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Bullying

Effects, prevalence and strategies for detection

Background

The mental, physical, social and academic consequences of bullying have an enormous impact on human and social capital.

Objective

This article describes the effects and prevalence of bullying on young people and presents strategies for its detection. Strategies for the facilitation of a multidisciplinary approach to bullying in adolescents are also presented.

Discussion

Given the existing high rate of bullying, assessment should be incorporated into a standard psychosocial screening routine in the general practitioner's clinic. Effective management is a multidisciplinary effort, involving parents, teachers and school officials, the GP, and mental health professionals. Given the variable effectiveness of schools in tackling bullying, GPs play an important role in identifying at risk patients, screening for psychiatric comorbidities, counselling families about the problem, and advocating for bullying prevention in their communities.

Keywords: adolescent; child, bullying



Bullying is a form of aggression, characterised by repeated psychological or physical oppression, involving the abuse of power in relationships to cause distress or control another.^{1,2} It is a complex and serious problem, which expresses differently according to age, gender, culture and technology.

Although bullying is traditionally understood as physical aggression, there are many other strategies that young people use to control and distress others (*Table 1*).

More recently, the phenomenon of cyberbullying³ has become prevalent. It specifically involves communication technology, especially the internet, mobile telephones and text messaging, to cause distress to individuals. (For detailed information about cyberbullying see *Resources*.)

Bullying and young people

Normal adolescent development is characterised by a mismatch between fundamental drives and self regulatory skills which manifests as difficulty expressing thoughts and feelings, seeing another's point of view and predicting the consequences of one's actions.⁴ This explains why bullying occurs most frequently in late primary school and early high school, when this mismatch peaks. It also makes it unlikely that bullying behaviour can ever be entirely eliminated, although it can certainly be minimised. Nevertheless, as outlined in the Kandersteg Declaration,⁵ every young person has the right to be respected and safe, and bullying is a violation of this basic human right. It is the responsibility of adults to ensure that these rights are defended and that healthy development and citizenship are promoted.

Prevalence

Although bullying has long been perceived an inevitable part of growing up, a recent American survey shows that children aged 8–15 years rate bullying as a greater problem than racism or peer pressure to have sex or use alcohol and other drugs.⁶ Australian data appears to reflect this trend; a 1996 study found 1 in 6 children reported being bullied weekly and being bothered by it.⁷ A recent Federal Government commissioned Australian study surveyed 7000 children from 124 schools nationally and found that bullying peaked in the final years of primary school, with 32% of students stating they



Table 1. Types of bullying

- Physical bullying: hitting, poking, tripping, pushing or damaging someone's belongings
- Verbal bullying: name calling, insults, homophobic or racist remarks and verbal abuse
- Social (covert) bullying: lying, spreading rumours, playing a nasty joke, mimicking and deliberately excluding someone
- Psychological bullying: threatening, manipulation and stalking
- Cyberbullying: using technology (eg. email, mobile telephones, chat rooms, social networking sites) to bully verbally, socially or psychologically

Bullying is not:

- mutual arguments and disagreements
- single episodes of social rejection or dislike
- single episode acts of nastiness or spite
- random acts of aggression or intimidation.

Source The National Centre Against Bullying www.ncab.org.au/Page.aspx?ID=206

were targeted.⁸ This data suggests that the prevalence of bullying is increasing and that Australia has one of the highest rates of bullying in the developed world. A recent review⁹ concluded that the effectiveness of school antibullying measures are modest at best, indicating that bullying is likely to be an ongoing problem.

Social and emotional impact

Although bullying among young people can occur in any setting, it typically occurs at school or on the way to and from school. Young people involved in bullying are at risk of poor school functioning, as measured by attitudes toward school, academic performance and absenteeism.¹⁰ They may suffer significant psychological distress,^{11,12} and in rare instances take their own life.¹³ Young people with serious psychosocial problems might experience problems associated with attention, behaviour, and emotional regulation, which interfere with their ability to learn.¹⁰

The evidence base demonstrating a link between the experience of being bullied with mental health problems in later life is growing.¹⁴ Therefore, although bullying and victimisation might occur early in life, longitudinal studies indicate that its effects can be long lasting. Longitudinal studies also indicate that the tendency to bully at school significantly predicts subsequent antisocial and violent behaviour.¹⁵ A study from the United States of America also 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.¹⁶

The role of the GP

General practitioners have a critical role to play in the assessment and management of young people affected by bullying. The key aspects of this role are outlined in *Table 2*.

Early detection

Given the high prevalence of bullying, GPs should incorporate an assessment for bullying into their standard psychosocial screening routine, ideally with every encounter with a young person.¹⁷

Young people are often reluctant to disclose that they are being bullied because they are ashamed, think it is their fault, may fear retaliation, or regard disclosure as 'dobbing'. An Australian study¹⁸ of 415 high school students found that more than half (54%) would not report bullying to adults. Of those that would report, students more frequently said they would tell a parent, followed by a school friend, and then a teacher.

Although young people are unlikely to spontaneously disclose the issue during a general practice consultation,¹⁷ parents/relatives or another third party may report it or a school may refer the victim to a GP. Many presentations should prompt consideration of bullying (*Table 3*).

Interestingly, young people who perpetrate bullying are just as likely as the victims to report these types of symptoms, and young people who both bully and are victimised might be at greatest risk.^{19,20} Young people who bully are also more likely to report alcohol and substance use.²¹

Assessment

Many adolescents are willing to discuss health concerns with their GP if engaged in an 'adolescent friendly' way. General practitioners are legally and ethically bound to keep information that is disclosed by patients confidential. Concerns about confidentiality are a major barrier for young people,²² so it is important to reassure them that the information they disclose will be kept confidential except in extreme circumstances. (Where, for example, the patient's life may be in danger, public interest or mandatory reporting obligations occur.)

So, once the young person's mental competence is established, it is important to ensure that at least part of each consultation is conducted without the presence of the parent. Removing the parent from the consultation room can be presented as usual protocol with a statement such as, 'Well Mrs Jones, before you leave, and I talk to Amy alone, do you have any more questions?'

Table 2. Tasks for the GP in managing young people affected by bullying

- Early detection
- Assessment of the severity and impacts
- Counselling and support
- Encouraging the young person to disclose the bullying to parents
- Developing an action plan with the family
- Appropriate referral
- Broader roles as required such as:
 - advocating on behalf of the young person to school officials or other community agencies
 - encouraging parents to engage their children in positive school and community activities
 - helping other adults to recognise the physical and psychological symptoms associated with bullying



The HEADSS (Home, Education and Employment, Activities, Drugs, Sexuality, Suicide/depression) psychosocial assessment strategy¹⁷ is a common method of establishing a meaningful rapport between the GP and the young person. It is a useful clinical tool, can usually be completed within the scope of most consultations, and provides a framework for GPs to effectively assess for bullying (see *Resources*).

The GP should ascertain the type of bullying, ie. physical, verbal, psychological (social exclusion, rumours, putdowns), sexual (which can be physical or verbal) or cyber, and determine if mandatory reporting is necessary. If there are concerns about online behaviour that involves sexual exploitation of a child this should be reported to the Australian Federal Police Child Protection Operations team (see *Resources*).

Further practical strategies to facilitate disclosure are described in *Table 4* and *5*.

Counselling and supporting the young person

Ongoing review and support of the young person and their family is very important. Although counselling skills are beyond the scope of this article, some cognitive behaviour therapy-style techniques that can be useful to teach young people include:

- ‘fogging’ – when other people make hurtful remarks, don’t argue and try not to become upset. Imagine that you are inside a huge, white fog bank: the insults are swallowed up by the fog long before they reach you
- staying in the neutral zone – reply to taunts with something short and bland: ‘that’s what you think’ or ‘maybe’, then walk away.

Interactive websites such as MoodGYM²³ and Reach Out Central²⁴ offer cognitive behavioural strategies to help reframe negative thinking patterns (see *Resources*).

There are five key messages that the GP should convey to the young victim of bullying.

1. That they have shown great courage coming forward and the good news is that they don’t have to face it on their own
2. It’s not their fault – but is most likely a reflection of the insecurities of the bully
3. All students have a legal right to learn in a safe environment
4. They should not try to tackle the bully by themselves
5. That bullies thrive on secrecy and the best option is to tell someone in authority.

Encourage disclosure to parents

Baring in mind the young person’s right to confidentiality, GPs should encourage the victim to disclose the facts of the bullying to their parents or legal guardians as soon as possible.

Some young people are reluctant to disclose this information to an adult carer. However, it is generally considered essential to involve parents in the remediation process. A GP may tackle this situation by providing a range of choices to empower the young person. For example, ‘I can appreciate that you may not want mum or dad to know

Table 3. Common clinical indicators of bullying^{29,30}

- School refusal or excuses for school avoidance (eg. feeling sick)
- Wanting to go to school a different way (eg. changing the route, or being driven instead of catching a bus)
- Being tense, tearful and unhappy before or after school
- Talking about hating school or other children
- Suspicious bruises or scratches
- Damage to, or loss of, personal belongings
- Sleeping difficulties including nightmares and enuresis
- Social withdrawal
- Refusing to discuss what happens at school
- Somatic symptoms such as headache or abdominal pain

Table 4. Useful questions about school¹

- What do you like about school?
- What are you good/not good at?
- How do you get along with teachers and other students?
- Is there an adult you can talk to at school about how you feel?
- Have your marks changed recently?
- Many young people experience bullying at school or at home via the net or mobile telephone, have you ever had to put up with this?

Table 5. Example of a bullying history

The ‘many young people’ technique allows sensitive questions to be asked in a nonthreatening way

- I have heard that many young people your age, experience bullying at school or at home – online or by phone – have any of your friends ever had to put up with this?
- Remembering what we said about confidentiality, that this was just between the two of us, can you tell me whether you have ever experienced this sort of harassment at school or at home – online or by telephone?
- What type of bullying was this (ie. is it cyberbullying, physical, psychological)?
- Have you told anyone about this?
- How often has this occurred? (assess intensity)
- How long has this been going on for? (assess duration)
- (If cyberbullying) – did you save any of the messages on your phone or computer as evidence?
- How many different places or relationships does the bullying occur in?



about what you have had to put up with, but in my experience, it is very helpful to let them know what has been going on. We can do this in a variety of ways: you can sit in while I tell them what's been going on; or you can wait outside while I let them know and then bring you in; or you can tell them in front of me.'

Develop a parental action plan

Proper parental support can be a protective factor for bullying, hence the GP's dual role in both detecting and managing bullying while educating parents about how best to prevent and manage it.

Parents should be encouraged to remain calm and under no circumstances contact the parents of the bully. *Table 6* lists tips for parents. Parents should be presented with a clear action plan and a follow up meeting with the GP so that progress can be evaluated and discussed.

The parental action plan should include:

- seeking a face-to-face meeting with the student's teacher, year level coordinator, deputy principal or principal to discuss the matter
- written communication that leaves a paper trail that may be useful should matters escalate
- reading the Federal Government report, 'What should I do if my child is being bullied?' (see *Resources*) or individual state or territory department of education websites
- moving up the 'chain of command' if parents feel that their concerns are being ignored
- at the school meeting, parents should be encouraged to remain calm, bring any evidence they have and ask three key questions:
 - How will this matter be investigated?
 - How long will this investigation take?
 - When can we have a follow up meeting to discuss the results and any sanctions that are handed out?

Encourage parents to record minutes of the meeting and create a record of what was agreed. The GP may also contact the school directly (if agreed by the young person) to discuss the matter with relevant notes made in the patient's file.

Screen for psychological distress and refer if necessary

If the bullying has been sustained, frequent or intense, then a screening questionnaire such as the K10 should be used to help detect clinically significant levels of anxiety or depression.^{25,26} Consider referral to a psychologist if screening indicates that the patient's mental health score is above the 'at risk' threshold or otherwise indicated.

Strategies used in schools

Schools apply rules relating to standards by which children are expected to treat each other. When bullying is identified then sanctions and punishments are appropriate. Useful strategies are outlined below.

Restorative justice

A form of conflict resolution which involves a mediated meeting between victim and offender aimed at making them understand the

harmful effects of their actions, the unacceptable nature of their behaviour and the development of a monitored plan to remediate the situation (see *Resources*).

Peer mediation

Peer mediation is a process in which students resolve disputes and conflict among their peers. Peer mediators are chosen by their own peers and receive training to work with both the bully and the victim to arrive at a nonaggressive, constructive solution. It has been used successfully with children in a number of school settings.²⁷

Shared concern

Simple disapproval and punishment of bullies may not prevent bullying. The shared concern approach is based on the assumption that bullies typically are insensitive to the harm they are doing to the victim (see *Resources*). This is because of their involvement in a group which gives legitimacy to bullying, reducing their sense of personal responsibility. This model uses the fact that bullies commonly feel uncomfortable with their own behaviour. An adult mediator uses specific techniques to demonstrate the impact of the bullying on the victim. Although the method involves a nonblaming approach, it does not seek to excuse or condone bullying and has been found to be effective in many settings.²⁸

Conclusion

Bullying is emerging as a significant but preventable mental health risk factor for young people. Once detected, a partnership involving the

Table 6. Important parental do's and don'ts

Do NOT

- Tell the young person to ignore the bullying as this often allows the bullying and its impact to become more serious
- Blame the young person or assume that they have done something to provoke the bullying
- Encourage retaliation
- Criticise how your child/teenager dealt with the bullying
- Contact the bully or parents of the bully

Do

- Listen carefully. Ask who was involved and what was involved in each episode
- Empathise and reinforce that you are glad your child/teenager has disclosed this
- Ask your child/teenager what they think can be done to help
- Reassure your child/teenager that you will take sensible action
- Contact the teacher and/or principal and take a cooperative approach in finding a solution
- Contact school authorities if bullying persists and escalate your communications up the chain of command



child, the parents, health professionals, teachers, and schools is more likely to lead to a positive outcome. The GP can play a central role in the detection, facilitation of a multidisciplinary approach, and ongoing management.

Resources

For GPs

- HEADSS: www.rch.org.au/clinicalguide/cpg.cfm?doc_id=11710#headdss
- Shared concern method training: www.readymade.com.au/method/previews/index.htm
- Australian Federal Police Child Protection: www.afp.gov.au/online_forms/ocset_form
- MoodGYM cognitive behavioural therapy training: moodgym.anu.edu.au/welcome
- National Centre Against Bullying provides useful resources and tips for health professionals, parents and young people: www.ncab.org.au
- Generation Next seminars and resources for health professionals, parents and teachers: www.generationnext.com.au
- Thorsborne M, Vinegard D. Restorative Justice Pocketbook. Alresford, Hampshire: Management Pocketbook Ltd, 2009

For patients and parents/carers/teachers

- 'What should I do if my child is being bullied?': www.deewr.gov.au/Schooling/NationalSafeSchools/Pages/whattodo.aspx
- Cyber(smart:) provides activities, resources and advice to parents and children on using the internet safely: www.cybersmart.gov.au
- National Centre Against Bullying: www.ncab.org.au
- Reach Out information on mental health and wellbeing resources and services: <http://au.reachout.com/find/articles/kids-help-line>
- Bully Blocking information and resources, including a newsletter and books in different languages: www.bullying.com.au

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