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# Violence: Recognition, Management and Prevention

## ROLE OF PEDIATRIC EMERGENCY PHYSICIANS IN IDENTIFYING BULLYING

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**Abstract—Background:** Bullying is an important public health issue with broad implications. Although this issue has been studied extensively, there is limited emergency medicine literature addressing bullying. The emergency department (ED) physician has a unique opportunity to identify children and adolescents that are victims of bullying, and make a difference in their lives. **Objective:** Our aim is to discuss the role of the emergency physician (EP) in identifying patients who have been victims of bullying and how to provide effective management as well as referral for further resources. **Discussion:** This document provides a framework for recognizing, stabilizing, and managing children who have experienced bullying. With the advent of social media, bullying behavior is not limited to in-person situations, and often occurs via electronic communication, further complicating recognition because it may not impart any physical harm to the child. **Recognition of bullying requires a high level of suspicion, as patients may not offer this history. After the stabilization of any acute or overt indications of physical injury, along with obtaining a history of the mechanism of injury, the EP has the opportunity to iden-**

**tify the existence of bullying as the cause of the injury, and can address the issue in the ED while collaborating with “physician-extenders,” such as social workers, toward identifying local resources for further support. Conclusions:** The ED is an important arena for the assessment and management of children who have experienced bullying. It is imperative that EPs on the front lines of patient care address this public health epidemic. They have the opportunity to exert a positive impact on the lives of the children and families who are the victims of bullying. © 2016 Elsevier Inc. All rights reserved.

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## INTRODUCTION

Bullying is an important public health issue for children and adolescents. It is a type of youth violence that threatens young people's well-being (1). Prevalence rates

for bullying vary widely depending on methodology and sample, but most large-scale surveys indicate that 1 in 3 youths are involved as a bully perpetrator, victim, or both (2). Although bullying has been studied extensively, there is limited discussion of it in the emergency medicine literature. Emergency departments (EDs) are potential venues for identifying bullying. The detection of bullying can be problematic and very challenging because children and teenagers may present with non-specific injuries and behaviors, and may not provide information regarding their bullying experience. ED staff should be vigilant for clues, which may help identify bullying. ED staff have a unique opportunity to make a positive impact on the lives of children who are victims of bullying by their recognition and making appropriate referrals.

Bullying is a complex issue influenced by individual, peer, family, and social factors. It can affect children of any age. What separates bullying from other forms of peer conflict is the power differential between the bully and victim. All forms of bullying can be potentially harmful. It has significant health impacts on those who are bullied, those who bully, and may even affect those who witness bullying. In addition, a victim of bullying may feel his or her only option is to retaliate in some way against the bully or bullies. Those involved in bullying at any level can experience academic difficulties, mental health challenges, and physical injuries. Bullying is also associated with an increased risk of substance abuse, suicidal ideation, and suicide attempts (3–5). Unfortunately, these difficulties can persist into adulthood.

Since bullying is common, emergency physicians (EPs) should consider screening for signs and symptoms of bullying on a routine basis and particularly in children with unexplained physical injuries and mental health complaints, such as suicidal ideation and suicidal attempts. An additional screening tool may be arduous, as the ED is already inundated with government mandates and challenged with patient crowding. Many of these issues lead to time constraints that make consistent screening for bullying difficult. However, EP already provide the initial assessment and stabilization for patients who may be victims of domestic violence, sexual assault, and child abuse; including bullying screening is consistent with the role of ED in detecting and ameliorating interpersonal violence. It is important to understand that through effective screening, counseling, and referral, we can protect victims of bullying and facilitate better physical and mental health outcomes. Indeed, the importance of bullying has been recognized by state legislation mandating schools to address bullying, such as the “zero tolerance” policy. In addition, the American Academy of Pediatrics strongly recommends that pediatricians advocate for bullying awareness for all students, both on and off campus (6).

## DISCUSSION

### *Definition of the Problem*

The Centers for Disease Control and Prevention defines bullying as any unwanted aggressive behavior(s) by another youth, or group of youths, that involves an observed or perceived power imbalance and is repeated multiple times, or is highly likely to be repeated (7). Bullying can be verbal, physical, or relational. Verbal bullying can include insults, teasing, taunting, and name-calling. Physical bullying includes pushing, pinching, spitting, hitting, fighting, etc. Relational bullying is an insidious form of bullying. It manifests itself in passive ways that usually involve peer and group behavior. Typical examples include the “silent treatment,” such as ignoring and exclusion. Bullying can also occur via text message(s), e-mail(s), and social media. These electronic forms of bullying are known as cyber bullying.

### *Prevalence*

School children in all age groups are at risk for bullying. In an ED-based study, 24% of children who presented with behavioral symptoms reported bullying (8). In a 2001 national survey of students in grades 6 to 10, 30% of respondents reported being involved in bullying, with 13% as bullies, 11% as victims, and 6% as both (9). According to the Indicators of School Crime and Safety 2013 report by the Bureau of Justice Statistics and National Center for Education Statistics Institute of Education Sciences, approximately 28% of students aged 12 to 18 years reported being bullied at school during the school year (10). Most bullying occurs in unstructured areas, such as playgrounds, cafeterias, hallways, and on buses (11,12). In addition to children and adolescents with disabilities, lesbian, gay, bisexual, transgender, and questioning (LGBTQ) children report a higher rate of bully victimization (13,14).

With childhood access to personal electronic devices at increasingly younger ages, it is not surprising that these devices have become a means of bullying. The 2011 Youth Risk Behavior Surveillance Survey reported 16% of high school students (grades 9 to 12) were cyberbullied in the past year (15). Children can be exposed to traumatizing messages even while at home. This aggression is conducted by electronic means, such as the Internet, e-mail, or mobile devices. Electronic aggression can occur almost anywhere at any time, 24 h/d. Additionally, it allows a larger number of people to witness the bullying. As opposed to a “face to face” bullying encounter, cyber bullying, especially images or messages, can remain on the Internet permanently.

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