What is bullying?

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Abstract

Bullying is a major public health problem affecting 20% of children in the United States and the United Kingdom. With the proliferation of online electronic and social media use among children, cyberbullying has become more pervasive in recent years and poses its own unique challenges in detection and intervention. Both bullying and cyberbullying cause long-term biological and psychological consequences for all those involved including victims, bully/victims and bullies. Clinicians who treat paediatric patients play a crucial role in not only screening for and addressing the impacts of bullying in their clinical settings, but can also help advocate for evidence-based anti-bullying programs and policies. In addition to clinicians, this issue demands the concerted and coordinated efforts of all those who are concerned with the care of children including teachers, school administrators, educators, and policy makers. This article aims to offer an introduction to identifying and screening for bullying and cyberbullying as well as approaches to addressing these issues in our clinics, schools, and the community at large.

Keywords bully/victim; bullying; bystander; cyberbullying; HEEADSSS; primary care; psychosocial; upstander

Key points

- Bullying is a common occurrence, affecting an estimated one third of children worldwide.
- Bullying is an unwanted aggressive behaviour by a person or group against a targeted victim with the intent to harm physically or emotionally and can take many forms including verbal, physical, relational, and cyber.
- Long-term consequences of bullying victimisation are widespread and include increased rates of anxiety, depression, PTSD, social isolation, and difficulties with interpersonal functioning.
- Long-term consequences for bullies and bully/victims include increased incidence of conduct and criminal behaviours, violence, and substance abuse.
- Clinicians who treat paediatric patients play a crucial role in not only screening for and addressing the impacts of bullying in their clinical settings but can also help advocate for evidence-based anti-bullying programs and policies in schools and communities.

Introduction

Bullying is a common occurrence affecting an estimated one third of children worldwide.[1] Bullying can occur anywhere from classrooms to online. Though at times it is dismissed as a childhood rite of passage, bullying is a form of aggression that can have long-lasting adverse health and psychological repercussions for all involved.[2] Bullying not only inflicts harm on the victim that results in physical, psychological, social or educational consequences but can also have serious ramifications for the bullies, bully/victims, and bystanders involved.[3] Clinicians are in a unique position to help identify and address the negative effects of bullying.[4]

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Definitions

Bullying is an unwanted aggressive behaviour by a person or group against a targeted victim that has the intent to harm either physically or emotionally.[2] This behaviour is repeated or has the potential to be repeated over time and involves a real or perceived power imbalance.[5] Bullying participants are defined in Table 1.

Types of bullying

Bullying can take many forms including verbal, physical, relational, and cyber. Verbal bullying involves teasing, name-calling, taunting, making inappropriate sexual comments, or making threats. Physical bullying can involve hitting, tripping, kicking, spitting, or taking or damaging someone's possessions. Relational or social bullying is a covert form of bullying that involves hurting someone's reputation or relationships by purposely excluding the victim from a group, spreading rumours, or embarrassing the person in public.[6]

With the explosion of electronic devices and social media use amongst youth, cyberbullying has become a reality for many.[7] Cyberbullying is the use of the internet, cell phones, or other electronic technology to send, post, or share negative, false, or hurtful content about someone else. It also includes sharing private or personal information to cause humiliation. Cyberbullying happens via email, webcams, text messages, online chat rooms, social media, and gaming communities. Compared to traditional bullying, cyberbullying poses unique challenges as it can be done at any time, often anonymously, and can be spread quickly to large audiences. Electronic content is difficult to

Definitions of bullying participants
Bullying: repetitive, aggressive behaviour directed toward an individual with the intent to cause harm or distress
Bully: the perpetrator of bullying behaviour
Victim: the target of bullying behaviour
Bully/Victims: both a perpetrator and target of bullying behaviour
Bystander: a witness to bullying behaviour including onlookers, supporters of bullies, or upstanders who intervene
Upstander: a witness to bullying behaviour who chooses to act to support the victim and/or intervene in the bullying behaviour

Table 1

remove, and cyberbullying is difficult for adults to discover and intervene.[7]

Epidemiology and risk factors for bullying

The UNESCO Institute of Statistics reports that bullying among youth ranges from 7% in Tajikistan to 74% in Samoa.[1] Nearly 20% of children in the United States and United Kingdom report having been bullied in the previous year.[8,9] Over 10% of children have suffered from chronic bullying lasting at least 6 months.[10] Rates of bullying victimisation are similar between boys and girls and tend to decline over time, with bullying being twice as common among 9 to 13-year-old children compared to 14 to 16-year-old children. Bullying victimisation is a risk factor for persistent bullying over time. Studies show that close to half of children who experienced bullying in primary school continue to experience bullying in secondary school.[11] Nearly 10% of children reported having bullied others at some point, while 4.5% report being bully/victims.[10] Both bullies and bully/victims are more likely to be male. Cyberbullying has become an increasingly significant problem, particularly among adolescent children. Nearly 15% of children report having been cyberbullied in the previous year. In contrast to traditional bullying, cyberbullying rates are higher among girls.[8]

Bullying tends to take place in settings with low adult supervision of youth. In school, this includes secluded areas of the playground, hallways, or restrooms during times with relative lack of adult supervision such as before and after school, lunchtime, or between classes. Outside of school, bullying may occur while children are walking to and from school, while riding the bus, or at parks near the home.[12] Cyberbullying occurs via electronic media or the Internet where there is often very little to no adult supervision. Cyberbullies can hide behind anonymity making it difficult to identify perpetrators.[13] The school climate, which includes teaching practices and attitudes, organizational structures, and norms and values, also plays a critical role in the perpetuation of bullying. Bullying occurs more frequently when teachers and administrators are less attuned to the signs of bullying or less willing to intervene.[14]

The prevalence of bullying victimisation among lesbian, gay, bisexual, and transgender (LGBT) youth is a significant concern, with close to a third of LGBT children reporting bullying victimisation (either traditional or cyberbullying) in the past year.[8] Other risk factors for bullying victimisation include having a disability or chronic medical condition such as asthma, food allergies, skin conditions, diabetes, learning disabilities, autism, or physical disability. Being an outlier in weight or height (on either extreme) is also reported as a risk factor for being bullied. Bullying victims are often socially isolated and lack a consistent friend group. Victims tend to have more anxiety and depression symptoms and report a lower self-esteem compared to non-victims.[15]

By contrast, bullies may be popular and of higher social status. They usually have positive attitudes toward violence and are impulsive. The more emotional support the bully receives from friends regarding their bullying behaviour, the more likely they are to continue engaging in bullying behaviour. Contrary to popular belief, bullies tend to have average to above-average self-esteem. Bully/victims are more aggressive and emotionally reactive, less sociable, and more likely to react provocatively to bullying. Like victims, bully/victims tend to have low self-esteem.[15]

Long-term effects of bullying

Long-term consequences of bullying victimisation are widespread and include increased rates of anxiety, depression, PTSD, social isolation, and difficulties with interpersonal functioning. Bullying victims also have more difficulties with job stability and higher rates of unemployment later in life.[5,16] Long-term consequences for bullies and bully/victims include increased incidence of conduct and criminal behaviours, violence, and substance abuse.[15]

Diagnosis and screening of bullying

Clinicians who manage paediatric patients play an important role in screening for and addressing the impacts and consequences of bullying. Clinicians should set aside time in the visit to discuss the child's psychosocial environment, including interpersonal relationships in the home, school, and community. The clinician should explicitly ask the child and caregiver about bullying and cyberbullying. They should clarify whether the child has been involved as a victim, bully, bully/victim, or bystander, and in which environments these interactions have taken place. Making time for a confidential interview between the clinician and child can help to facilitate such discussions. Allowing the parent to step outside the room should be standard practice for adolescents over 12 years of age.[4]

The way in which bullying is asked about and framed is of critical importance. Normalizing the conversation and letting the child know that they are in a safe space in which they can share information is key to ensuring that the child feels comfortable sharing. Children are often hesitant to disclose their involvement in bullying for fear of retaliation, shame, or the belief that it is their fault.[17] In addition, some children may not understand their involvement in or effects of bullying. As a result, it may be prudent to initiate the conversation without directly utilizing the terms "bullying" or "cyberbullying".[4] Instead, ask about the child's general psychosocial environment, as outlined in Table 2. For adolescents, one screening tool that can help guide the conversation and also identify potential coexisting mental health concerns and psychosocial risk factors is the HEEADSSS (home environment, education/employment, eating behaviours,

Clinician questions to elicit bully exposure

What do you like/not like about school?

How do you get along with other students and teachers at school?

Do you have friends at school? Outside school? What do you like to do with your friends?

Do you feel safe at school? At home? In your neighbourhood?

What makes you feel safe/unsafe at school? At home? In your neighbourhood?

Has anyone teased you or been mean to you at school? Outside school? Through social media or phone/texting?

Have you ever teased or been mean to anyone at school? Outside school? Through social media or phone/texting?

Have your marks changed recently?

Is there anyone at school or at home who you can trust to talk to about how you feel?

Many young people experience bullying at school, at home, or in other settings. The bullying can be in-person, via text messaging or phone calls, or via social media (often referred to as cyberbullying). Is this something that you or someone you know has been affected by? How does this make you feel?

Adapted from[4,17,18]

Table 2

activities with peers, drug use, sexuality, suicide/depression, safety) assessment.[4] It is vital to reassure the adolescent that the information they disclose will be kept confidential unless there is a safety issue (risk of harm to self or others or concerns for child abuse or neglect).

A host of behavioural changes, somatic complaints, mood and anxiety concerns, and clinical findings may be indicative of bullying victimisation. Several behavioural patterns and familial risk factors can be associated with perpetration of bullying as well.[15] These findings are outlined in Table 3. Children affected by bullying should be screened for common coexisting mental health conditions such as depression and suicidality, anxiety, PTSD, and ADHD. Because of the high likelihood of bullies being victims themselves, it is advised that all children affected by bullying (whether as a bully, victim, bully-victim, or bystander) be screened for such mental health conditions. Broad-based screening checklists such as the Pediatric Symptom Checklist (PSC) or the Child Behavior Checklist (CBCL) may be useful to screen for psychological impairment in general.[18] More specific screening measures such as the Revised Children's Anxiety and Depression Scale (RCADS), Patient Health Questionnaire (PHQ-9) modified for teens, Beck Depression Inventory, and the NICHQ Vanderbilt Assessment Scale may be of utility if there are concerns for a specific mental health diagnosis.

Interventions for bullying

Clinical interventions

The clinician should provide support, counselling, and appropriate referrals for the child or adolescent who is impacted by bullying. The first step is to emphasize to the youth that they have demonstrated great courage in disclosing this information and that there is help available. For victims, it is important to highlight that the bullying they are experiencing is in no way their fault. Let them know that they are not alone and encourage them to disclose their experiences to their caregivers or other trusted adults. Provide children and parents with clear, up-to-date information and resources about bullying and its impacts.[4] Examples include the Stop Bullying website from the United States Department of Health and Human Services, the BullyingUK website from Family Lives, and the Cyberbullying Research Center website.[19,20] Prompt and appropriate referral to mental health professionals should be made for coexisting conditions.[4] Further interventions for bullying victims include participation in extracurricular activities that encourage positive peer relationships and promote self-esteem such as sports, school clubs, and community service organizations.[18]

School-based interventions

Clinicians can work with schools and communities to advocate for bullying prevention and intervention programs. A systematic review of bullying interventions found that whole-school anti-bullying programs were most effective in reducing bullying.[21] A whole-school approach entails a collaborative action plan involving the entire school community including senior school leadership, teachers and staff, parents, and students.[21] These interventions can include teacher trainings, increased supervision of students' outdoor activities, consistent reporting and response strategies, classroom curriculum, conflict resolution training, individual counselling, and school policies that foster a positive social climate of anti-bullying on campus.[21,22]

Interventions empowering bystanders to become upstanders also decrease bullying and are less resource-intensive than whole-school approaches.[23] There is a witness in 80% of bullying situations, and if that witness intervenes there is a 50% chance of stopping the bullying act.[24] Upstanders can be taught to safely intervene by telling a teacher or helping the victim escape the situation.[23]

The KiVa anti-bullying program,[25] a whole-school intervention from Finland, has been adopted by many U.K. schools and offers online toolkits. The All Together Online Hub from the Anti-Bullying Alliance[26] helps schools create action plans and audit their current anti-bullying practices (see Key References). Some ineffective practices to avoid include large anti-bullying assemblies, zero tolerance policies, disciplinary actions such as suspensions, or direct peer mediation between the bully and victim.[22]

Red flags for identifying bullying participant status

Victim	**Physical complaints:** -insomnia -abdominal pain -headaches -new-onset enuresis	**Psychological symptoms:** -depression -loneliness -anxiety -suicidal ideation/gestures	**School problems:** -academic failure -social problems -lack of friends
	Behavioural changes: -irritability -poor concentration -school refusal -substance abuse	**Unique features:** -children with chronic medical illnesses -physical deformities -students in special education	**Physical examination:** -torn or damaged clothing or belongings -unexplained cuts, bruises, and scratches
Bully	**Attitude toward behaviour:** -desire to obscure the problematic behaviour	**Features:** -aggressive -overly confident -lack empathy -oppositional or conduct problems	**High-risk families:** -physical punishment -model violent behaviour in conflict resolution
Bully-Victim	**Physical complaints:** -Psychosomatic complaints (insomnia, headaches, abdominal pain, etc.) similar to victims.	**Psychological symptoms:** -externalizing behaviour and conduct disorder problems -depression and anxiety -suicidality -substance use or abuse	**School problems:** -school disengagement and academic failure -social isolation and exclusion by peers -increased likelihood of bringing weapons to school
Bystander	**Psychological symptoms:** -anxiety -depression -suicidal ideation	**School problems:** -academic difficulties -school avoidance -feeling unsafe at school	

Adapted from[4,22,30]

Table 3

Educating youth and parents about cyberbullying is important for prevention. A meta-analysis summarized promising school-based cyberbullying intervention programs.[27] Parents should be advised to keep home computers in easily visible places, discuss expectations for responsible online behaviour, and encourage their children to notify adults immediately of cyberbullying. Clinicians should advise families to document harmful posts, report the cyberbullying to online platforms, and if a potential crime is occurring then notify police.[28]

Policy and advocacy

Clinicians should be aware of government laws surrounding bullying to help advocate for families. In the U.K., by law all state schools must have a behaviour policy preventing all forms of bullying among students. Schools must also follow anti-discrimination laws to prevent harassment, discrimination, and victimization in the school (gov.uk, 2020).[29] In the U.S., each state has its own anti-bullying laws and regulations. For example, California requires school districts to implement policies that prohibit bullying, set procedures to investigate bullying, provide resources to support LGBT and other at-risk students, and create retaliation protections for complainants. Information about state-specific anti-bullying laws can be found at the stopbullying.gov website.

Clinicians can also engage stakeholders and build partnerships to address policies that affect bullying and violence such as access to weapons, improving built environments, and supporting programs that build youth self-esteem, empathy and resilience to help foster an anti-bullying culture in the community.[22]

Summary

Bullying is a public health issue affecting youth across the globe. The harmful ramifications of bullying experiences often extend beyond childhood and adolescence. Clinicians need to remain informed to better identify and intervene in cases of bullying. This can be through performing screenings, providing counselling and resources, and advocating for bullying and cyberbullying prevention and intervention programs in schools and in the community. Clinicians can play a role in reducing harm associated with bullying and cyberbullying. ◆

REFERENCES

1 United Nations Educational, Scientific, and Cultural Organization. Behind the numbers: ending school violence and bullying. 2019. Available at: https://unesdoc.unesco.org/ark:/48223/pf0000366483 (accessed 11 January 2021).

2 Olweus D. School bullying: development and some important challenges. *Annu Rev Clin Psychol* 2013; **9:** 751–80.

3 Moore S, Norman R, Suetani S, et al. Consequences of bullying victimization in childhood and adolescence: a systematic review and meta-analysis. *World J Psychiatry* 2017; **7:** 60–76.

4 Stephens C-F. Childhood bullying: implications for physicians. *Am Fam Physician* 2018; **97:** 187–92.
5 Arseneault L. Annual Research Review: the persistent and pervasive impact of being bullied in childhood and adolescence: implications for policy and practice. *JCPP (J Child Psychol Psychiatry)* 2017; **59:** 405–21. https://doi.org/10.1111/jcpp.12841.
6 U.S. Department of Health and Human Services. StopBullying.gov. 2020. Available at: https://www.stopbullying.gov/ (accessed 20 January 2021).
7 Englander E, Donnerstein E, Kowalski R, Lin C, Parti K. Defining cyberbullying. *Pediatrics* 2017; **140:** S148. https://doi.org/10.1542/peds.2016-1758U.
8 Kann M. Youth risk behavior surveillance — United States, 2017. *MMWR Surveillance summaries* 2018; **67:** 1–114. https://doi.org/10.15585/mmwr.ss6708a1.
9 Ditch the Label. The annual bullying survey 2018. 2018. Available at: https://ditchthelabel.org (accessed 20 January 2021).
10 Wolke L. Long-term effects of bullying. *Arch Dis Child* 2015; **100:** 879–85. https://doi.org/10.1136/archdischild-2014-306667.
11 Bowes M. Chronic bullying victimization across school transitions: the role of genetic and environmental influences. *Dev Psychopathol* 2013; **25:** 333–46. https://doi.org/10.1017/S0954579412001095.
12 Smokowski. Bullying in school: an overview of types, effects, family characteristics, and intervention strategies. *Child Sch* 2005; **27:** 101–10.
13 Juvonen J, Graham S. Bullying in schools: the power of bullies and the plight of victims. *Annu Rev Psychol* 2014; **65:** 159–85. https://doi.org/10.1146/annurev-psych-010213-115030. Epub 2013 Aug 5. PMID: 23937767.
14 Farmer ML. Revealing the invisible hand: the role of teachers in children's peer experiences. *J Appl Dev Psychol* 2011; **32:** 247–56. https://doi.org/10.1016/j.appdev.2011.04.006.
15 Hensley V. Childhood bullying: a review and implications for health care professionals. *Nurs Clin N Am* 2013; **48:** 203–13. https://doi.org/10.1016/j.cnur.2013.01.014.
16 Copeland W. Adult psychiatric outcomes of bullying and being bullied by peers in childhood and adolescence. *JAMA Psychiatr (Chicago, Ill)* 2013; **70:** 1–8. https://doi.org/10.1001/jamapsychiatry.2013.504.
17 Carr-Gregg M, Manocha R. Bullying—effects, prevalence and strategies for detection. *Aust Fam Physician* 2011; **40:** 98–102.
18 Shetgiri R. Bullying and victimization among children. *Adv Pediatr* 2013; **60:** 33–51. https://doi.org/10.1016/j.yapd.2013.04.004.
19 Bullying UK. Bullying general advice. 2020. Available at: https://www.bullying.co.uk/ (accessed 20 January 2021).
20 Cyberbullying Research Center. Cyberbullying resources. 2020. Available at: https://cyberbullying.org/resources (accessed 20 January 2021).
21 Vreeman R, Carroll A. A systematic review of school-based interventions to prevent bullying. *Arch Pediatr Adolesc Med* 2007; **161:** 78–88.
22 Vanderbilt D, Keder R. Bullying. Chapter 33: bullying. In: Zuckerman B, Augustyn M, eds. Zuckerman parker handbook of developmental and behavioural pediatrics for primary care. 4th ed. Lippincott Williams & Wilkins, 2019; 163–7.
23 Barnett J, Fisher K, O'Connell N, Franco K. Promoting up stander behavior to address bullying in schools. *Middle Sch J* 2019; **50:** 6–11.
24 Polanin J, Espelage DL, Pigott TD. A meta-analysis of school-based bullying prevention programs' effects on bystander intervention behavior and empathy attitude. *Sch Psychol Rev* 2012; **41:** 47–65.
25 KiVa Program & University of Turku. KiVa program. 2020. Available at: https://www.kivaprogram.net/ (accessed 20 January 2021).
26 Anti-Bullying Alliance. All together: a whole school anti-bullying programme. 2020. Available at: https://www.anti-bullyingalliance.org.uk/ (accessed 20 January 2021).
27 Espelage D, Hong J. Cyberbullying prevention and intervention efforts: current knowledge and future directions. *Can J Psychiatr* 2017; **62:** 374–80.
28 Feinberg T, Robey N. Cyberbullying: intervention and prevention strategies. *Natl Assoc School Psychol* 2009; **38:** 1–4.
29 Gov.UK. Bullying at school. 2020. Available at: https://www.gov.uk/bullying-at-school (accessed 20 January 2021).
30 Midgett D. Witnessing bullying at school: the association between being a bystander and anxiety and depressive symptoms. *School Mental Health* 2019; **11:** 454–63. https://doi.org/10.1007/s12310-019-09312-6.