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Intervening in Primary Care against Childhood Bullying:

an increasingly pressing public health need

Short title: Primary Care and Childhood Bullying

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Abstract

Childhood bullying is a major risk factor for physical and mental health, educational attainment and social relationships. Epidemiological evidence has highlighted that its adverse consequences continue into adulthood leading to substantial health and wider societal costs. With the advent of cyber bullying, childhood bullying is increasingly pervasive. Children can now be reached and subjected to systematic peer abuse at all times. Given the limited impact of school-based initiatives, there is increasing interest in developing the role of primary care services to support the early identification and response to childhood bullying, but evidence-based interventions are lacking.

This paper considers the scale and health-related consequences of childhood bullying. It argues the need for greater awareness and responsiveness in primary care as part of a community-wide, integrated approach to stemming its harmful effects. Primary care is well-placed to identify affected children, provide support to children and their parents to help improve coping skills and mitigate the effects of bullying, where necessary making referrals to appropriate agencies for associated physical and mental health problems. However, evidence-based guidance on how best to achieve this is lacking. Effective interventions that can be delivered in primary care to identify affected children and intervene to minimise the consequences of being bullied are needed, and this paper suggests a number of research questions that need to be addressed.

CHILDHOOD BULLYING: THE SCALE OF THE PROBLEM

Childhood bullying is increasingly recognised as a major public health concern.[1] It has serious effects on health leading to substantial costs for individuals, their families and society at large.[2 3] This paper considers the importance of healthcare professionals, particularly in primary care, becoming more aware of childhood bullying as a significant risk factor and safeguarding issue. It argues that there is a need to develop evidence-based approaches to more effectively recognise and manage affected children.

Bullying is a systematic abuse of power characterised by repeated psychological or physical aggression with the intention to cause distress to another person. In the UK alone, over 16,000 young people aged 11-15 are estimated to be absent from state school with bullying as the main reason, and 78,000 are absent where bullying is one of the reasons given for absence.[4] Approximately 50% children report having been bullied at some point in their lives, and 10 - 14% experience chronic bullying lasting for more than six months.[5] It affects physical and mental health, social relationships and academic achievement, and throws a lifelong shadow over health causing considerable suffering and avoidable costs for society (Box 1). As stated by President Obama in 2011, there is a pressing need *"... to dispel the myth that bullying is just a harmless rite of passage or an inevitable part of growing up. It's not."*[6]

Bullied children are twice as likely as non-victims to suffer from psychosomatic problems, such as headaches, abdominal pain, sleeping problems, poor appetite and enuresis.[7] They are at highly increased risk (3-6 times) of psychosis symptoms, borderline personality disorder, depression, eating disorders, self-harm and suicidal behaviour.[8,9] They are more likely to have high rates of absenteeism or worries at school leading to poor academic performance.[10,11]

Long term social consequences include difficulties with holding down employment, managing finances and social relationships, and mental health consequences include general anxiety disorder, panic disorder, agoraphobia, depression, and suicidal acts[3]. Accurate economic modelling of its consequences is lacking in the UK, but in the USA it has been estimated that preventing high school bullying results in lifetime cost benefits of over $1.4Million per individual.[12]

Childhood bullying is a problem that is not confined to schools, but is increasingly community-based. With the advent of social networking sites and the ubiquity of mobile phones, childhood bullying can

happen at all times, and in all places.[13] Victims may experience public humiliation from which there is no respite, even when within the comfort of their homes. Bullies are found in all socioeconomic strata, at fairly similar rates.[14] Both minority ethnic and white youths report comparable levels of victimisation, highlighting the necessity for all children to be considered at risk.[15]

Many bullied children suffer in silence, and are reluctant to tell their parents or teachers about their experiences, for fear of reprisals or shame.[16] Up to 50% children say they would rarely, or never, tell their parents, while between 35% and 60% would not tell their teacher.[17] Children are less likely to disclose to parents who are either harsh in their parenting ("harden up") or over protective (e.g. likely to initiate immediate wide-ranging complaints to the school).[18]

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Given that bullying is frequent, found in all social groups and occurs within and outside schools, society-wide inter-agency approaches that encompass education, primary care, mental health services, families and other organisations has been advocated. This has been reinforced recently by the Global Health Initiative for the Prevention of Bullying (GHIPB),[19] an international group of leading researchers who aim to seek the partnership of health organisations around the world with the objective of advising all clinicians to routinely enquire about patients' participation or exposure to bullying and detect bullying related morbidity in all clinical encounters.

Until now, UK policy has tended to focus on tackling bullying in schools, providing educational staff with guidance and support to design and implement anti-bullying policies.[20] Unfortunately, such policies alone tend to have little effect and most school-based anti-bullying interventions have led to only modest results.[21] in some cases, they have even led to further victimisation of the bullied child.[22] To increase recognition of bullying as a community problem, charities such as BeatBullying are campaigning for Ayden's Law to be included in the UK Government's newly drafted Anti-social Behaviour, Crime and Policing Bill, currently before parliament. This would include a 'community trigger' that allows members of communities to request a review in situations where there have been several complaints about bullying. Community remedies are important because they are civil rather than criminal and ensure an alternative to criminal prosecution in the majority of cases. (www.thebbgroup.org/blog/entry/aydens-law-progress-update)

WHY PRIMARY CARE?

Primary care, as the point where children generally make first contact with health services, is well-placed to take a more active role in identifying and addressing bullying in children. NICE guidance

(CG28) recommends primary healthcare professionals be trained to improve the evaluation of psychosocial risk factors in childhood, including the development of anti-bullying strategies.[23] Early detection and intervention has the potential to improve health during childhood as well as preventing the long term damaging effects of childhood bullying. This should be considered within the wider context of primary care initiatives aimed at promoting health in children and young people, which includes identifying and addressing other sensitive issues, such as sexual abuse, substance abuse, obesity, smoking and inactivity.

At present, data are lacking of the extent to which children attending general practice are currently experiencing bullying. However, given the associations between being bullied and experiencing acute mental and physical health problems it is to be expected that such children are more likely to encounter primary care professionals than do their non-bullied peers.

A crucial issue is the willingness of children to speak to a healthcare professional about being bullied. Most under-16 year olds attend the GP with a parent present, who will often be unaware of the child's experience of being bullied. Given the lack of evidence on this subject, we recently created a public-facing webpage with an online questionnaire to gather evidence on children's views with regards to talking to their general practitioners about being bullied. Links to the webpage were posted by several national anti-bullying charities' websites and 96 responses were gathered from children 16 years and under and 43 from parents of children who have experience of being bullied (www.warwick.ac.uk/gpbullyingresearch/resultssummary). While the findings should be interpreted cautiously given the limitations of this small convenience, nonetheless they indicate interest in developing the role of general practice to support bullied children. Of the child respondents, 93% felt GPs should be better able to recognise and help young people affected by bullying, and 55% agreed that they would feel comfortable being asked about experiences of being ullied by their GP if they were attending the GP for an everyday problem such as a headache. Of the parents, 86% stated they saw it important that GPs should be better able to recognise bullying, and 81% were positive in regards to asking their child to answer a screening questionnaire in a GP waiting room. Importantly, while 53% saw bullying as a health problem only 33% of parents had approached their GP for help, and only half of these found the encounter useful.

Evidence is lacking of the extent to which primary care services are identifying and being responsive to the needs of children who are experiencing bullying. Some initiatives to encourage greater recognition are starting to emerge, particularly in the United States. The American Academy of

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Pediatrics has suggested tips for doctors to post on office walls and share with patients with regards to bullying.[24] These include teaching the child when and how to ask for help, standing tall and staying calm in a difficult situation. The impact of this guidance has not been evaluated.

In addition to the effects that bullying has on affected children, it also may contribute to distress to parents and siblings, a further reason for considering this as a primary care issue. Certain parenting styles such as abusive or harsh parenting but also overprotective parenting such as 'mollycoddling' can increase the chances of a child being bullied.[18] Furthermore, children who are bullied at home by their siblings are more likely to become targets at school.[25]

Sensitive, but firm and fair parenting and good sibling relationships can reduce the effects of being bullied on mental health outcomes.[26] Primary health care professionals are well-placed to take a whole-family view of the bullied child, to consider the role and effects that other members of the family may be having on the child, and so provide appropriate support and intervention on issues surrounding bullying.

EVIDENCE TO INFORM POLICY AND PRACTICE

Evidence is still rudimentary for the role that primary care may play in identifying children involved in bullying and providing effective support. Several issues need further consideration (Box 2), within the context of integrated, community-wide initiatives that are required to ensure that at risk children are identified. The effectiveness of different approaches to identification of bullied children in schools, general practice, school nursing, emergency departments, paediatric clinics, children and adolescent mental health services (CAMHS) and other services where children present needs to be investigated.

At present, for reasons which may include lack of awareness, fear of offending or embarrassing patients and their parents, the absence of clear clinical guidelines and effective interventions, together with lack of time, primary care professionals appear to rarely consider that a child is being bullied. Empirical evidence is needed to understand health professionals' views about childhood bullying and their support for different approaches to improving its recognition.[27] The feasibility of screening within the constraints of everyday practice, particularly given the prevalence of childhood bullying, should be investigated.[28] This should inform the development of brief training materials for healthcare professionals to promote enquiry about bullying and the delivery of effective responses.

For children identified as experiencing the effects of chronic or severe bullying, effective interventions are needed. These might incorporate educational or brief psychological interventions aimed at coping with victimisation and the associated health-related consequences, as local care pathways to other services. The applicability of intervention components that have been found to be effective at reducing bullying in non-healthcare settings should be considered. These include videos showing bully situations, disciplinary methods, parent training, and cooperative work between professionals including health and mental health providers.[29] Bullying interventions that enable children to actively learn how to deal with a range of real life bullying situations within a safe environment, such as solution-focussed virtual learning approaches, may be particularly suitable and warrant exploration.[30] Novel programs that integrate virtual or web-based delivery may be particularly relevant to the target population of young people, and feasible to offer from a primary care setting.

CONCLUSION

Childhood bullying has serious health consequences. It affects a substantial proportion of children of all social classes and ethnic groups. However, there appears to be a huge void between knowledge of the established adverse consequences of bullying and awareness, enquiry and intervention by healthcare providers. Given children's reluctance to seek help from school, and with affected children experiencing health problems which may lead to increased use of primary care services, there is a persuasive case for greater awareness and responsiveness to childhood bullying among the primary care professionals with whom they come into contact. Primary care professionals have a responsibility to recognise children in distress and to intervene where possible to prevent the adverse outcomes associated with childhood bullying. However, to date there has been little research into the role that primary care professionals might play, and of the effectiveness of different approaches to screening and management.

Evidence to inform policy, public health and clinical guidelines is urgently needed for health professionals to become more aware of and sensitised to confronting this major risk to children's health. There is a need for schools, health services and other agencies to coordinate their responses to bullying, and research is needed to evaluate such interagency policies and processes.

KEY MESSAGES

- Childhood bullying is a significant risk factor leading to harmful physical, psychological and social effects that can last a life time
- There is a need for greater awareness and responsiveness in primary care as part of a community-wide, integrated approach to stemming the effects of childhood bullying.
- Evidence-based guidance is lacking on how best to identify affected children in primary care, provide support to children and their parents and where necessary make referrals to appropriate agencies for associated physical and mental health problems.
- Effective interventions that can be delivered in primary care to minimise the consequences of being bullied are needed.

CONTRIBUTORS and SOURCES:

JD and DW led the drafting of the paper. JD is a professor of primary care and practising general practitioner and is guarantor for the work. DW is a professor of psychology and an expert in researching childhood bullying. RR is research assistant with psychology and health services research experience who contributed to the literature searching and drafting. In addition, Catherine Winsper and Alison Hipwell participated in discussion and drafting that informed some of the content of this paper.

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REFERENCES

1. Scrabstein JC, Merrick J. Bullying is everywhere: an expanding scope of public health concerns. *International journal of adolescent medicine and health.* 2012;24(1).
2. Wolke D, Copeland WE, Angold A, Costello EJ. Impact of Bullying in Childhood on Adult Health, Wealth, Crime and Social Outcomes. *Psychological science.* 2013.
3. Olweus D. School bullying: development and some important challenges. *Annu Rev Clin Psychol.* 2013;28(9):751-780.
4. Brown V, Clery E, Ferguson C. Estimating the prevalence of young people absent from school due to bullying. *National Centre for Social research* 2011;1:1-61.
5. Analitis F, Velderman M, Ravens-Sieberer U. Being bullied: associated factors in children and adolescents 8 to 18 years old in 11 European countries. *Pediatrics.* 2009;123(2):569-577.
6. Lee J. President Obama & the First Lady at the White House Conference on Bullying Prevention. 2011; http://www.whitehouse.gov/blog/2011/03/10/president-obama-firstlady-white-house-conference-bullying-prevention. Accessed 20/08/2013.
7. Fekkes M, Pijpers FIM, Fredriks AM et al. Do Bullied Children Get Ill, or Do Ill Children Get Bullied? A Prospective Cohort Study on the Relationship Between Bullying and Health-Related Symptoms. *Pediatrics.* May 1, 2006 2006;117(5):1568-1574.
8. Wolke D, Lereya ST, Fisher H L, et al. Bullying in elementary school and psychotic experiences at 18 years: a longitudinal, population-based cohort study. Psychological Medicine, FirstView, 2013: 1-13. doi: doi:10.1017/S0033291713002912
9. Lereya ST, Winsper C, Heron J, et al. Being Bullied During Childhood and the Prospective Pathways to Self-Harm in Late Adolescence. Journal of the American Academy of Child and Adolescent Psychiatry, 2013: 52(6), 608-618.e602. They are more likely to have high rates of absenteeism or worries at school leading to poor academic performance.10,11
10. Wolke D, Copeland WE, Angold A, Costello EJ. Impact of Bullying in Childhood on Adult Health, Wealth, Crime, and Social Outcomes. Psychological Science 2013: 24(10), 1958-1970. doi: 10.1177/0956797613481608
11. Nakamoto J, Schwartz D. Is Peer Victimization Associated with Academic Achievement? A Meta-analytic Review. Social Development, 2010: 19(2), 221-242.
12. Masiello M, Schroeder D, Barto S, et al. *The Cost Benefit: A First-time Analysis of Savings*: Highmark Foundation;2012.
13. Smith PK, Mahdavi J, Carvalho M et al. Cyberbullying: its nature and impact in secondary school pupils. *Journal of child psychology and psychiatry, and allied disciplines.* 2008;49(4):376-385.
14. Due P, Merlo J, Harel-Fisch Y, et al. Socioeconomic inequality in exposure to bullying during adolescence: a comparative, cross-sectional, multilevel study in 35 countries. *American journal of public health.* 2009;99(5):907-914.
15. Tippett N, Wolke D, Platt L. Ethnicity and bullying involvement in a national UK youth sample. *Journal of adolescence.* 2013;36(4):639-649.
16. Chamberlain T, George N, Golden S, Walker F, Benton T. *Tellus4 national report*: National Foundation for Educational Research. The Department for Children, Schools and Families 2010.
17. Radford L, Corral S, Bradley C, Fisher HL. The prevalence and impact of child maltreatment and other types of victimization in the UK: Findings from a population survey of caregivers, children and young people and young adults. *Child abuse & neglect.* 2013.
18. Lereya ST, Samara M, Wolke D. Parenting behavior and the risk of becoming a victim and a bully/victim: A meta-analysis study. *Child abuse & neglect.* 2013.

19. Scrabstein JC. Be Aware of Bullying: A Critical Public Health Responsibility. The physician's responsibility to detect acts of bullying and intervenes to help those who bully and are victims of bullies. *Virtual Mentor.* 2009;11(2):173-177.
20. Department for Education. Bullying. 2013; http://www.education.gov.uk/schools/pupilsupport/behaviour/bullying. Accessed 20/08/2013.
21. Samara M, Smith PK. How schools tackle bullying, and the use of whole school policies: changes over the last decade. *Educational Psychology.* 2008;28(6):663-676.
22. Merrell KW, Gueldner BA, Ross SW, Isava DM. How effective are school bullying intervention programs? A meta-analysis of intervention research. *School Psychology Quarterly.* 2008;23(1):26.
23. NICE. Social and Emotional Wellbeing in Primary Education. 2008; http://www.nice.org.uk/nicemedia/pdf/ph012guidance.pdf. Accessed Accessed 20/08/2013.
24. Committee on Injury V, & Prevention, P. Role of the Pediatrician in Youth Violence Prevention. *Pediatrics.* 2009;124(1):393-402.
25. Ensor R, Marks A, Jacobs L, Hughes C. Trajectories of antisocial behaviour towards siblings predict antisocial behaviour towards peers. Journal of Child Psychology and Psychiatry, 2010: 51(11), 1208-1216. doi: 10.1111/j.1469-7610.2010.02276.x
26. Sapouna M, Wolke D. Resilience to bullying victimization: The role of individual, family and peer characteristics. *Child abuse & neglect.* 2013.
27. Hensley V. Childhood bullying: a review and implications for health care professionals. *The Nursing clinics of North America.* 2013;48(2):203-213.
28. Caudle NJ, Runyon K. Bullying among today's youth: The important role of the primary care physician. *Osteopathic Family Physician.* 2013;5:140–146.
29. Ttofi MM, Farrington DP. Effectiveness of school-based programs to reduce bullying: a systematic and meta-analytic review . [Review]. *Journal of Experimental Criminology.* 2011;71(1):27-56.
30. Sapouna M, Wolke D, Vannini N, et al. Virtual learning intervention to reduce bullying victimization in primary school: a controlled trial. *Journal of child psychology and psychiatry.* 2010;51(1):104-112.

Box 1: Recognised consequences of childhood bullying

Physical Health	Mental Health	Societal Problems
Headaches	Depression	School absenteeism
Poor appetite	Self-harm	Elective home education
Abdominal pain	Suicide	Poor employability
Sleeping Problems	Psychosis	Lowered income
Enuresis	Anxiety	Drug Use
	Personality disorder	Offending behaviour

Box 2: Key issues needing further consideration

Questions	Considerations	Research Needs
To what extent are bullied children identified in general practice?	How to raise awareness in primary care	Establishing prevalence of bullied children among those attending general practice
What are children's, parents' and health professionals' views and concerns about screening for childhood bullying in primary care?	Understanding concerns and training needs. Identifying potential risks and harm	The acceptability, cost and benefits of screening in primary care
What types of primary care intervention are needed and how should these be targeted?	Involving all stakeholders (primary care, mental health, schools, children, parents, charities, policy makers) in the design of interventions	Design, feasibility, acceptability and uptake of intervention components
How effective are interventions to address childhood bullying	Validity and reliability of outcome measures to evaluate	Evidence of the effectiveness of primary care-based

that are delivered from the primary care setting?	short-, medium, and longer term impact on health and quality of life	interventions in recognising and aiding victims of bullying