Bullying: An Update

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KEYWORDS

• Bullying • Prevention • Adverse child experience • Peer aggression

KEY POINTS

- Bullying refers to repetitive and intentional peer aggression where there exists a power imbalance.
- Research has increasingly documented the serious and long-term behavioral and health consequences of bullying.
- Several strategies have demonstrated efficacy in addressing and preventing bullying on the individual level and more broadly within schools and communities.

INTRODUCTION

This article represents an updated version of the authors' original article from 2018.[1] Bullying is a complex and widespread public health issue that affects children of all ages and adults. For decades, childhood bullying has been viewed as an unpleasant but generally harmless rite of passage that carries with it few long-term consequences. Portrayals of bullying in countless books and movies depict bully-victims as inevitably resilient and victorious, whereas the bully eventually meets with justice. In the real world, however, such an optimistic view has been tempered by many high-profile suicides coupled with an accumulating literature that has revealed, to the surprise of many, how serious and widespread the sequelae of bullying can be. Current thinking now reflects an understanding of bullying less as an inevitable component of growing up and more as a form of trauma with long-term serious physical and psychological consequences for bullies, victims, and those who oscillate between both roles (bully-victims). With this increased concern about bullying has fortunately come a surge of research directed at advancing basic understanding of bullying behavior and at guiding antibullying interventions on the individual and community level. The following sections address several features of bullying including epidemiology, psychological and physical impact, and the role of health care providers in bullying detection, intervention, and prevention.

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DEFINITION AND PHENOMENOLOGY OF BULLYING

Bullying is often defined as repetitive and intentional aggressive behavior by one individual or group against another in situations where there exists some sort of power differential between the bully and the victim in terms of physical size, social status, or other features.[2] Bullying behavior can include anything from name-calling to outright physical assault. What has been termed relational bullying can involve actions that can occur between friends and acquaintances such as spreading rumors or the active ignoring or exclusion of certain individuals.

Of particular interest lately is cyberbullying, which involves harassing and demeaning text messages, emails, and social media posts. Following the writing of the authors' original article, the landscape of social media has expanded with the arrival of more apps with unprecedented capabilities for communication and connection. With this emergence has also come more potential cyberbullying opportunities and vulnerabilities. Per the Pew Research Institute, "the likelihood of teens facing abusive behavior varies by how often teens go online" with particular concern for "constant users." The duration of time online correlates with an increased risk of bullying, with 67% of teens who are online almost constantly reporting being a target of cyberbullying compared with 53% of those who use the internet less frequently.[3]

Although there is evidence that traditional and cyberbullying often occur together, there remains debate concerning how distinct these types of bullying are.[4] Taken together, at least moderate levels of bullying are estimated to occur in about 30% of school age children, although estimates vary widely because of differences in definition and methodology.[5] A recent study of 13 European and Asian countries found a nearly identical rate of overall victimization of 29.6%, although marked differences were found from one country to the next.[6] One piece of good news, however, is that there is evidence that the prevalence of bullying in the United States may be decreasing,[7] despite headlines to the contrary. A report from the Department of Education cites a rate of bullying at school of 22%, the lowest level since the data were gathered in 2005 (http://nces.ed.gov/blogs/nces/post/measuring-student-safety-bullying-rates-at-school).

School grounds remain the most common site for bullying (other than cyberbullying), and physical appearance is the most common target of bullying behavior.[8] Sexual orientation is also a common focus. Boys tend to bully more than girls, although this difference is diminished, if not reversed, when the definition includes more relational types of bullying.[9] Furthermore, boys tend to be more likely to bully those outside of their core group of friends, whereas girls are more likely to bully individuals within their social network.

Longitudinal studies reveal distinct patterns regarding bullying through childhood and adolescence. Early bullying can be readily identified in elementary school children but tends to peak in the middle school years and early adolescence. It often diminishes later in adolescence and adulthood, although there remains a minority of youth who increase their level of bullying through adolescence.[10]

Many studies of bullying have traditionally divided groups of children into those who are (1) bullies only, (2) victims only, and those who are (3) both bullies and victims. Other groups that are occasionally identified are bystanders, defenders, assistors, and reinforcers.[11] Although broad terms, such as bullies, are admittedly overly heterogeneous,[12] efforts have been slow to identify potentially more meaningful subtypes and categories. For example, there may be a group of more "alpha" bullies who tend to be popular, more socially dominant, and with less comorbid psychopathology in contrast to another group of bullies who are more dysregulated ("delta" bullies), less

socially skilled, and with more associated behavioral and cognitive problems. Such distinctions could prove meaningful with regard to future research studies and intervention strategies.

NEGATIVE EFFECTS OF BULLYING

The negative effects of bullying are being increasingly appreciated. Indeed, bullying has been cited as one of the principle causes for the recent increase in depressive/anxiety symptoms and suicides that have been noted over the past decade among youth.[13] Although bullying as the root of our youth's declining mental health remains debated, the research is clear regarding its negative impact. Bullying is estimated to cause children to miss approximately 160,000 days of school each year according to the National Education Association (http://www.ncpc.org/topics/bullying/what-parents-can-do). A loss of up to 1.5 letter grades due to bullying has also been documented during the middle school years.[14] In the area of mental health and psychiatric disorders, bullying has been linked to future levels of anxiety, depression, suicidality, psychosis, and self-harm behaviors, among others.[15,16] And although the link has yet to be firmly established, bullying has been frequently invoked in the lead up to mass shooting events.[17] Overall, the level of trauma with regard to bullying has been found to be roughly equivalent to a child being placed outside of the home[18] and may be more severe than other forms of child maltreatment.[19] Outside of direct psychiatric illness, bullying in childhood has also been associated with higher levels of chronic inflammation in adulthood.[20]

The picture is more mixed with regard to the relations between bullies and mental health problems. Some studies have demonstrated that many bullies, especially those who also have been bully-victims, show elevated levels of psychopathology. Other studies, however, show evidence that more "pure" bullies may have relatively low rates of mental health problems.[21]

BULLYING DETECTION AND INTERVENTION

Many organizations including the American Academy of Pediatrics (AAP) and the American Academy of Child and Adolescent Psychiatry have emphasized the role of mental health professionals and other health care providers in reducing and preventing bullying. Giving anticipatory guidance, using effective tools to screen for bullying and making efforts in early intervention can lead to marked differences in the lives of many children and their families.

This section discusses methods to help identify bullies and their victims and then presents an overview of prevention strategies both at the individual and at the community level. One useful resource for clinicians is the Connected Kids Web site from the AAP (www.aap.org/), which provides information about screening, family guidance, and bullying interventions with a focus on violence prevention in routine health care visits.

Identification

A first step in preventing bullying is effective identification. Interventions against bullying start with early detection, as shown in **Box 1**. Often bullying is subtle and hidden, especially with regard to more covert relational bullying. It is also important to keep in mind that children often underreport bullying because of a fear of repercussions or feelings of disempowerment and shame.

When bullying victims do present for help, it is often in the context of general somatic complaints without an obvious cause. Victims may also show symptoms of

Box 1
Opportunities for bullying prevention in pediatric primary care (middle childhood)

1. Screen for bullying risk factors including sudden reports of changes in behavior (more depressed, suicidal ideation), truancy, and chronic somatic symptoms without a discernible cause.
2. Provide anticipatory guidance for elementary school students, especially those at risk (perceived as anxious, weaker than other children) before the peak bullying age in middle school. See section on individual level interventions for details.
3. Discuss openly, directly, and gently a child's experience at school. Do not dispute a child's report of bullying even if it is not perceived by parents or teachers.
4. Advocate for schools to adopt elements of effective bullying prevention programs.

social phobia, depression, or attention problems. They may also experience poorer grades or begin missing school.[22]

If bullying is suspected, further questions are warranted, which may include inquiries found in **Box 2**. Such questions can open the topic and reveal possible avenues for intervention, such as a more focused pediatric psychiatric referral or a discussion with the school principal to advocate for effective school-based interventions. For some children who seem reluctant to discuss their own personal history about bullying, initial questions that refer to the general climate of the school (eg, "Is bullying a problem at your school?") can sometimes help begin a conversation. It may also be worthwhile to remind young patients about the protection and limits of confidential discussions.

If more detailed information is needed, several screening and assessment tools are available. The Centers for Disease Control has published a compendium of instruments that are freely available to use to assess potential bullies, victims, and bully-victims.[23]

Individual-Level Interventions for Bully-Victims

Once bullying is suspected or uncovered, there are some general principles that can guide individual-level interventions in the office. Clinicians may find it helpful to

Box 2
Sample bullying screening questions

- I'd like to hear about how school is going. How many good friends do you have in school? (Child) Is your child being picked on at school? (Parent)
- Do you ever feel afraid to go to school? Why?
- Do other kids ever bully you at school, in your neighborhood or online? Who bullies you? When and where does it happen? What do they say or do?
- What do you do if you see other kids being bullied?
- Who can you go to for help if you or someone you know is being bullied?
- When you go for help, what is done about it?

Data from US Department of Health & Human Services. How to talk about bullying. Available at: www.stopbullying.gov. Accessed August 7, 2015.

differentiate lower levels of bullying (name calling, teasing) from higher levels (overt threats, physical violence, and intimidation), keeping in mind that all forms can be potentially harmful.

For lower level bullying, the following points are helpful to remember when working with kids directly and in helping parents help their children:

- Do not underestimate the power of sympathetic listening. Overt expressions to a child that he or she does not deserve this and that such behaviors are really hurtful can be very important to many kids. Positive experiences with friends and families can also go a long way to counteract a negative encounter with a bully.
- Coach bully-victims about how to respond. The old adage of telling a bully that he or she is hurting your feelings has been replaced with advice to react calmly and simply state one's disapproval of the bully's words or behavior or to leave the situation if possible. Some children also are helped by rehearsing specific responses or learning to join nonthreatening peer groups during higher risk activities.
- Engaging a child in general health promotion activities can be helpful. One study from the National Youth Risk Behavior Survey found that regular exercise (4 or more days a week) was associated with a 23% reduction in suicidal ideation among bullied students.[24]
- With cyberbullying, a discussion about Internet breaks or time away from social media platforms may seem a natural suggestion in order to limit a child's risk for exposure. There may, however, be some hazards to this approach, given the growing dependence on social media for educational and other communication needs and fears from adolescents of restriction. Rather than institute new limits, which may feel as a punishment and prevent disclosure of bullying behavior in the future, encouragement to save and report the offensive material may be preferable.
- Consider the option of an anonymous report to a school principal or guidance counselor. As an example, although school personnel may be unable to make a direct response, they might be able to provide more monitoring at high-risk areas, such as bathrooms, school buses, or locker rooms.

For higher levels of bullying, the role of the school, parents, and sometimes even law enforcement is more prominent. The government Web site www.stopbullying.gov/ includes several helpful suggestions and guidelines. Although the response in these instances may often be similar to lower level bullying, adults have a greater responsibility to determine what has happened and to design a response for the bully, if indicated. Many states now have mandatory bullying prevention and intervention policies. Although parents of bullying victims may have strong and natural urges to confront directly the parents of the alleged bully, this step often does not help the situation and can make things worse. Finally, if there is evidence that bullying is having a strong negative impact on the child, a more in-depth evaluation to rule out anxiety disorders, depression, posttraumatic stress disorder, and the presence of any suicidal or homicidal thinking is strongly considered.

Bullies

More evidence-based guidance is needed on how to identify and intervene with bullies individually. Keeping in mind that many youth who bully have histories of victimization and comorbid psychopathology, some may benefit from further evaluation and treatment. Alerting parents to bullying behavior and considering a referral for parent behavioral training can also be useful, although it should not be assumed that bullies

necessarily come from dysfunctional households. According to some experts, common interventions that may exacerbate the harms associated with bullying include group therapy, "zero tolerance" approaches involving suspension or expulsion, or mediation sessions between the victim and bully.

Recently, the tide of intervention for bullies has focused on positive parenting. Positive parenting includes many elements associated with an authoritative parenting style that includes good communication, warmth, and respect, along with good levels of parental supervision. It also avoids harsher modes of discipline and criticism. Positive parenting has been found to have significant, albeit modest, preventative associations with bullying.[25] In addition, there is evidence that promoting increased empathy for the victim is more effective than condemning the bully's behaviors. In a randomized study of hundreds of children in 28 schools, it was found that bullies who were approached with a focus on building empathy for the victim rather than a strict condemnatory approach developed more insight and intention to stop their bullying behaviors.[26]

Taken together, there is evidence that some prevention of bullying is possible by parents and other adults through the cultivation of empathy.

School- and Community-Based Programs

Several comprehensive strategies for prevention and intervention of bullying behavior have been developed, including those that target cyberbullying and programs directed specifically toward bullies, victims, bystanders, teachers, educators, community members, families, and health care practitioners. In the context of bullying as a public health problem, many efforts are directed changing cultural attitudes, with strategies that target the social climate of schools and the greater community.

One of the pioneers in bullying research is Dan Olweus, a researcher on this topic since the 1970s at the University of Bergen in Norway. His work was inspired by several tragic adolescent deaths by suicide that were linked to bullying. The Olweus Bullying Prevention Program is arguably the most researched and widely adopted bullying prevention program in the world.[2] Its aim is to create a supportive school climate through repeated surveys of the school climate from staff, parents, and students. The program recommends the use of varied interventions that include group meetings and interactive videos to foster this change in climate over time.

The degree to which various antibullying programs have been scrutinized and tested varies considerably. The early literature on systematic bullying interventions tended to show improvement in knowledge and attitudes about bullying with little change in actual behavior.[27]

More recent meta-analyses of school-based antibullying programs have been more promising in finding that programs on average were effective at reducing bullying by around 20%.[28,29] Although research has not identified a specific program that has demonstrated superiority, universal programs seem to be as effective as more targeted interventions. Larger effect sizes have also been associated with more comprehensive multifaceted programs and those that reach out to students and use peer involvement.[30] Antibullying program can also be cost-effective, with a study done with the Finnish KiVa program estimating that their teacher administered program saved an estimated $66,172 over 50 years in their group of 200 students.[31]

CURRENT CONTROVERSIES AND SUMMARY

Although consensus continues to move forward regarding issues related to bullying and bullying intervention, there remain areas that are controversial and debated.

Even the definition of bullying is under scrutiny. The Global Health Initiative for the Prevention of Bullying (http://www.ghipb.org/definition-of-bullying.html), for example, disputes the requirement for intentionality and would include, under bullying, aggressive acts that are the results of a person being impulsive or dysregulated. The conceptualization of a bully is also under debate between the view of bullies as symptomatic individuals who themselves are suffering from mental health problems and the portrayal of bullies as more socially dominant individuals who use a *strategy* to maintain their rank within the peer community. Further research is needed to examine potentially meaningful subtypes when it comes to bullies and bully-victims.

With regard to intervention, there does seem to be some tension between the desire of schools and communities to demonstrate that they take bullying seriously while incorporating the increased recognition that purely punitive approaches to bullying are lacking in effectiveness. At the other end of the spectrum, interventions that involve the bully and victim directly meeting to work out their problems with the help of an adult or even peer mediator are no less controversial, with some experts finding this intervention both ineffective and potentially traumatic for the victim, similar to situations of domestic violence.[32]

It is clear from the research that there is no quick and easy solution to bullying. Clinicians of all types can reduce trauma and help patients and families on the individual level while advocating for effective programs for the broader community. Research suggests that many of the most successful programs incorporate all students in a school universally and promote long-term shifts in the school culture that can only occur with broad participation from students, staff, parents, community members, and families. Nevertheless, there remains much to learn on many levels about bullying and the ways that this important public health issue can be more fully addressed and prevented.

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