

# Childhood Bullying: Implications for Physicians

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Childhood bullying has potentially serious implications for bullies and their targets. Bullying involves a pattern of repeated aggression, a deliberate intent to harm or disturb a victim despite the victim's apparent distress, and a real or perceived imbalance of power. Bullying can lead to serious academic, social, emotional, and legal problems. Studies of successful antibullying programs suggest that a comprehensive approach in schools can change student behaviors and attitudes, and increase adults' willingness to intervene. Efforts to prevent bullying must address individual, familial, and community risk factors, as well as promote an understanding of the severity of the problem. Parents, teachers, and health care professionals must become more adept at identifying possible victims and bullies. Physicians have important roles in identifying at-risk patients, screening for psychiatric comorbidities, counseling families about the problem, and advocating for bullying prevention in their communities. (*Am Fam Physician* 2004;70:1723-8,1729-30. Copyright© 2004 American Academy of Family Physicians.)

► **Patient information:** A handout on school bullying, written by the authors of this article, is provided on page 1729.

See page 1621 for definitions of strength-of-recommendation labels.

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Childhood bullying has long been perceived as an inevitable part of growing up. However, recent survey data show that American children eight to 15 years of age rate bullying as a greater problem than racism or pressure to have sex or use alcohol and other drugs.<sup>1</sup> In 1999, the U.S. Departments of Education and Justice estimated that almost 1 million students 12 to 18 years of age (4 percent) reported being afraid during the previous six months that they would be attacked or harmed in the school vicinity; about 5 percent reported avoiding one or more places in school, and 13 percent reported being targets of hate-related language.<sup>2</sup>

Bullying has come under increased scrutiny in the United States amid reports that it may be a marker for more serious violence-related behaviors. A nationally representative study<sup>3</sup> of U.S. schoolchildren in grades 6 through 10 found that bullies were more than five times more likely to carry weapons than children who did not engage in such behavior. Students who were bullied weekly were 60 percent more likely to carry a weapon to school, 70 percent more likely to be in frequent fights, and 30 percent more likely to be injured than students who were not bullied. The National

Threat Assessment Center<sup>4</sup> found that the attackers in more than two thirds of 37 mass school shootings felt "persecuted, bullied, threatened, attacked, or injured by others," and that revenge was an underlying motive. An examination of school-associated violent deaths in the United States between 1994 and 1999 indicated that the attackers were twice as likely as the victims to have been bullied by their peers.<sup>5</sup>

## Nature of the Problem

The perceived imbalance of power that is associated with bullying can be a result of age, strength, or size, with the more powerful child or group attacking a physically or psychologically vulnerable victim.<sup>6,7</sup> A repeated, ongoing pattern of aggression distinguishes bullying from other aggressive behaviors. Bullying can be direct or indirect, and can be accomplished through physical, verbal, or other means (*Table 1*).<sup>6-8</sup>

## EPIDEMIOLOGY

Although bullying among children and adolescents can occur in any setting, it typically occurs at school or on the way to and from school.<sup>6,9</sup> The racial composition and setting of the school (e.g., urban, rural) are not

predictive of bullying. During elementary school, bullying is consistently more prevalent among boys than among girls. However, the prevalence in each sex decreases during junior high school and continues to decrease into high school.<sup>6,7,9</sup> Boys tend to use physi-

cal and verbal bullying, while girls use more subtle and psychologically manipulative behaviors such as alienation, ostracism, and character defamation.<sup>6-9</sup>

In 2001, the National Institute of Child Health and Human Development<sup>10</sup> published the first nationally representative research on bullying. Of the 15,686 public and private school students in grades 6 through 10 who were surveyed, 17 percent reported being bullied “sometimes” or more frequently during the school term, and 19 percent reported bullying others “sometimes” or more often. Six percent reported that they had both bullied others and been bullied themselves.

#### BEHAVIORAL INFLUENCES

Children with certain personality traits are more prone to being involved in bullying than other children (*Tables 2 through 4*).<sup>6,7,11-13</sup> However, it is important to avoid labeling or stereotyping these children as “bullies” or “victims.”<sup>11,14</sup> There is no one clinical type of bully or victim, nor is there any clear cutoff point for classifying children into these categories. Furthermore, some children alternate between these classifications.

Several factors affect the manifestation of bullying and its impact on child health and development.<sup>6,7,10-12,15-20</sup> These factors may include aspects of innate temperament, as well as influences by family, friends, school, the community, and the cultural environment. Resilience to bullying is strengthened by the involvement of caring adults; the development of cognitive and social skills; and the presence of strong social support systems.<sup>19</sup> These social support systems may include close family relationships, attachment to school personnel, and membership in positive peer groups (e.g., sports teams, community service groups).<sup>6,11,19,20</sup>

A child’s peer group is a key influence in the development and maintenance of bullying behaviors.<sup>6,7,21,22</sup> Children who participate in bullying can be “assistants,” who physically help the bully; “reinforcers,” who incite the bully; inactive “outsiders,” who pretend not to see what is happening; and “defenders,” who help the victim by con-

**TABLE 1**  
**Common Forms of Bullying**

| <i>Type of bullying</i>   | <i>Direct acts</i>   | <i>Indirect acts</i>  |
|---------------------------|--|---|
| Physical                  | Hitting, kicking, shoving, slapping, sexual grabbing, destruction or theft of property | Enlisting a friend to assault someone for the bully                               |
| Verbal                    | Taunting, teasing, racist remarks, sexual harassment, name calling, insults            | Spreading rumors  |
| Nonverbal and nonphysical | Threatening or obscene gestures  | Exclusion from a group, manipulation of friendships, threatening notes or e-mails |

*Information from references 6 through 8.*

**TABLE 2**  
**Characteristics of Children Who Bully**

- Impulsive, “hot-headed,” dominant personalities; many are physically strong, with good or inflated self-esteem, and feel little or no responsibility for their actions
- Easily frustrated; have difficulty conforming to rules
- Expect others to pick on them; see threats where none exist
- Antisocial; defiant toward adults
- Unable to understand the emotional experiences of others
- Have a positive attitude toward violence
- May have psychiatric disorder contributing to aggressive behavior (e.g., antisocial personality disorder, attention-deficit/hyperactivity disorder)
- May experience peer rejection and social isolation, contributing to an increased risk of depression, suicide, and antisocial personality disorder
- May experience or witness violence and abuse at home (e.g., by parents or other caretakers)
- May experience lack of parental involvement, supervision, and nurturing during childhood
- At increased risk for school failure and dropout, and future problems with violence, delinquency, and substance abuse; in boys, increased risk for multiple criminal convictions in adulthood

*Information from references 6, 7, and 11 through 13.*

fronting the bully.<sup>21</sup> A child's peers can empower and give bullies popularity and status, or they can be a positive influence through friendship and by acting on behalf of victims. Some children who witness bullying remain silent or choose not to intervene out of fear that telling someone or defending the victim will provoke retaliation. A bully is likely to interpret lack of intervention as support for his or her behavior.

### Strategies to Prevent Bullying

Because bullying can begin at an early age, preventive actions should start at home before children begin school. During early childhood, parents and other caregivers can teach young children how to interact socially, resolve conflicts, and deal with frustration, anger, and stress. Parent training programs teach developmentally appropriate parenting skills and ways to deal with young children who display antisocial behaviors.<sup>23,24</sup> For older children, schools have taken the lead in bullying prevention and intervention. The most effective strategies are comprehensive, involving the whole school, with a long-term commitment to changing social and behavioral norms.<sup>6,7,25</sup> Although numerous programs are available, few have been evaluated scientifically.

The Olweus Bullying Prevention program,<sup>6,7,25</sup> which originally was developed and evaluated in Norway, is the best documented and most effective program for reducing bullying among elementary and junior high school students. The program aims to alter social norms by changing school responses to bullying incidents. Rules about bullying are provided and enforced, and efforts are made to protect and support victims.

The Olweus program is endorsed by a number of professional organizations and federal agencies<sup>24,26-29</sup> and is identified as an Exemplary Program by the Center for Substance Abuse Prevention (Substance Abuse and Mental Health Services Administration). The University of Colorado's Center for the Study and Prevention of Violence identifies the Olweus program as one of 11 model violence-prevention programs that meet a high scientific standard of effectiveness.<sup>24,25</sup> These

programs, called Blueprints, have been shown to reduce adolescent violent crime, aggression, delinquency, and substance abuse.

The Olweus model has undergone little independent evaluation in the United States. Although research indicates that it is beneficial for elementary school, middle school, and junior high school students, its effectiveness for high school students is uncertain. A pilot study<sup>25</sup> conducted several years ago in South Carolina showed a 25 percent reduction in bullying when the Olweus system

**TABLE 3**  
**Characteristics of Children Who Are Bullied**

|  |
|--|
| <p>Quiet, cautious, sensitive, insecure; may have difficulty asserting themselves; appear to do nothing to provoke attacks and are unlikely to retaliate if attacked or insulted</p> <p>May be perceived as being "different" or weak</p> <p>May be isolated socially and report feeling sad or lonely</p> <p>May experience psychosomatic symptoms (e.g., sleep disturbances, enuresis, unexplained abdominal discomfort, or headaches)</p> <p>Chronic bullying may interfere with social and emotional development and academic performance</p> <p>May become cynical if they think authority figures let the bullying persist</p> <p>May accept that they deserve to be taunted, teased, and harassed (similar to victims of domestic violence and other forms of abuse)</p> <p>In rare cases, may harm themselves or others, or even consider suicide rather than endure continual harassment and humiliation</p> <p>At risk for depression and poor self-esteem later in life</p> |
|--|

*Information from references 6, 7, and 11 through 13.*

**TABLE 4**  
**Characteristics of Reactive Targets of Bullying (Bully/Victims)**

|   |
|---|
| <p>Are targets of bullying and also bully younger or weaker children</p> <p>May be difficult to identify at first because they seem to be victims of other bullies; a reactive victim may provoke a bully into action, fight back, then claim self-defense</p> <p>Hyperactive, quick-tempered, emotionally reactive children; prone to irritating and teasing others to create tension; attempt to fight back when insulted or attacked</p> <p>At particular risk for persistent social and behavior problems, including social isolation, failure in school, smoking, and drinking</p> |
|---|

*Information from references 6, 7, and 11 through 13.*

was used. This project has been expanded and is undergoing further evaluation.

### Implications for Physicians

Childhood bullying is a complex abusive behavior with potentially serious consequences. The effects of bullying are rarely obvious, and it is unlikely that a child will present to a physician with a chief complaint of bullying or being bullied. However, physicians can identify at-risk patients, counsel families, screen for psychiatric comorbidities, and advocate for bullying-prevention programs in schools.

#### IDENTIFYING AT-RISK CHILDREN

Physicians should be vigilant for possible warning signs of bullying. It is difficult to characterize the typical bully or target. Academically advanced students often are abused or teased by students who are academically challenged. Obese and physically disabled children are common targets. Homosexual, bisexual, and transgendered students are at particular risk for bullying and harassment at school and in their communities. Appropriate intervention can minimize immediate and potential long-term effects in bullies and victims.<sup>10,12,14,16</sup>

Particular attention is needed to identify aggressive, provocative, or reactive victims (i.e., bully/victims; *Table 4*<sup>6,7,11-13</sup>), because they may experience higher levels of psychosocial pathology.<sup>10-14,16</sup>

There is no accepted psychologic profile or assessment method to predict bullying behavior. Physicians should ask about bullying when children and adolescents present with unexplained psychosomatic and behavior symptoms; when they experience problems at school or with friends; if they begin to use tobacco, alcohol, and other drugs; and if they express thoughts of self-harm or suicide.<sup>30,31</sup> *Table 5*<sup>11</sup> provides open-ended questions about relationships with peers, which can be followed up with recommendations for resolving conflicts and questions about specific behaviors (e.g., pushing, hitting, being afraid, being hurt).<sup>11</sup> Children who say they are being bullied must be believed and reassured that they have done the right thing in reporting it.

#### COUNSELING FAMILIES

Families affected by bullying should be counseled to help them understand the problem. Explaining the potentially serious consequences of bullying can underscore the need to take corrective action. Parents should be advised to discuss the problem with school personnel. To prevent further incidents, physicians can discuss effective intervention and coping strategies, including information about teaching children the appropriate response to bullying.

#### SCREENING FOR PSYCHIATRIC COMORBIDITIES

Children should be evaluated for possible psychiatric problems if the bullying (or being bullied) does not stop, or if it interferes with functioning at school or with friends. If a patient is a bullying victim, physicians can screen for separation and generalized anxiety disorder, dysthymia, depression, and panic disorder.<sup>11</sup> Patients identified as bullies should be screened for conduct disorder and other psychiatric comorbidities.<sup>11,32-34</sup> Referral for psychiatric evaluation and therapy may be indicated, and parents also may require evaluation.

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## ADVOCATING FOR PREVENTION

As consultants to schools, police departments, and community groups, physicians can educate other adults who interact with children about the potential impact of bullying. They can stress the importance of building supportive home, school, and community environments that value caring, respect, and diversity.

Physicians can advocate for school-based programs tailored to students' ages, developmental needs, and capacities. Emphasis should be placed on primary prevention and early intervention. Early intervention should focus on social and cognitive skills training, problem-solving techniques, and anger management. Parent training is essential to reinforce the need for adequate nurturing and supervision, appropriate discipline practices, and modeling of positive social behaviors.

Finally, physicians can encourage medical societies to participate in national, state, and local efforts to address childhood bullying. Participation includes support for system-wide change through research, education and training, intervention, and public-policy efforts. The Maternal and Child Health Bureau, in partnership with other federal agencies and national organizations, including the American Medical Association (AMA), recently released a resource kit as part of a national bullying prevention campaign (available online at <http://www.stopbullyingnow.hrsa.gov>). The AMA is addressing bullying through its National Advisory Council on Violence and Abuse, through the work of the AMA Alliance, and by dissemination of a comprehensive youth violence prevention training and outreach guide for health professionals (available online at <http://www.ama-assn.org/go/violence>).<sup>35</sup>

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TABLE 5  
Evaluating Bullying

### Questions for children

Have you ever been teased at school?  
What kinds of things do children tease you about? Have you ever been teased because of your illness/handicap/disability? Do you have any nicknames?  
What do you do when others pick on you?  
Have you ever told your teacher or other adult? What happened?  
Do you know of other children who have been teased?  
At recess, do you usually play with other children or by yourself?

### Questions for parents

Are you concerned that your child is having problems with other children at school?  
Has your child's teacher ever mentioned that your child is often by himself or herself at school?  
Does your child visit the school nurse frequently?  
Has your child ever said that other children were bothering him or her?  
Do you suspect that your child is being harassed or bullied at school for any reason? If so, why?

*Adapted with permission from Glew G, Rivara F, Feudtner C. Bullying: children hurting children. Pediatr Rev 2000;21:186.*

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**Strength of Recommendations**

**Key clinical recommendation**

**Label**

**References**

Physicians should ask about bullying when children and adolescents present with unexplained psychosomatic and behavior symptoms; when they experience problems at school or with friends; if they begin to use tobacco, alcohol, and other drugs; and if they express thoughts of self-harm or suicide.

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Patients identified as bullies should be screened for conduct disorder and other psychiatric comorbidities.

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