Approach to bullying and victimization

Jennifer Lamb MD Debra J. Pepler PhD CPsych Wendy Craig PhD

Case 1

Sally's mother brings her to her family physician because of recurrent stomachaches that have caused Sally to miss several days of school. When the family physician questions Sally and her mother, they reveal that Sally has been sleeping more than usual and seems sad. Sally's teachers have reported that she does not seem as interested in school as she used to be.

Case 2

Jimmy comes into his family physician's office for his annual periodic health examination. His mother expresses concern that Jimmy has been caught drinking and smoking marijuana on several occasions. He has become increasingly aggressive with his younger brother, and over the past few months Jimmy's grades have dropped.

Bullying is a form of abuse that can take various forms at various ages. In this article, we have limited our discussion to bullying among children and adolescents; however, bullying can occur within the family, in the workplace, or in any other setting and at any age.

Bullying is defined as the use of power and aggression to cause distress or control another.[1-3] Although bullying was traditionally thought of as physical aggression, this is only one of many strategies that children use to control and distress others. Bullying can be broadly categorized into direct and indirect forms of aggression.[2] *Direct bullying* is an overt expression of power and can include physical aggression (eg, hitting, kicking) and verbal aggression (eg, insults, racial or sexual harassment, threats). *Indirect bullying* (or *relational aggression*) is the covert manipulation of

This article has been peer reviewed.
Cet article a fait l'objet d'une révision par des pairs.
Can Fam Physician 2009;55:356-60

Abstract

OBJECTIVE To review the epidemiology, identification, and management of bullying and victimization among children in the primary care setting.

SOURCES OF INFORMATION Information was obtained from PsycINFO and MEDLINE databases, as well as the authors' own clinical and research experience. Information is based on levels II and III evidence.

MAIN MESSAGE Involvement in bullying is a destructive relationship problem, with important health implications. Physicians need to be aware of the physical and psychosocial symptoms commonly associated with involvement in bullying so that they can screen and identify those children involved. This article presents a review of bullying and associated symptoms, a tool for assessing bullying involvement, and an overview of intervention and management.

CONCLUSION Bullying is a substantial problem affecting Canadian children. With an increased awareness and understanding of bullying as a health problem, physicians can play an instrumental role in identifying children involved in bullying and providing them with the support needed to develop healthy relationships.

Résumé

OBJECTIF Rappeler l'épidémiologie, la détection et la prise en charge de l'intimidation et de la victimisation chez les enfants en contexte de soins primaires.

SOURCES DE L'INFORMATION L'information a été tirée des bases de données PsycINFO et MEDLINE, et aussi de l'expérience de clinique et de recherche des auteurs. Elle repose sur des preuves de niveau II et III.

PRINCIPAL MESSAGE L'intimidation est un problème relationnel destructif qui a d'importantes conséquences pour la santé. Le médecin doit être conscient des symptômes physiques et psychosociaux souvent associés à l'intimidation, de façon à pouvoir dépister et identifier les victimes. Cet article présente une revue du harcèlement et des symptômes associés, un outil pour détecter sa présence et un aperçu des interventions et de la prise en charge.

CONCLUSION L'intimidation est un problème important pour plusieurs enfants canadiens. En étant plus conscient et mieux renseigné de ce problème de santé, le médecin de famille peut jouer un rôle clé pour identifier les enfants qui en sont victimes et leur fournir le support nécessaire au développement de relations saines.

social relationships to hurt (eg, gossiping, spreading rumours) or exclude the individual being victimized. In recent years, cyberbullying has emerged with technology, involving the use of the Internet and text messaging to cause distress to individuals.

Two elements of bullying are key to understanding its complexity. First, bullying is a form of aggressive behaviour imposed from a position of power: Children who bully (note that we avoid labeling children as *bullies* or *victims* because these labels constrain thinking of the problem as solely a characteristic of the individual, rather than as a problem that emerges from complex social dynamics) have more power than the children they victimize, and this power is often not evident to adults. Children's power can derive from a physical advantage (such as size and strength) or from a social advantage (such as a higher social status in a peer group or strength in numbers). Recent research indicated that children with special health care needs were more likely to be victimized, whereas those with chronic behavioural, emotional, or developmental problems were more likely to be involved in bullying others or in both bullying and being victimized.[4] The second key element is that bullying is repeated over time, and with each repeated incident, the power dynamics become consolidated. Although formal definitions include repetition, children believe that even a single occurrence of the use of power and aggression should be identified as bullying.[5] Research reveals bullying as a destructive relationship problem: Children who bully are learning to use power and aggression to control and distress others; children who are victimized become increasingly powerless and unable to defend themselves from this form of abuse. Interventions are required to support children, neutralize the power dynamics, and promote healthy relationships.

Sources of information

PsycINFO and MEDLINE databases were searched from 1980 to 2008 using the key words *bully, health, physical health, mental health, prevalence,* and *intervention.* Results were limited to peer-reviewed journals and those articles examining child-to-child bullying only. All research cited in this paper is based on levels II or III evidence; owing to practical and ethical constraints, level I evidence does not exist in this field of study. The authors' own clinical and research experience was also incorporated.

Levels of evidence

Level I: At least one properly conducted randomized controlled trial, systematic review, or meta-analysis
Level II: Other comparison trials, non-randomized, cohort, case-control, or epidemiologic studies, and preferably more than one study
Level III: Expert opinion or consensus statements

Signs and symptoms

Bullying problems have been perpetuated by misconceptions that hinder the recognition of bullying as a critical issue affecting children's development. These misconceptions include ideas such as "bullying only occurs in schools," "bullying is a problem that children naturally grow out of," and "bullying is harmless." Although these ideas are refuted by research,[6-8] their perpetuation contributes to the lack of recognition of bullying as a chronic problem for a substantial proportion of Canadian children and youth. National data gathered through the World Health Organization's Health Behaviour in School-aged Children survey (level II evidence) have shown 5% to 8% of girls and 10% to 13% of boys aged 11 to 15 years have reported bullying others regularly; in the same age group, regular victimization has been reported by 9% to 19% of girls and 9% to 21% of boys.[9]

Research points to a strong association between involvement in bullying and substantial health problems. Both children who bully and those who are victimized experience increased physical and psychosocial health problems, although there is a stronger body of research on the health problems associated with victimization. Early indicators of health problems and their potential link to bullying might not come to the attention of parents and clinicians because of the covert nature of bullying and the shame and fear in reporting experiences of victimization. Given the prevalence of bullying involvement, physicians need to be aware of the variety of symptoms and problems that children might present with, to be able to include bullying and victimization in differential diagnoses. The health indicators for bullying and victimization are discussed below and summarized in **Table 1** (level II evidence).

Children who are victimized are more likely to report experiencing physical symptoms (such as headaches or stomachaches) or psychosomatic symptoms (such as difficulty sleeping or bed-wetting) than nonvictimized children[10,11]; children who bully are as likely as victimized children to report these types of symptoms, and children who both bully and are victimized might be at greatest risk.[12,13] Children who bully are also more likely to report alcohol and substance use.[14] Psychological symptoms are more strongly associated with bullying involvement than physical symptoms are.[10] Depression and anxiety symptoms are more likely to be reported by children who bully or are victimized, and especially by those involved in both roles, compared with children not involved in bullying.[10,11,13,15] These children are also at higher risk of suicidal thoughts.[13,15]

Although physical, psychosomatic, or psychological symptoms might be the first to present to a physician, there are other concomitant indicators that might be identified with further questioning of the child or parents. Children involved in bullying are at risk of poor school

functioning, as measured by attitudes toward school, grades, and absenteeism.[16-18] Children who are victimized are more likely to dislike and avoid school[16]; physically aggressive children are more likely to drop out of school.[17] Children with serious psychosocial problems might experience problems associated with attention, behaviour, and emotional regulation, which interfere with their abilities to learn at school.[18]

Screening

The relatively high prevalence of bullying and victimization identified by the World Health Organization survey among Canadian children suggests that primary care practitioners are likely to encounter this problem frequently. Although there are currently no clinical practice guidelines or research findings within a primary care context, the health symptoms described above are serious enough to warrant intervention. In the absence of established guidelines, we present a potential strategy and rationale for screening and management of children's involvement in bullying (level III evidence).

Physicians can incorporate screening for bullying involvement into their practices in a number of ways. First, be aware of the health and social symptoms commonly associated with bullying and victimization, as discussed above and in **Table 1**. Presentation of any of these symptoms can be followed up with questioning about peer relationships and school functioning; physicians can be straightforward and ask children if they are being bullied or bullying others in school, in sports, in recreational activities, or in their neighbourhoods. Awareness of the home environment is also important, as children who are exposed to domestic violence are almost twice as likely to be involved in bullying or victimization.[19] Screening can also be incorporated into routine visits or periodic health examinations by asking children directly about bullying involvement and inquiring about the presence of any of the associated symptoms. The goal is to ensure that the child has a trusted adult to turn to if bullying or victimization occurs.

Once bullying involvement is suspected or identified, the physician should attempt to elicit more detail from the child and family with 4 additional questions, summarized in **Table 2.**

Table 2. Four questions to assess bullying involvement

QUESTION	CHILD WHO IS BULLYING OTHERS	CHILD WHO IS BEING BULLIED
1	How often do you bully others?	How often are you bullied?
2	How long have you bullied others?	How long have you been bullied?
3	Where do you bully others?	Where are you bullied?
	eg, school, sports, home, neighbourhood	
4 a)	How do you bully others?	How are you bullied?
	eg, hitting, insults, gossiping, text messaging	
b)	How do you think the kids you bully feel?	How do you feel when you are bullied?

How often does the bullying occur? The more frequently children are involved in bullying, either victimized or bullying others, the higher their risk of health and other problems.[12]

Over what period of time has this child been involved in bullying or victimization? Children with prolonged involvement are more likely to have established behaviour patterns and reputations within their peer groups that maintain their involvement. With prolonged involvement in bullying or victimization, the risk of associated problems will increase.[20]

In how many different places or relationships does the bullying or victimization occur? Although children most often report that bullying occurs at school, it can also occur at home, in community settings, and on the Internet.[21,22] When bullying occurs across different relationships, it is an indication that behaviour patterns

Table 1. Indicators of bullying and victimization

INDICATORS OF BULLYING	INDICATORS OF VICTIMIZATION
Children bullying others might exhibit the following indicators: • Physical symptoms (headaches, stomachaches) • Psychosomatic symptoms (difficulty sleeping, bed-wetting) • Depressive symptoms • Anxiety symptoms • Alcohol and substance use • Poor school functioning (low grades, dropping out) • In extreme cases, suicidal thoughts or suicide	**Children being bullied might exhibit the following indicators:** • Physical symptoms (headaches, stomachaches) • Psychosomatic symptoms (difficulty sleeping, bed-wetting) • Depressive symptoms • Anxiety symptoms • Absenteeism from school, refusal to attend school • A drop in school motivation and performance • In extreme cases, suicidal thoughts or suicide
Parents might have observed other behavioural signs of bullying: • Little concern for others' feelings • Aggressive or manipulative with siblings, parents, and others, or with animals • Possesses unexplained items or extra money	**Parents might have observed other behavioural signs of victimization:** • Loses items, needs money, hungry after school • Injuries, bruising, damaged clothing, broken items • Threatens to hurt self or others

related to bullying or victimization are consolidated and that the child is experiencing substantial relationship problems. Because relationships are a critical social determinant of health, children who experience problems across multiple relationships will be at risk of health problems.

What forms of bullying have been used and what effects are associated with the bullying? Bullying might be physical, verbal, relational, or electronic (cyberbullying). Although it is difficult to directly compare the effects of various forms of aggression, such as physical bullying versus cyberbullying, the seriousness of the behaviour can be measured by the level of distress it causes the victimized child. The more serious the bullying or the more substantial the effect on the child being victimized, the more likely it is that both the child who is bullying and the child who is being victimized are at risk of the health problems described above.

Management

Identification and assessment of the extent of involvement is the first step to helping children and parents address problems associated with bullying and victimization. While symptoms or injuries requiring immediate attention must be appropriately attended to, long-term strategies for managing bullying involvement require addressing the underlying issue: peer relationships. Because bullying is a relationship problem, the interventions to address bullying must comprise relationship solutions. Children who bully require interventions to stop their aggressive behaviour, promote empathy and prosocial behaviour, and reduce reinforcement patterns within the peer groups for bullying. Children who are victimized might need support in developing assertive strategies, as well as friendship skills and opportunities. Parents of children exposed to domestic violence might require support to model healthy relationships for their children.

Resources for bullying involvement

For parents and children

- Promoting Relationships and Eliminating Violence Network (**www.prevnet.ca**)*
- Stand Up 2 Bullying, Canadian Red Cross (**www.redcross.ca/article.asp?id=24700&tid=108**)*
- Stop Bullying Now, US Department of Health and Human Services (**www.stopbullyingnow.hrsa.gov**)

For professionals

- Canadian Public Health Association (**http://acsp.cpha.ca/antibullying/english/bigdeal/bigdeal.html**)*
- Substance Abuse and Mental Health Services Administration (**http://mentalhealth.samhsa.gov/15plus/health/**)

*Canadian source.

EDITOR'S KEY POINTS

- Bullying is a chronic problem for a substantial proportion of Canadian children and youth. Indicators of involvement in bullying include physical and psychosomatic symptoms, depression and anxiety, alcohol and substance use, and poor school functioning or absenteeism.
- Family physicians should ask children directly about bullying. If you suspect a child is involved in bullying or victimization, ask the child about how often bullying occurs, how long the child has been involved in bullying, how many different places or relationships the bullying occurs in, what forms of bullying have occurred, and what effects bullying has had.
- Bullying is a relationship problem, and the interventions to address bullying must comprise relationship solutions. Management of bullying involvement is a multidisciplinary effort, involving parents, teachers and school officials, primary care physicians, and mental health specialists.

POINTS DE REPÈRE DU RÉDACTEUR

- L'intimidation est un problème récurrent chez une proportion importante d'enfants et de jeunes canadiens. Les indices chez les victimes incluent: symptômes physiques et psychosomatiques, dépression et anxiété, abus d'alcool et de drogues, et mauvais rendement scolaire ou absentéisme.
- Le médecin de famille devrait interroger directement les enfants concernant l'intimidation. Si on soupçonne qu'un enfant en est victime, demandez-lui à quelle fréquence cela survient, depuis combien de temps, à combien d'endroits ou d'occasions différents, sous quelles formes et quels en sont les effets sur lui.
- L'intimidation est un problème relationnel, et les interventions pour y répondre doivent inclure des solutions relationnelles. La réponse à l'intimidation exige un effort multidisciplinaire auquel participent parents, professeurs, responsables scolaires, médecins de première ligne et spécialistes de la santé mentale.

Management of bullying involvement is a multidisciplinary effort, involving parents, teachers and school officials, primary care physicians, and mental health specialists. The physician's role in these interventions might involve helping other adults to recognize the physical and psychological symptoms associated with bullying involvement; supporting the children; directing parents toward resources; advocating on behalf of the children to school officials or other community agencies; providing referrals to treatment settings as appropriate; encouraging parents to take an active role in monitoring

their children and engaging them in positive school and community activities.

Case 1 resolution

The family physician asks Sally if she is being bullied. Sally reports that in the past year a group of girls in her class have been bullying her through gossip, text messaging, and the Internet. On a couple of occasions there have been physical confrontations after school. Sally confesses that she is afraid to walk home after school and sometimes hides in the washroom until the other girls have left. The family physician provides Sally and her mother with some on-line resources to help deal with bullying, advises Sally's mother to contact school officials, and refers Sally for counseling. She encourages Sally to return for follow-up anytime.

Case 2 resolution

When Jimmy is questioned, he admits to bullying his brother and some of his peers at school, using verbal threats and physical violence. His mother admits that Jimmy has been exposed to domestic violence at home. The family physician refers both Jimmy and his mother for counseling and provides them with on-line resources.

Conclusion

Physicians play an important role in promoting the health and well-being of Canadian children and youth. With an increased understanding of bullying as a health problem, and motivation to identify and support children who are at risk of these relationship problems, physicians can be catalysts in promoting healthy relationships and social change. With the potential to help children, their parents, schools, and communities, small efforts by physicians to help children at risk because of bullying or victimization can have profound systemic effects in promoting healthy relationships in all of the contexts in which children and youth live, work, and play.

Dr Lamb is a family medicine resident in the Department of Family and Community Medicine at the University of Toronto in Ontario. **Dr Pepler** is a Distinguished Research Professor of Psychology at York University in Toronto, a Senior Associate Scientist at the Hospital for Sick Children, and Scientific Co-Director of PREVNet (Promoting Relationships and Eliminating Violence Network). **Dr Craig** is a Professor of Psychology at Queen's University in Kingston, Ont, and Scientific Co-Director of PREVNet.

Acknowledgment

The research for this paper was supported, in part, by a Canadian Institutes of Health Research New Emerging Team grant.

Contributors

Drs Lamb, **Pepler**, and **Craig** contributed to the literature review, selection and review of studies, and preparation of the manuscript for publication.

Competing interests

None declared

Correspondence

Dr Jennifer Lamb, University of Toronto, Department of Family and Community Medicine, Women's College Hospital, Burton Hall, 60 Grosvenor St, Toronto, ON M5S 1B2; e-mail **jennifer.lamb@utoronto.ca**

References

1. Juvonen J, Graham S. *Peer harassment in school: the plight of the vulnerable and victimized.* New York, NY: Guilford Press; 2001.
2. Olweus D. Bully/victim problems among school children: some basic facts and effects of a school-based intervention program. In: Pepler D, Rubin K, editors. *The development and treatment of childhood aggression.* Hillsdale, NJ: Lawrence Erlbaum Associates, Inc, Publishers; 1991. p. 411-48.
3. Pepler D, Craig W. *Making a difference in bullying.* Report No. 60. Toronto, ON: LaMarsh Centre for Research on Violence and Conflict Resolution, York University; 2000.
4. Van Cleave J, Davis MM. Bullying and peer victimization among children with special health care needs. *Pediatrics* 2006;118(4):e1212-9.
5. Smith PK, Levan S. Perceptions and experiences of bullying in younger pupils. *Br J Educ Psychol* 1995;65(Pt 4):489-500.
6. Pepler DJ, Craig WM, Connolly J; Crime Prevention Council of Canada. *Bullying and victimization: the problems and solutions for school-aged children.* Ottawa, ON: Public Health Agency of Canada; 1997.
7. Duncan RD. Peer and sibling aggression: an investigation of intra- and extra-familial bullying. *J Interpers Violence* 1999;14(8):871-86.
8. Farrington DP. Childhood aggression and adult violence: early precursors and later-life outcomes. In: Pepler DJ, Rubin KH, editors. *The development and treatment of childhood aggression.* Hillsdale, NJ: Lawrence Erlbaum Associates, Inc, Publishers; 1991. p. 5-29.
9. Chapter 2, section 4: risk behaviours. In: Currie C, Gabhainn SN, Godeau E, Roberts C, Smith R, Currie D, et al, editors. *Inequalities in young people's health: HBSC international report from the 2005/2006 survey.* Health Policy for Children and Adolescents, No. 5. Copenhagen, Denmark: WHO Regional Office for Europe; 2008. p. 159-66.
10. Due P, Holstein BE, Lynch J, Diderichsen F, Gabhain SN, Scheidt P, et al. Bullying and symptoms among school-aged children: international comparative cross-sectional study in 28 countries. *Eur J Public Health* 2005;15(2):128-32.
11. Williams K, Chambers M, Logan S, Robinson D. Association of common health symptoms with bullying in primary school children. *BMJ* 1996;313(7048):17-9.
12. Kaltiala-Heino R, Rimpelä M, Rantanen P, Rimpelä A. Bullying at school—an indicator of adolescents at risk for mental disorders. *J Adolesc* 2000;23(6):661-74.
13. Brunstein Klomek A, Marrocco F, Kleinman M, Schonfeld IS, Gould MS. Bullying, depression and suicidality in adolescents. *J Am Acad Child Adolesc Psychiatry* 2007;46(1):40-9.
14. Pepler DJ, Craig WM, Connolly J, Henderson K. Bullying, sexual harassment, dating violence, and substance use among adolescents. In: Wekerle C, Wall AM, editors. *The violence and addiction equation: theoretical and clinical issues in substance abuse and relationship violence.* New York, NY: Brunner/Rouqtledge; 2001. p. 153-68.
15. Kaltiala-Heino R, Rimpelä M, Marttunen M, Rimpelä A, Rantanen P. Bullying, depression, and suicidal ideation in Finnish adolescents: school survey. *BMJ* 1999;319(7206):348-51.
16. Rigby K. Consequences of bullying in schools. *Can J Psychiatry* 2003;48(9):583-90.
17. Tremblay RE. When children's social development fails. In: Keating DP, Hertzman C, editors. *Developmental health and the wealth of nations: social, biological, and educational dynamics.* New York, NY: Guilford Press; 1999. p. 55-71.
18. Nishina A, Juvonen J, Witkow MR. Sticks and stones may break my bones, but names will make me feel sick: the psychosocial, somatic, and scholastic consequences of peer harassment. *J Clin Child Adolesc Psychol* 2005;34(1):37-48.
19. Baldry AC. Bullying in schools and exposure to domestic violence. *Child Abuse Negl* 2003;27(7):713-32.
20. Pepler D, Jiang D, Craig W, Connolly J. Developmental trajectories of bullying and associated factors. *Child Dev* 2008;79(2):325-38.
21. Pepler D, Craig W, Ziegler S, Charach A. A school-based anti-bullying intervention: preliminary evaluation. In: Tattum D, editor. *Understanding and managing bullying.* Portsmouth, UK: Heinemann Books; 1993. p. 76-91.
22. Raskauskas J, Stoltz AD. Involvement in traditional and electronic bullying among adolescents. *Dev Psychol* 2007;43(3):564-75.