Essay

The Royal Society of Medicine

Journal of the Royal Society of Medicine; 2014, Vol. 107(6) 219–223
DOI: 10.1177/0141076814525071

# Intervening in primary care against childhood bullying: an increasingly pressing public health need

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## 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 (Table 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 $1.4 million 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]

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 have 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

**Table 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 |

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 General Practitioner (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 regard to talking to their GPs about being bullied. Links to the webpage were posted by several national anti-bullying charities' websites, and 96 responses were gathered from children aged under 16 years and 43 from parents of children who have experience of being bullied (www.warwick.ac.uk/gpbullyingresearch/results summary). 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 bullied 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 with regard 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 USA. The American Academy of Pediatrics has suggested tips for doctors to post on office walls and share with patients with regard 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 and 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 healthcare 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 to 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 (Table 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 victimization 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-focused virtual learning approaches, may be particularly suitable and warrant exploration.[30] Novel programmes 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

**Table 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 that are delivered from the primary care setting? | Validity and reliability of outcome measures to evaluate short-, medium- and longer-term impact on health and quality of life | Evidence of the effectiveness of primary care-based interventions in recognising and aiding victims of bullying |

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 lifetime.
- 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.


## Declarations

**Competing Interests:** None declared

**Funding:** None declared

**Ethical approval:** Not applicable

**Guarantor:** JD

**Contributorship:** JD and DW led the drafting of the paper. RR 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.

**Acknowledgements:** None

**Provenance:** Not commissioned; peer-reviewed by Helen Fisher


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