychological, behavioral, and substance abuse problems as well as academic difficulties, and safety issues that can persist into adulthood. Primary care physicians can play a critical role in assisting youth and their families overcome the psychological and physical effect of bullying. Research has shown that youth who receive primary care-based interventions (screenings and education) have better outcomes in relation to bullying behaviors. This article discusses the importance of a multidisciplinary approach to the primary care management of bullying. Screening youth in the office setting for bullying behaviors, educating parents and youth about potential sequelae of bullying, providing appropriate referrals, being aware of school resources to address the issue, and being knowledgeable about bullying legislation are important steps that primary care physicians can take to help patients and families cope with this important issue.

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Introduction

Definition and epidemiology

Bullying is “a specific type of aggression in which (1) the behavior is intended to harm or disturb, (2) the behavior occurs repeatedly over time, and (3) there is an imbalance of power, with a more powerful person or group attacking a less powerful one.”¹

Bullying often involves physical, verbal, and relational forms of aggression. Physical bullying can include hitting, pushing, or kicking. Verbal bullying may involve name-calling and teasing in a malicious way. And examples of relational bullying include social exclusion and spreading rumors. Cyberbullying, or electronic bullying, is also a prevalent form of bullying that involves electronic equipment such as personal computers and cell phones.² Youth involved with bullying and victimization may be (1) bullies (those who engage in bullying), (2) victims (those who are recipients of bullying), and (3) bully-victims (those who both engage in and are recipients of bullying).

Bullying behaviors are common among elementary, middle, and high school youth.¹³ One study examining a nationally representative sample of 2232 children demonstrated that

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children report bullying involvement as early as the ages of 5-7.¹ However, many studies have shown that bullying occurs most frequently during middle school,^{1,20} in 1 out of every 5 students,³⁸ and most commonly occurs at school or on the way to school.^{3,4} In a survey of 15,686 youth in the sixth through 10th grade, almost one-third of youth reported moderate to frequent involvement in bullying, while decreasing numbers of youth reported engaging in bullying (13%), experiencing bullying (10.6%), and both engaging in and experiencing bullying (6.3%).¹ The 2007 School Crime Supplement to the National Crime Victimization Survey showed that approximately 33% of youth between the ages of 12 and 18 years experienced bullying during the 2007-2008 school year and one-quarter of school administrators reported bullying as a daily occurrence.⁶ Bullying behaviors are seen internationally as well; a study examining the prevalence of bullying among 11-, 13-, and 15-year olds in 40 countries showed that 35% of youth reported bullying others, 34% were bullied, and 39% reported being involved in a physical fight over the past few months.⁵

Bullying is a widespread public health problem that affects youth from all ethnic, cultural, socioeconomic, and gender groups. Research has shown that males are more likely than females to bully and be bullied.^{1,5,12} Males tend to engage more in physical and verbal forms of bullying, also known as direct bullying, whereas females are more involved in relational bullying, a form of indirect bullying.^{1,2} A study involving a nationally representative sample of students in sixth through 10th grades reported no differences in the bullying rates reported by youth from urban, suburban, town, and rural areas.¹

Effect of bullying and victimization on youth

Research has shown that youth involved in bullying behaviors (bullies, victims, and bully-victims) experience negative consequences that affect their psychosocial health, safety and violence involvement, and academic performance.

Studies have shown that bullies, victims, and bully-victims experience short-term and long-term psychosocial sequelae. Youth involved in bullying often experience higher levels of health and academic problems and have poorer emotional and psychological adjustment than uninvolved youth.^{1,9} Those involved in bullying may also experience health problems (psychological, behavioral,² and substance abuse), academic difficulties, and safety and violence issues.^{7,8}

Although primary care physicians can play critical roles in assisting youth and their families in overcoming the psychological and physical effect of bullying, relatively little attention has been given to what physicians can do to address bullies, victims, and bully-victims in the primary care setting. This paper offers information about bullying involvement, its effect on youth, and offers concrete steps

physicians can take to reduce the effect of bullying as well as future incidents of bullying.

Psychosocial effects

Research examining the effects of bullying on youth has consistently found that bullies and the recipients of bullying demonstrate poorer psychosocial functioning than non-involved peers.¹ The psychosocial effects on youth often co-occur with psychiatric problems.¹⁰ It is important for primary care providers to be knowledgeable about the potential psychosocial sequelae that bullies, victims, and bully-victims may experience as a result of bullying involvement.

The recipients of bullying have been shown to be at an increased risk for anxiety, depression, and suicidal ideation.^{10,11} Nansel et al. showed that youth who are bullied tend to have poor social and emotional adjustment, report loneliness, and have difficulties making friends.¹ They have also been noted to be socially marginalized.¹² In a study by Fekkes et al. youth aged 9-12 years who were being bullied, had a higher risk for symptoms such as headaches (odds ratio, 3.0), sleeping problems (odds ratio, 2.4), abdominal pain (odds ratio, 3.2), and bed-wetting (odds ratio, 2.9).¹³

Bullies are also at risk for psychosocial sequelae. Several studies have shown that bullies are at increased risk for anxiety, depression, suicidal ideation, and suicide attempts than those not involved in bullying.^{10,11} Being a bully during childhood has been linked to antisocial personality disorders in adulthood,¹⁰ and bullies are more likely than victims to drink alcohol and smoke.^{1,9} Delinquent behavior, increased anger, poor interpersonal relationships, and poor quality of life are also associated with bullying.¹⁴

Several longitudinal studies suggest that bully-victims may have the poorest psychosocial adjustment among all the youth involved in bullying and are at highest risk for emotional and social difficulties.^{9,12} Those who bully others and are bullied report emotional difficulties, relational problems, and health issues similar to those experienced by youth who are bullied alone. They also have increased antisocial personality tendencies and increased alcohol abuse, which bullies often exhibit.^{9,10} Bully-victims have tendencies for developing psychiatric disorders in adulthood,¹⁰ and are more verbally and physically aggressive and more likely to exhibit hyperactivity and sadness than youth who do not bully or only bully.¹⁵

Health and medical effects

Aside from the obvious medical effect of physical bullying, such as cuts, bruises, scrapes, abrasions, and broken bones in severe cases, little is known about the long-term health effect of bullying. Nonetheless, stress evokes a flight-or-fight response that increases cortisol levels and adrenaline levels, which have been associated with immediate and future health problems. It is postulated that the increased stress associated with ongoing bullying may be associated

with health problems. Although more research is needed to assess the health-related outcomes of bullying, researchers have identified that victims of bullying were more likely to report experiencing poorer general health⁴⁰ and to have more migraine headaches⁴¹ than their nonbullied peers. In a recent study of 3000 adults, those who were bullied during childhood demonstrated poorer overall health, fatigue, pains, and more colds⁴² than those who were not bullied.

Safety and violence

Safety is a concern for youth who are involved in bullying. In 2000, the United States Secret Service Safe School Initiative reported that in more than two-thirds of cases of school violence, the attacker felt "persecuted, bullied, threatened, attacked or injured" prior to the incident.⁸ Research has shown that bullies, victims, and bully-victims are more likely than bystanders to feel unsafe at school.⁷ In a study of 2215 Finnish adolescents aged 13-16 years, 1 in 4 victims of cyberbullying reported that it made them fear for their safety.¹⁶

Studies have shown consistent relationships between bullying and violent behavior.¹⁷ A study of over 3000 third-, fourth-, and fifth-grade students found that children who endorsed beating up others who started fights had twice the odds of being bullies themselves.⁷ Nansel et al. noted that involvement in bullying (bullies and victims) is associated with greater odds of weapon carrying, fighting, and injury from fighting. In this particular study, the relationship was strongest not for the victims, but rather for the bullies themselves.¹⁷ This research implies a relationship between bullying and involvement with violent behaviors and suggests that bullying is a marker for more serious violent behaviors.¹⁷ In a study examining violent deaths in schools in the United States between 1994 and 1999, researchers reported that homicide perpetrators at school were twice as likely as homicide victims to have been bullied by peers.³⁹ This study also supports the association between being bullied and violent behavior. Another study of youth in an urban public school district showed that bully-victims were more likely than bystanders to endorse carrying a gun to school.³⁴

Frequent bullying in childhood may be a predictor for criminality in late adolescence.¹⁸ One study by Olweus found that former bullies had a 4-fold increase in criminal behavior at the age of 24; 60% of the former bullies had at least 1 conviction and 35%-40% had 3 or more convictions.¹⁹ In another study, 2551 boys were initially assessed for bullying behaviors at 8 years of age and then reassessed for criminal behavior between 16 and 20 years of age. Those who were bullies and bully-victims, who also had high levels of psychiatric symptoms at 8 years of age, accounted for 8.8% of the sample but committed 33% of the juvenile crimes between the ages of 16 and 20 years. Furthermore, 21.1% of bully-victims and 15.9% of bullies

were repeat offenders compared with 6.8% who did not bully frequently.¹⁸

Academic difficulties

Youth involved in bullying may exhibit increased academic difficulties compared with youth who are not involved in bullying behaviors. A study of 204 rural Midwestern middle and high school students found that 75% of the students were bullied; 90% of the bullied students said they had a drop in grades as a result of bullying.²⁰ Another study which used grades and the Stanford Achievement Test to measure academic performance found an association between low test scores and being a victim of bullying.²¹ In a study of 3530 third, fourth, and fifth graders, students with 10% higher achievement scores had 20% lower odds of being a victim or a bully-victim.⁷

In addition to academic difficulties, research has showed that youth involved in bullying may have difficulty with school activities in general. Nansel et al. has shown that bullies tend to have poorer school adjustment and lower academic achievement scores than victims.¹ A study of 1985 sixth graders showed that bullies, victims, and bully-victims were less engaged in school activities than uninvolved youth.¹² Glew et al. demonstrated that elementary youth involved in bullying were more likely to be suspended, to be expelled, or to feel unsafe. These youth were also more likely to feel like they did not belong at school and would endorse cheating if they could get away with it, when compared with uninvolved children.⁷

Decreased concentration, anxiety, and sadness are also associated with bullying and may directly affect a child's school performance.⁷ Absenteeism has also been linked to bullying behaviors¹⁵; in the Sharp study, 20% of 723 British elementary, middle, and high school students who were surveyed stated that they would skip school as a bullying-avoidance strategy.²²

What can the primary physician do to address bullying in youth?

The first step to addressing bullying and victimization in young patients is to understand the unique problems of youth who bully, those who are bullied, and those who are both bullies and the recipients of bullying, as outlined earlier in this article.¹² Physicians need to be knowledgeable about the interventions available to assist children involved in bullying so as to overcome the myriad of potential psychosocial and behavioral consequences of bullying. The management of bullying should involve a multi-disciplinary approach²³ and should include screening children in the office setting, educating parents and children, providing appropriate referrals when needed, being aware of school resources, and being knowledgeable about bullying legislation.

Screening

In many instances, the primary care physician is the first point of contact for a child who is involved with bullying. Despite this, many youth do not report being involved in bullying behaviors,²⁴ and feelings of shame, blame, or the fear retaliation may play a role in this.³³ Therefore, it is critical for physicians to incorporate bullying screening into routine office visits. Healthcare professionals should ask direct questions about bullying and screen for youth's involvement in bullying. Physicians should also assess youth for physical signs and psychosocial symptoms that signal a child is at risk for being involved with bullying.^{23,24}

Although there is no psychological profile or assessment that is pathognomonic of bullying, it is important for physicians to ask about bullying during routine examinations, especially when youth present with unexplained somatic and behavioral symptoms.²⁵ An assessment of bullying includes screening for emotional and behavioral problems, assessing a youth's relationships or interactions with peers, and asking specific questions about bullying behaviors. Questions related to these topics can identify youth who are bullied as well as those who bully.

The pediatric symptom checklist (PSC-17) is a standardized measure that is frequently used by physicians to screen for emotional and behavioral problems in youth.²⁶ It consists of 17 items that assess internalizing (eg, feels sad and worries a lot), externalizing (eg, fights with other children and teases others), and attention (eg, fidgety and unable to sit still) problems. The outcome of the brief screen can help the physician determine if a child is at risk for being bullied or for bullying others. Youth who are bullied will likely present with more internalizing symptoms compared with their bullying counterparts who will present with more externalizing symptoms. Whereas, those who are bullied and bully others will likely present with a combination of both internalizing and externalizing difficulties.

Lyznicki et al. recommend asking youth (particularly those with unexplained somatic complaints) about their relationships with peers including conflict resolution strategies and whether they ever feel afraid or threatened during peer interactions.²⁵ To obtain the most amount of information regarding a youth's experiences, physicians should ask both the parents and youth open-ended questions as well as follow-up questions related to bullying behavior. For an example dialog, please refer to [Table 1](#).

Assessments should include evaluating the specific nature of bullying behaviors, the effect of these behaviors, the youth's relationships, and school performance. Specific questions for youth that are recommended by Lyznicki et al. include²⁵

- Have you ever been teased at school?
- What do other children tease you about?
- How do you respond when others pick on you?
- Have you ever told your teacher or other adult about

Table 1 Example dialog

Pediatrician: "I notice that you answered "yes" to fighting with other children. Tell me more about that."
Child: "The kids are always picking on me in class, because I don't read fast."
Pediatrician: "How often does this happen?"
Child: "Almost every day."
Pediatrician: "How does it make you feel?"
Child: "Sad and alone."
Pediatrician: "Do you ever tell the teacher or anyone else?"
Child: "No, it would make it worse. That's why we end up calling each other bad names."
Pediatrician: "What kind of bad names?"
Child: "They call me stupid and a retard."
Pediatrician: "That must hurt your feelings. Let's talk about who you can tell that would help the teasing stop."
Child: "My teacher or my mom."
Pediatrician: "Those are great examples of who you can tell to get help. Let's practice how to tell them."

being teased?
How did they respond?

Questions for parents include

- Are you concerned that your child is having problems with other children at school?
- Does the teacher describe your child as being alone?
- Does your child make frequent visits to the school nurse?
- Has your child complained of other children bothering him or her?
- Do you suspect your child is being harassed or bullied?

In addition, it is important to ask direct questions to assess the frequency of bullying, where bullying occurs, and the types of bullying experienced (ie, verbal, emotional, physical, or cyberbullying). Direct questions include the following: "How often are you bullied/How often do you bully others?," "How long have you been bullied/How long have you bullied others?," "Where are you bullied/where do you bully others?," "How are you bullied/How do you bully others?," and "How do you feel when you are bullied/How do kids feel when they are bullied?"²³

Research has documented that screenings and mental health referrals by physicians have been shown to reduce future involvement in bullying behaviors.²⁷ Screening for bullying can be conducted over the course of several appointments, and medical assistants, nurses, or other staff can interview the youth and administer standardized measures, such as the PSC-17.²⁶

Education

After screening for bullying, it is important for primary care physicians to define bullying for parents and children, educate them about the negative health, safety, and

academic effects of bullying, discuss the importance of parental involvement, and review helpful resources for parents.

Parental involvement is very important, as studies have shown that it not only prevents adolescents from bullying others, but also protects them from being bullied.² Examples of parental involvement include providing proper supervision and being aware of the child's bullying problems in school.²⁸ Physicians should provide parents with bullying information and resources. One such resource is Kidpower, an educational organization developed by Bleistein, a primary care physician, which focuses on, among other things, bullying prevention by providing educational materials.

Although well-child visits are brief, Kidpower skills can be incorporated in increments across several visits.²⁹ Bleistein estimates that, in approximately 2 minutes, the physician can review with parents of children as young as 3-4 years of age the elements of developing a safety plan for use at home and in public. She encourages parents to repeatedly role play or practice the safety plan with their children (a critical element that research has documented for young children to incorporate the plan into their behavioral repertoire.³⁵).

In addition to the physician asking questions to identify bullying involvement, older children can be encouraged to practice using skills, such as the Kidpower trash can to throw away hurting words, remain calm, and safely remove themselves from bullying situations to avoid a fight. They should also be taught to tell and get help from trusted adults. During this process, children should identify trusted adults and practice how to ask them for help. Parents are encouraged to continue practicing these skills with their children at home. For additional information, refer to www.kidpower.org. Although it is unknown whether the Kidpower program as a whole has been empirically examined, many of the skills and the importance of behavioral rehearsal for learning these skills have been documented in numerous prevention and intervention studies with youth experiencing various types of abuse and violence.³⁵⁻³⁷

Another helpful tool is *Connected Kids: Safe, Strong, Secure*, a program established by the American Academy of Pediatrics to address violence prevention. Established in 2005, *Connected Kids* encourages primary care physicians to discuss violence, screen for the risk of violence, and connect physicians, patients, and parents to community counseling and treatment resources. *Connected Kids* is an online resource that consists of clinical guides, parent or patient brochures, and training materials. It is specifically designed to assist physicians in incorporating injury-prevention messages, such as bullying prevention, into the daily practice of medicine.³⁰ One example of how clinicians might engage parents in the discussion of bullying involves utilizing *Connected Kids'* educational brochure entitled, "Bullying: It's Not Ok." This brochure offers facts about bullying and strategies for parents to help stop bullying,

whether their child is a victim, a perpetrator, or a bystander. *Connected Kids* suggests having these brochures in office waiting rooms for parents to read; physicians can then ask parents follow-up questions during the office visit. Visit www.aap.org/connectedkids for more information.

Other valuable resources for physicians, parents, and children include www.stopbullying.gov, www.safeyouth.gov, and www.findyouthinfo.gov. Physicians who take the time to educate children and parents about bullying and discuss available resources can have a very powerful effect on reducing a child's exposure to bullying.

Referrals

Bullying can be identified and managed by primary care physicians. However, in some instances of youth who have significant emotional and behavioral responses to bullying and comorbid psychiatric disorders, making appropriate referrals for additional interventions may be an important step in assisting them. In a randomized controlled trial, 224 children, aged 7-15 years, were screened for psychosocial problems with the PSC-17. The youth with a clinically significant score were then randomly assigned to either an intervention group or a control group along with their parent.²⁷ In the intervention group, physicians reviewed the results of the psychosocial screening, made appropriate psychosocial referrals, and made a telephone-based parenting education program available. Compared with the control group, the children in the intervention group demonstrated significant decreases in aggressive behavior, delinquent behavior, and attention problems after 9 months. Both parents and children reported less bullying. Parents also reported less physical fighting and fight-related injuries that required medical attention. Another benefit of the intervention was the reduction in parental depression and use of corporal punishment.²⁷

This example illustrates how referrals for mental health intervention can be beneficial for patients. While screening for bullying, primary care physicians may discover that a child has experienced significant psychosocial consequences related to bullying. As such, youth may benefit from the psychotherapy, which may assist them in dealing with the effect (eg, depression, anxiety, behavior problems, and delinquent behavior) of bullying involvement as well as concomitant disorders (eg, attention deficit hyperactivity disorder, oppositional defiant disorder, and major depressive disorder). Nickel et al. reported that outpatient family therapy is a helpful treatment option.¹⁴ Parenting education programs can also help reduce bullying involvement and behavioral problems among children.²⁷ Youth may also benefit from programs that address bullying in the school setting.

School resources

Schools can be important sources of information for parents and physicians to gain insight into a child's experience with

bullying. Clinicians are often not able to observe children in school and school staff or teachers often do not see children outside of school—this can complicate the parents' and the physicians' ability to provide appropriate interventions.¹² Thus, it is important for parents and physicians to involve school personnel (teachers, counselors, and principals) when evaluating a child for bullying involvement.

Many schools provide bullying-prevention education to students via programs that range from single-level interventions to comprehensive school-wide antibullying programs. This is important, given that bullying occurs more commonly at school than in other environments.³ The Olweus Bullying Prevention Program is one such example of an evidence-based program that involves school-wide, classroom, and individual components to address bullying.^{31,32} It has been identified as an Exemplary Program by the Substance Abuse Mental Health Administration.^{31,32}

It is also important to establish referral relationships with school personnel and be familiar with the services offered in the school that address bullying. In addition to whole-school bullying programs, many schools provide counseling and maintain disciplinary policies and regulations used to address bullying on an individual level. These programs and policies vary from school to school, thus being educated about these policies and practices is recommended.

Legislation

Public awareness campaigns are an important part of educating professionals and parents about the dangers of bullying. These campaigns also serve the important purpose of encouraging youth to speak out about bullying.¹³ Bullying legislation which has supported the states' ability to address bullying in schools has increased over the years. For a list of states with antibullying legislation, please visit <http://regions.hrsa.gov/adults/state-laws.aspx>. Government websites such as www.stopbullying.gov are also helpful resources.

Conclusions

Bullying is a widespread public health problem that is associated with psychosocial sequelae as well as academic and safety consequences in children. With knowledge about the definition of bullying, the potential sequelae of bullying, and the resources available to assist parents and youth, primary care physicians can help many youth and families cope with this important issue. For example, research has shown that youth who receive primary care-based intervention that includes screenings and education have better outcomes in relation to bullying behaviors.²⁷ It is therefore important for primary care physicians to address bullying in the office setting. Physicians should provide screening, education, and appropriate referrals, when additional intervention is needed, to address bullying at well-child visits as well as when youth present with complaints. Although the primary health physician spends a brief time

with youth and their parents during each well-child visit, spending a few minutes in increments over several sessions to assess bullying behavior, develop a safety plan, and teach self-protection skills can have a very powerful effect.

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