Bullying

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When a resolute young fellow steps up to the great bully, the world, and takes him boldly by the beard, he is often surprised to find it comes off in his hand, and that it was only tied on to scare away the timid adventurers.

― Ralph Waldo Emerson

Learning Objectives:
1. Define bullying, including prevalence and contributing factors.
2. Understand the long-term consequences of bullying both for the bully and the victim.
3. Learn how to effectively screen for bullying and encourage family discussion.
4. Know about resources to provide guidance for families.

Primary Reference:

CASE ONE:

You are seeing Victor Tim, an 11-year-old boy, for a well child visit. When asking about school you learn that Vic is failing several subjects and is frequently sent to the principal for acting out in class, talking back to his teacher, and being generally disruptive. His mother reports that he has missed school on multiple occasions because of headaches and stomach cramps and has asked to stay home from school several times recently. The school is threatening suspension because of his behavior and poor attendance. His problems extend to home where he has been moody, often slamming doors and not wanting to talk to his parents. He isolates himself in his room and has stopped going to karate, which he used to love. After his mother leaves the room, Vic divulges that he is being picked on at school.

1. What would you consider in the differential diagnosis for his school failure and behavior problems?

The differential is broad for a child doing poorly in school or acting out. In addition to being bullied, diagnostic possibilities include ADHD, learning disabilities, unstable home environment, child abuse, and psychiatric disorders such as mood disorders, conduct disorders, substance abuse, or personality disorders.

Gaining an understanding of the parent’s and child’s perspectives on the potential etiology is important, as is allowing them to outline details of behavior at home and school, school performance (including school attendance, grades, any other correspondence between the school and parents), and evaluations or interventions done thus far. Allow the child to discuss stressors at home and school, both in private and with the parent present. Ask about changes in the family situation, safety (at home, at school, and in the community), social supports, and friends. Discuss day-to-day activities and interests, general mood, and changes from baseline. Determine parental education level and degree of involvement in school. Family history should focus on learning disabilities and psychiatric problems, including substance abuse.

2. Define bullying and the scope of the problem.

The AAP policy statement on youth violence defines bullying as “a form of aggression in which one or more children repeatedly and intentionally intimidate, harass, or physically harm a victim who is perceived as unable to defend herself or himself.” Bullying can be subclassified as verbal, physical, or relational (the manipulation of social relationships to hurt or exclude the victim).
A 2009 study of 11-15 year olds in 40 countries found that 1 in 4 adolescents surveyed had been involved in bullying in the last two months. Of these, 47% were aggressors, 40% were victims, and 13% were involved in both types of behaviors. Similar percentages have emerged in other studies, including the 2015 CDC Youth Risk Behavior Surveillance. While males and females are affected equally, and all ethnicities and socio-economic levels are involved, there are features that are associated with higher rates of bullying. Cross-sectional studies reveal that perpetrators of bullying are more likely to demonstrate early childhood depressive symptoms, have a history of school suspension and school failure, and lack parental supervision. Victims of bullying are often targeted because of being seen as different from their peers. The specific differences are wide-ranging (e.g., weight, clothing, race, sexual orientation, disability). Additionally, having poor social competence has been shown to be a risk factor for victimization. Both bullies and victims report rates of parental conflict (including domestic violence and divorce) at greater rates than those not involved.

Red flags for being bullied include multiple somatic complaints, decreased motivation/school performance, school avoidance, frequently losing items, being very hungry after school, always asking for money, unexplained injuries or damaged clothes and threatening to hurt self or others.

3. What are the long-term consequences of being bullied? What are the consequences for the bully?

An international, cross-sectional survey of over 100,000 students revealed that compared to students not involved in bullying more than twice in the last school term, victims of bullying reported worse peer relationships, greater health problems, and greater difficulty with emotional and school adjustment. Children who are bullied are more likely to have generalized somatic complaints, such as headaches, stomachaches, incontinence, and sleep disturbance. They are at higher risk of poor self-esteem, and school performance tends to suffer; self-perception as a victim of bullying predicts lower GPAs and is associated with lower academic achievement on teacher rating scales.

An understanding of the long-term implications of bullying is emerging. Studies have revealed increased rates of depression and anxiety, and lower quality of life and self worth in adolescents who had been bullied in childhood. Rates of suicidal ideation and suicide attempts are higher among victims, even when adjusting for confounding factors. These associations are greater when bullying is ongoing during adolescence. A British longitudinal birth cohort study revealed that these associations persist at age 50. Additionally in this study, former bullying victims suffered higher rates of economic hardship in adulthood.

Perpetrators of bullying are also more likely to have ill effects than peers not involved in bullying. Studies show that victims and bullies have similar rates of depression, suicidal ideation, and social impairments. However, bullies are at higher risk of delinquency, school failure, substance abuse, conduct disorder in childhood, and anti-social personality disorder in adulthood.

Not surprisingly, children who engage in bullying behavior and are also victims of bullying have the highest rates of long-term psychiatric illness. In a longitudinal Finnish study, 30% of bully/victims experienced long-term psychiatric illness (compared to 18% for bullies only, 17% for victims only, and 9% for non-bully/non-victims). The directionality of these associations is unclear, but child-health providers should follow victims and perpetrators of bullying closely for signs and symptoms of mental illness and school failure.

4. What can a healthcare provider do to address bullying?

Given the prevalence of bullying, child health providers should maintain a high suspicion in order to detect bullying behavior. The AAP falls short of recommending universal screening, though emphasizes the importance of equipping parents with skills necessary to prevent bullying before it occurs in the early childhood years. This anticipatory guidance should include: 1) dispelling notions that bullying is a rite of passage in childhood; and 2) reviewing the importance of cognitive stimulation and emotional support at home (which have been shown to instill resilience in children, a trait that is protective against bullying behaviors). Parents and siblings can be reminded that it is not only important to display warmth by their supportive and empathetic statements, tone of voice, and overall display of
enjoyment in the child, but also by maintaining a home atmosphere that is happy, child-friendly, clean, and organized.

A multi-disciplinary approach is key to the prevention and management of bullying. Parents, teachers, school officials, primary care providers, and mental health specialists are all important. The first goal of anti-bullying programs is to create awareness of the problem. Beyond that, interventions are focused on improving peer relations. For the bullies, this means stopping aggressive behavior, learning empathy, and reducing peer reinforcement of bullying behaviors. Victims should be helped in developing strategies to be assertive and improving social skills, and must be provided with opportunities to make friends. Bystanders can be encouraged to speak up when witnessing bullying, or help without putting themselves at harm (e.g., avoid giving positive attention to bullying behavior, include victims in group activities, take a trusted friend with you when reporting bullying to an adult).

In Norway, a school-based bullying prevention program was set up by Olweus in response to an increase in suicides secondary to bullying. His program is based on four principles where adults: 1) are encouraged to show warmth and positive interest in their students; 2) set limits for unacceptable behaviors; 3) have consistent consequences when rules are broken; and 4) serve as authorities/positive role models. This program established a bullying prevention committee that routinely administers questionnaires and creates school-wide bullying policies, and students participate in monitoring and enforcement. There is also increased adult supervision of student activities and a timely response with appropriate discipline. Involved students and their parents participate in individualized meetings where action plans are developed. Other communities have replicated this model and anti-bullying legislation (e.g., in Connecticut) has been based on this template. There is reason for optimism; a 2017 study found an overall decrease in bullying over 10 years of surveillance, postulated to be a result of improved awareness translating to effective school climate initiatives.

While primary care providers can become involved in school-based and community-wide efforts to meet these goals, at the individual patient level, the role of the provider is somewhat different. Direct health implications of bullying must be addressed (e.g., injuries, psychiatric illness). Families should be directed to local resources (such as the program described above) and providers can help families access services through the school system (as bullying often goes unnoticed by teachers, and victims are often afraid to report it). Parents should be reminded of the importance of modeling healthy relationships within the home and monitoring their child’s activities. Open communication allows for early recognition and prevention.

Moderators can highlight online resources for bullying awareness and prevention developed by the AAP (see Resources section).

CASE TWO:

You receive a frantic call from the mother of Aggy Ressor who just discovered a distasteful Facebook site Aggy created to taunt another student. She has not yet confronted Aggy about this and asks for your help.

1. What is cyber-bullying? How can parents help their children navigate use of social media?

Cyber bullying is using text, instant messaging, email or social networking sites to:
- spread rumors or lies
- trick people into revealing personal information
- send or forward hostile messages, posts, or pictures
- create web pages devoted to attacking a particular person

Cyber-bullying is of particular concern because the perpetrator may remain anonymous, the victim is easily “visible,” and there is a larger potential audience.

The AAP released a clinical report on the impact of social media in 2011 that highlights a number of recommendations:
- child health providers and parents must increase their own knowledge of digital technologies to maintain a frame of reference in communicating with children and adolescents
• parents should discuss online use with their children and develop a plan for responsible use and monitoring (e.g., discuss “sexting,” establish communal internet space within home instead of within the bedroom)

• parental involvement and supervision should move beyond remote monitoring software and privacy settings

The 2015 CDC Youth Risk Behavior Surveillance report revealed that 15% of students in grades 9-12 reported being electronically bullied within the previous 12 months. Parents must be aware of this relatively new form of bullying and should encourage open discussion with children, as they should with other complex issues that children face. On a more global scale, authorities are beginning to patrol social networking sites and to press charges against perpetrators of cyber-bullying. Recently, six teens involved in bullying were indicted with felony charges after a 15-year-old victim committed suicide. Moderators may refer to the dedicated chapter on Social Media for a more in-depth exploration of this topic.

CASE continued:

After a long conversation with Aggy, her mom has her remove the website and apologize to the victim. Mrs. Ressor brings Aggy into the office to discuss the situation where you also have an opportunity to discuss the importance of responsible use of social media with Aggy and her mother.

Additional References:


**Resources:**

1. Bullying resources for children and families developed by HRSA: http://www.stopbullyingnow.hrsa.gov/


3. Information for healthcare providers about violence prevention from AAP: http://www.aap.org/connectedkids/

4. Handout for parents related to social media from AAP: http://www.aap.org/advocacy/releases/june09socialmedia.htm