media images on the mental health of children.[11 12]

Children of different ages have very different capacities for understanding media violence, and adults' perceptions of what is violent may not agree with children's. Developmental factors, including the degree of attachment to parenting adults, ability to control aggression, cognitive ability, and moral development are particularly relevant to how children experience, understand, and process media violence.[13]

The advent of videos depicting the mutilation, torture, and dismemberment of humans and the violation and degradation of women has called into question the validity of studies done with more conventional images.[4] Concern about possible adverse effects led to the Video Recordings Act 1984 and to the penalties for supplying unclassified videos to young people being stiffened in the Criminal Justice and Public Order Act 1994.

Technological advances, including satellite and cable television, interactive computer games, and the information superhighway, give children easier access to a wide range of violent images, with less prospect of effective censorship. The need is therefore to consider how best to protect and educate children. Parents need more objective information about the content of films to supervise their children better. They also need education courses about the media and should participate in decisions about the appropriate classification of films and videos.[14] Media studies is now a part of the national curriculum for English, albeit a marginal one, and more systematic, coordinated provision of such studies is needed. Training in non-violent methods of resolving conflict is effective in reducing aggression in young children, and these techniques deserve wider promulgation.[10 15]

Some people argue that horror films can offer a form of vicarious training in coping with fear and that they are little more than a contemporary form of fairy tale, which explains their popularity. Although most children can learn to distinguish fiction from fact quite early and many enjoy a feeling of fear, which they know will be resolved by a "happy" ending, in fiction, factual violence and horror may be more frightening as the end is unpredictable and uncontrollable. Research findings on this, however, are equivocal and inconsistent (D Buckingham, unpublished literature review).

Children need the help of adults to interpret what they see and to protect them from unsuitable programmes. It is perhaps the children most vulnerable to the effects of viewing violence who are the most likely to see violent programmes or videos and to see them unsupported by adults. Not all parents realise the need for supervision or can exercise it. Doctors doing home visits are more aware than most of how prevalent television sets and video cassette recorders are in children's bedrooms.

In our current state of knowledge, the advice practitioners may wish to give worried parents is that, although frequent, lengthy, and unsupervised viewing of violence and horror is likely to affect the behaviour and mental health of some vulnerable children and young people adversely, occasional viewing is unlikely to harm most children. For the future we need more discussion, informed by findings from well designed empirical research studies, of the characteristics of both the material and the viewer that are associated with an increase in aggressive and disturbed behaviour.

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Bullying in schools: doctors' responsibilities

To ignore bullying is to condemn children to misery now and perhaps also in adult life

Bullying is the intentional, unprovoked abuse of power by one or more children to inflict pain on or cause distress to another child on repeated occasions. It includes several different activities: hitting, pushing, spreading slanders, provoking, making threats, extortion, and robbery. A common, international phenomenon, it occurs to some extent in all schools.[1-3] Whitney and Smith's study of more than 6000 pupils in 23 schools in Sheffield found that 27% of junior and middle school pupils and 10% of secondary school pupils said that they had been bullied sometimes or more often that term; 10% of junior and middle school pupils and 4% of secondary school pupils were being bullied at least once a week.[3] Most had not told a teacher or anyone at home.

Bullying can be considered to be a form of child abuse: peer abuse.[4] Like other forms of abuse, it is an abuse of power and is surrounded by fear, secrecy, and a misplaced loyalty to the perpetrator(s). Victims suffer adverse effects in the short and long term. Victims of regular bullying lack confidence, have lower self esteem, regard themselves as less competent,[5] and have fewer close friends than children who are not bullied.[2 5] Distress and preoccupation with their predicament may affect their concentration on their schoolwork. Bullying may be a contributory factor in why some children harm themselves or commit suicide, although this has not been systematically studied. When bullied children grow up they may be vulnerable to anxiety, depression, and loneliness (A H N Gillessen, annual convention of American Psychological Association, 1992)[2] and may have difficulties with heterosexual relationships.[6] Because bullying is usually unseen teachers, parents, and other adults often underestimate its prevalence and effects.

Children who are bullied may be reluctant to attend school and may absent themselves.[7] They may be presented to doctors with a variety of symptoms, including fits, faints, vomiting, limb pains, paralysis, hyperventilation, visual symptoms, headaches, stomachaches, fugue states, and

hysteria.[8] No study has examined the mental health problems of children who are regularly bullied, although clinical experience suggests that bullying may contribute to the referrals of some children to child psychiatrists. Similarly, coping mechanisms and factors that promote resilience have yet to be described.

Bullies also deserve attention. They are learning to achieve dominance over others through the misuse of power. Bullying may be one component of a more general pattern of antisocial and rule breaking behaviour that shows considerable stability over time. As adults, bullies are more likely to have criminal convictions and be involved in serious, recidivist crime.[2]

Schools can adopt several approaches to deal with bullies.[9] These include developing a policy for the school, tackling bullying through classroom and curriculum material, training playground supervisors, and working directly with bullies and victims. A clear account of the nature and implementation of these approaches is given in a recently published handbook, *Tackling Bullying in your School.*[9]

As bullying is so common all doctors dealing with children are likely to see some who are regularly victimised at school by their peers. This bullying may be an important factor in the development and maintenance of symptoms and should be considered in their management. If bullying is regarded as a form of abuse then professionals have a duty to detect it, take it seriously, and ensure that it is dealt with to reduce the child's suffering and minimise the potential long term effects. Olweus argues that it is a child's fundamental democratic right to attend school without being bullied.[2] As with other forms of abuse, children are unlikely to disclose it spontaneously as they feel ashamed and embarrassed and fear recriminations. Eventually they may believe that they deserve the bullying that they are subjected to.

Doctors should therefore ask directly about bullying. If children say that they are being bullied, they should be believed and reassured that they have done the right thing in telling. Parents should be informed and advised to take the matter up with the school (teachers or governors) directly. Children can be advised of simple measures to protect themselves—for example, ignoring name calling, making friends with a child who is not involved, and telling someone such as a teacher or playground supervisor.

Doctors and allied professionals need to know about bullying and what can be done. Research in Scandinavia[2] and Britain[10] has shown that intervention programmes in schools can successfully reduce bullying by up to half; they can also reduce truancy and antisocial behaviours in general and can increase pupils' satisfaction with school life. Two new books about bullying at school have been published recently.[9,10] They summarise the Sheffield bullying project and provide the basis for the Department of Education's package for schools, *Bullying: Don't suffer in Silence—An Anti-Bullying Pack for Schools.*[11] Organisations such as Kidscape run training courses and have information packs and advice leaflets for parents and teachers.[12] To ignore bullying is to condemn children to further misery and may prejudice their academic achievements and adjustment in adult life.

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Imprisonment, injecting drug use, and bloodborne viruses

A threat of transmission but an opportunity for prevention

See pp 285, 289, 293

The possibility that imprisonment is a risk factor for HIV transmission has been much debated, even though the association between imprisonment, use of injecting drugs, and the transmission of another bloodborne virus, hepatitis B, was recognised more than 20 years ago.[1] In the past five years, clusters of cases of acute hepatitis B infection in imprisoned men in England and Wales have been regularly reported to Public Health Laboratory Service Communicable Disease Surveillance Centre. Nearly a fifth of 258 infections in known male adult injecting drug users reported in this time were diagnosed in prison.

Many injecting drug users have been imprisoned, and for some this will have been a repeated experience.[2] In England and Wales in any year, an estimated 15 000 prisoners[3]—or between one in 13 and one in seven prisoners[4]—will have a history of injecting drug use. In Australia, more than one in three prison entrants were reported as having such a history.[5] Between a quarter and two thirds of prisoners who have ever injected drugs have done so within prison, where use of injecting equipment previously used by others is the norm. The reports from Scotland and Australia in this week's journal emphasise that there is no room for complacency about the risks involved and illustrate the vulnerability of prisoners who inject drugs to infection with bloodborne viruses. At least eight HIV infections due to sharing of equipment by injecting drug users occurred within a Scottish prison during the first half of 1993,[6,7] and in Australia an incidence of 41 hepatitis C infections per 100 person years in young male prison re-entrants in 1991-2 is described.[8]

There is a paradox, however, at the heart of these observations. If most injecting drug users spend time in prison, and equipment sharing within prison is a major risk factor for HIV transmission, why did 10 years elapse between the recognition of AIDS in injecting drug users and the first report of an outbreak of HIV infection in prison and why has evidence of HIV transmission within prison been so slow to accumulate?[9-11] Why, if HIV transmission through injecting drug use in prison occurs frequently, has the seroprevalence in injecting drug users in the community not been rising?[4,8]

McKee and Power have suggested that imprisonment may reduce the overall risk of HIV transmission.[12] Although those who inject in prison are more likely to share equipment,[3,6]