Youth Bullying: Implications for Primary Care Providers

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ABSTRACT

Bullying is a form of violence and has become a worldwide epidemic affecting children of all ages. Research has indicated that there are both physical and mental adverse health outcomes associated with childhood bullying that are exhibited both during the time the bullying is occurring and into adulthood. Primary care providers and clinic staff should be sensitive to subtle physical and emotional indicators and have policies and procedures in place to communicate any concerns. In addition, providers should have resources available to offer to children and families who have experienced bullying.

Keywords: bullying, implications, primary care, youth

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Bullying is not a new phenomenon and has become a worldwide epidemic affecting children of all ages.[1,2] Previous studies have demonstrated that there are both physical and mental adverse health outcomes associated with being a victim of childhood bullying, such as headaches, stomachaches, sleep difficulties, anxiety or depression, even suicide.[3,4] These adverse outcomes can be exhibited during the time the bullying is occurring but have been shown to last into adulthood for the victim and the perpetrator.[3]

Given the pervasive problem of bullying, primary care providers (PCPs) and clinic staff should be sensitive to subtle physical and emotional indicators of bullying and have policies and procedures in place to communicate any concerns.

Youth bullying was first systematically researched in Sweden and Norway by Olweus and his colleagues in the 1970s.[1] All too frequently, a report of a school shooting or the suicide of a gay or lesbian adolescent is a reminder that bullying can become a life-threatening experience. Bullying is commonly defined as a specific form of aggression that is intentional, repeated, and involving a disparity of power between the victim and perpetrators.[1]

The following story demonstrates the need for all clinic staff to be trained on how to handle reports of violence in an office setting. Explicit office policies are important for all staff members.

Eric is a slightly overweight, talkative, Mexican-American 8-year-old who is hanging around the reception area of the clinic while his mom and older brother are seeing the nurse practitioner (NP). He asks the receptionist if he can help her straighten up the lobby since they are the last patients of the day. He seems to want to chat, so she asks him about his day. He volunteers that it was a really bad day. She asks if he wants to talk about it, and he does. "You see," he says, "today they really did it." Some older kids at school cornered him at lunch, hit him, and pushed him into a trashcan. It is not the first time these kids have bothered him. He says that last week they followed him to the bathroom and pushed him on the floor in one of the stalls and kicked him.

The receptionist asks Eric if he has talked to his mom or the principal, and he says no. The kids said they would beat him up worse if he told anyone. He insists he does not know who these older kids are. The staff person tells Eric that if none of the adults know that someone is hurting him at school, they can't protect him. Eric reluctantly says he will tell his older brother what happened, and maybe his mom.

After the appointment, the family leaves quickly because their ride is waiting. The receptionist is not able to tell the NP about her conversation with Eric until the family is

gone. After hearing the story, the NP reassures the staff person that she did a good job talking to Eric. However, the NP stresses that next time someone shares information that they might not be safe at home, work, or school, it would be very important to let the NP know in order to figure out how to respond together. The NP calls Eric's house, but the line is busy. She leaves a message on his mom's cell.

Different forms of bullying are commonly recognized: physical, verbal, relational, and cyber.[3] The bullying behavior that the child described in the case study would be considered physical because it included physical contact and was intentional and repeated. The child in this scenario was followed, hit, pushed to the floor, kicked, and pushed into a trashcan. There are, however, additional forms of physical bullying. Specific examples of each type of bullying are noted in Table 1.

Girls are more often involved in verbal and relational bullying, such as social exclusion and spreading rumors, while boys are more often involved in physical and verbal bullying.[4] As was demonstrated in the case study, the bullying done by the boys was physical. Current data in the United States suggests verbal and relational forms of bullying are more prevalent compared with physical bullying in middle-school children.[4]

Historically, bullying occurred during the school day and most often stopped after school and on the weekends. However, timing, location, and methods have changed over the years. In addition to the traditional verbal and physical acts of bullying, the use of technology now allows a child to be bullied 24 hours a day, 7 days a week, 365 days a year. Cyber bullying is a newer type, occurring with the use of technology such as a personal computer or cell phone. This technology-based bullying can take the form of E-mail, instant messages, phone calls, or text messages.[3] Girls are more likely to be the victim of cyber bullying, while boys are more likely to cyber bully.[4]

Recent studies have shown that children are now more likely to be the victim of more than 1 type of bullying (physical, verbal, social exclusion, cyber, and spreading rumors).[6-8] A national survey of US adolescents in grades 5 through 10 reported that 20.8% of students had been involved, either as the victim or perpetrator, in physical bullying at school in the previous 2 months, 53.6% involved in verbal bullying, 51.4% in relational bullying, and 13.6% in electronic bullying.[6]

Researchers have identified that bullying includes more than just the relationship between the bully and the victim. There is a triad of relationships that include the bully, the bullied, and the bystander.[5] The bystander is a child who happens to be present when another child is being bullied. The child who is observing the incident has a range of choices in response to the situation. One response is support the bully by cheering him or her on and encouraging the behavior to continue. Other children choose to be a passive audience to the bullying by watching and doing nothing to help the victim. Lastly, the bystander can denounce a bully's actions and provide support to the victim.

In 2009, the American Academy of Pediatrics (AAP) officially recognized bullying as a form of youth violence and recommended that clinicians should screen children who are most at risk of being a victim.[9] Although there is no typical bully or victim, certain children are more at risk. Academically advanced students may be abused or teased by students who are academically challenged.[10] Obese and physically disabled children are also at risk of being targeted.[11] Homosexual, bisexual, and

Table 1. Types of Bullying

Physical	Verbal	Relational	Cyber
Hitting	Name-calling	Social exclusion	Chat room
Shoving	Taunting	Spreading rumors	Online
Slapping	Racist remarks		Instant messaging
Destruction or theft of property	Insults		On a mobile phone
Pushing	Teasing in a manner		E-mails
Kicking	to hurt the person		

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