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The Role of Health Care Providers in Cyberbullying

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Bullying is often considered an educational or criminal justice problem, although it also represents a significant public health issue. Although traditional or 'schoolyard' bullying remains a significant issue worldwide, in recent years, technologies have provided new platforms on which bullying can take place. These electronic forms of communication include a variety of technologies such as social-networking websites (e.g., Facebook, Twitter), online games, text messaging, and mobile phone pictures. This phenomenon has been come to be known as cyberbullying.

To date, most efforts to prevent, identify, and intervene with bullying are initiated and directed by the education system.[1] Health care providers (HCPs), including physicians, psychologists, social workers, and nurses, remain at the fringes of efforts to prevent, educate, and address cyberbullying. HCPs are important stakeholders in promoting child health; HCP roles may include identification of health conditions, provision of health education, and advocacy within communities. Thus, in this editorial, we argue that the involvement of HCPs is integral to child health, as bullying is associated with significant health problems.[2] Although HCPs are rarely the direct witnesses of bullying behaviour, bullying of any type can be difficult for adults to witness or detect. Furthermore, cyberbullying represents a particular area of need for HCPs' involvement, as many schools have excluded cyberbullying from their mandate for intervention. Finally, recent studies support that youth who have experienced bullying want the involvement of HCPs.[3]

There are several ways in which HCPs can play an important role in preventing and intervening in cyberbullying.

Addressing Cyberbullying in Clinical Settings

A previous article by Beeson and Vaillancourt[1] suggested that in the absence of established guidelines on the role of HCPs and bullying, providers can rely on roles they often play in many other health-related scenarios such as vaccines or obesity prevention. In the area of vaccines, HCPs can provide education about the role of vaccines in reducing the burden of infectious disease on a global scale to patients in clinical settings, as well as in schools, parent groups, and community settings.[4] In clinical settings with patients, providers can screen, validate concerns, and provide nonjudgmental evidence and resources. HCPs can consider similar roles in addressing cyberbullying.

Anticipatory Guidance

A key role that HCPs can play in the prevention of bullying and cyberbullying is by including discussions of bullying as part of anticipatory guidance. Well-child visits, also called health supervision visits, typically include education and guidance targeted to critical public health risks at each child's age and developmental state.[5] Topics addressed during anticipatory guidance may include recommendations about seat belts, media use, and peer relationships. Thus, discussion about prevention, identification, and addressing of bullying are well placed in these discussions. Including bullying as a topic within anticipatory guidance validates bullying as an important health issue. Furthermore, addressing this issue routinely at yearly health supervision visits may contribute to breaking down family's preconceived ideas about stigma around bullying or addressing myths about bullying.

Be Aware of Symptoms and Signs of Bullying

It is rare to have a patient present to the clinic with a chief complaint of bullying. Thus, HCPs should be aware of common signs and symptoms that are associated with bullying

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experiences. These signs and symptoms can include the following (www.stopbullying.gov[6]):

- Avoiding school (more truancy and absences, leaving school due to reported health problems, less willing to attend; other academic problems)
- Lower self-esteem, increased depression and/or anxiety
- Reporting health problems (e.g., stomach aches, headaches)
- Trouble sleeping or frequent nightmares
- Detachment from friends
- Sudden withdrawal at home
- Sudden anger/rage
- Self-destructive behaviour such as cutting

Screening in Clinical Settings

Many paediatric clinics provide paper or online clinical intake forms that a patient completes prior to seeing the HCP. These clinical intake forms may include questions about medical history, family history, health behaviour, or experience. These screening forms may be useful in the case of bullying, as studies suggest it may be better to ask youth about their exposure to bullying and cyberbullying using a questionnaire rather than asking them directly.[3] HCPs should review their clinical intake forms to ensure that questions related to bullying and cyberbullying are included to assess whether the patient has had experiences bullying others or being bullied by others. One common form used in the United States is the Guidelines for Adolescent Preventive Services form, which includes screening across a variety of health behaviour and experiences, including bullying.[7]

Furthermore, it is typically recommended for HCPs to provide every adolescent patient individual time with the provider without their parents present to support discussion of topics that may be more private or stigmatising and to promote the adolescent patient's development.[8] Evidence supports that many adolescents would prefer that their parents were not present when they discuss their experiences with bullying.[3]

When screening in person or following up on questionnaire answers, Lam et al.[9] suggest that physicians routinely ask their patients 4 questions: 1) How often do you get bullied (or bully others)? 2) How long have you been bullied (or bullied others)? 3) Where are you bullied (or bully others)? and 4) How are you bullied (or bully others)? It is important to note during screening that most targets (and perpetrators) of cyberbullying are also bullied in traditional ways[10-13]; thus, screening for both types of experiences should be standard practice for HCPs.

Studies support that screening can take place in a variety of clinical settings and does not need to be reserved for a well-child or acute visit related to bullying. Ranney et al.[14] surveyed adolescents in an urban emergency department and found that they reported high levels of exposure to physical peer violence (46.5%), cyberbullying (46.7%), and community violence (58.9%). Results support youth's willingness to engage on these topics in urgent as well as nonfamiliar clinical settings. Thus, urgent care, school-based clinics, emergency rooms, and inpatient hospital stays are all appropriate clinical settings to address bullying.

In addition to screening for bullying experiences, HCPs should screen for health conditions known to be associated with bullying experiences. Depression and anxiety are among the most common health conditions associated with cyberbullying experiences.[15-20] HCPs working with adolescents should be aware of the strong and independent association between cyberbullying and suicide[17] and include screening questions for self-harm and suicide.

Provide Support and Resources

HCPs working with adolescents likely recognise the importance of building rapport, establishing trust, and validating concerns to engage with patients.[8] HCP demeanor and approach are also critical attributes to engaging patients so that they feel comfortable disclosing experiences with cyberbullying. In their review, Beeson and Vaillancourt[1] suggest that patients and parents will likely be more willing to disclose concerns with bullying if the physician handles the disclosure in a caring manner. Thus, if a youth patient endorses bullying experiences, an initial step is to validate his or her experiences and provide both support and empathy.

It is unlikely that an HCP can resolve a bullying issue in a single patient visit. Typically, HCPs have the opportunity to provide support and empathy, as well as resources for the patient and family to follow up and seek additional support. Many resources for cyberbullying are accessible online (e.g., http://www.stopbullying.gov/cyberbullying/index.html; http://www.cyberbullying.ca/; http://www.prevnet.ca/). Before recommending a website, the HCP should explore that website's content. A previous study found that some cyberbullying websites promoted a commercial product.[21] Thus, HCPs should review websites before providing them as resources to provide unbiased and evidence-based resources to families, such as government-sponsored resources.

Policy

Policy in cyberbullying often arises from critical cases of an individual's experience. Individual experiences that led to legislative changes included Amanda Todd and Rehtaeh Parsons, who both died from suicide after significant cyberbullying. These cases led to the Nova Scotia Cyber-safety Act, enacted in May 2013. At present, at least 9 provinces now have legislation or laws that specifically address cyberbullying.[22] These scenarios have an analogy in the medical field, where individual case reports about single patients have led to new diagnoses or breakthrough treatments. The

involvement of HCPs in promoting policies that can positively affect patients is important; these efforts could lead to improved prevention and intervention programs for bullying.

Education

HCPs can play an important role in providing and supporting education about bullying. HCPs have opportunities to collaborate with schools and families to help youth develop positive social relationships[1] and provide support and education to teachers as well. HCPs should consider being part of the creation and dissemination of educational resources addressing bullying so that patients can receive quality educational materials without commercial interests. Many HCPs now engage in dissemination of health content via social media and blogs.[23] These online platforms provide new ways for HCPs to promote best practices around bullying. Furthermore, integration of bullying into continuing medical education at the hospital, regional, and national levels is critical to ensuring that HCPs are up to date on trends and improved clinical approaches.

Contribute to Research

A final area in which HCPs can contribute to improved understanding and practices regarding cyberbullying is through research. HCPs can contribute to research by collaborating with researchers and providing insights from clinical practice. HCPs can contribute by providing access to patients in the clinic to partake in research studies. Given the experience and expertise of HCPs in clinical issues related to bullying, HCPs can inform and advance research in significant ways to improve the care of patients.

Conclusion

Cyberbullying is a multifaceted problem that requires input and engagement from educators, criminal justice experts, public health practitioners, and HCPs. Although cyberbullying shares many characteristics with traditional bullying, few evidence-based programs exist for prevention and intervention. Schools are primarily involved in bullying prevention and intervention efforts. Opportunities for increased clinical involvement are important, as patients and families often seek guidance from HCPs about how to address bullying and cyberbullying.

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