Identifying and responding to bullying in the pre-teen years: the role of primary health care practitioners

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> Aboriginal and Torres Strait Islander peoples should be aware that this resource may contain images or names of people who have passed away.

Key messages

- The pre-teen years (9–12 years old) are a critical period of vulnerability for bullying behaviours.

- There is a growing awareness that bullying is best addressed as a public health problem that needs a collaborative, community-wide solution.

- Parents and children identify primary health care professionals as a potential support for identifying and responding to experiences of bullying.

- Primary health care providers across a range of sectors can play a valuable role in a public health response to bullying.

This resource was written for health professionals. If you are a parent who needs information about childhood bullying, please check out our Emerging Minds Families resources.

Introduction

The association between bullying in childhood and later mental health problems, including depression, anxiety and suicidality, is well established (Copeland, Wolke, Angold & Costello, 2013; Takizawa, Maughan & Arsenault, 2014). In order to reduce mental illness burden in the adult population, effective prevention of and responses to bullying behaviours in childhood is needed.

With increasing use of the Internet and social media by children and young people, bullying behaviours in childhood are less confined to school hours. Yet, there continues to be an emphasis on school-based solutions, when a wider public health prevention and early intervention response is warranted.

This paper explores how primary health care providers can play a role in a public health response to bullying, and what we know about this role to date. In particular, the paper focuses on bullying in the pre-teen years (9–12 years), due to its onset in this age group, prevalence and the relative lack of focus on solutions in comparison to the teenage years.

What is bullying?

Bullying is a highly complex issue. The way that bullying is defined by researchers is the subject of some disagreement, which impacts on the interpretation of findings and prevalence rates (O'Brien, 2019).

In this paper, we use the national definition of bullying for Australian schools:

> Bullying is an ongoing and deliberate misuse of power in relationships through repeated verbal, physical and/or social behaviour that intends to cause physical, social and/or psychological harm… [with] immediate, medium and long-term effects on those involved, including bystanders.[1]

There are three main features of bullying that are reflected in this definition and that differentiate it from other types of conflict. They are:

– Misuse of power in a relationship;

– Ongoing and repeated behaviour; and

– Behaviour that causes harm.

In recent years, there has been a delineation between 'traditional' or 'offline' bullying and 'cyber' or 'online' bullying experienced by children and young people, and it is important to note that not all research differentiates between the two types of bullying and their respective impacts. Traditional bullying is typically conducted in person and predominantly at or in relation to school. Examples are hitting, shoving, spitting, taunting, name calling, harassment, rumour spreading and exclusion.

Cyberbullying is best conceptualised as another form of bullying, rather than distinctly different. Both forms are often a continuation of the other, for example, bullying within school hours that continues later via social media (Vaillancourt, Faris & Mishna, 2017).

However, some elements of cyberbullying make it more difficult to fit into the core definitional criteria of bullying above. For example:

– Intent is more difficult to establish without cues such as vocal tone and facial expressions;

– Repetition is more complicated when the harmful act may only have been committed once by the perpetrator, but shared several times by others; and

– Technology itself can be the vehicle by which a power imbalance exists, as opposed to pre-existing power imbalances in traditional bullying, e.g. via perceived anonymity, or the social status of the perpetrator online (i.e. number of supporters) (Vaillancourt et al., 2017).

Children may be victims of bullying, engage in bullying behaviours against others, or be both a victim and a bully. Data from the Longitudinal Study of Australian Children (LSAC) indicated that children aged 12–13 years old who had experienced bullying behaviours were far more likely to use these behaviours against other children (46%) than not (7%) (Australian Institute of Health and Welfare, 2020).

How children and young people define bullying

Understanding children and young people's own views on what constitutes bullying can further inform effective responses. O'Brien (2019) found that young people have various understandings of what bullying is. For example, physical aggression was considered bullying, but name calling was a more ambiguous concept which may be interpreted as 'banter'. Young people also considered repetition as indicative of 'serious' bullying, which resulted in a greater likelihood of disclosure (O'Brien, 2019).

In 2018, the Commissioner for Children and Young People (SA) consulted with almost 300 children and young people to understand their experiences and perspectives on bullying.[2]

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[1] See the full definition: https://www2.education.vic.gov.au/pal/bullying-prevention-response/policy#definitions

[2] Read the full report: https://www.education.sa.gov.au/sites/default/files/connected-community-approach-bullying-prevention.pdf

The participants described the majority of bullying as negative interactions about a range of issues, including:

– belonging and identity

– physical appearance

– intelligence

– race

– sexuality

– family slurs; and

– 'slut shaming'.

Bullying was identified as occurring most frequently in person and at times including additional online cyberbullying. Interestingly, these young people also referred to bullying that occurred in public spaces (e.g. bus stops, shopping centres and sporting facilities). This indicates a need to think more broadly about what constitutes bullying and where children experience it.

Similarly, the *Speaking Out Survey 2019*, conducted in Western Australia with more than 4,900 Year 4–12 students, showed that of those who reported having been bullied or cyberbullied in the past 3 months, 45% of students had been bullied somewhere other than school, 38% reported being bullied at home and 32% on the way to or from school (Commissioner for Children and Young People, 2020).

Where bullying happens

Proportion of Year 4 to Year 12 students who had been bullied in the last 3 months reporting where the bullying has occurred, by location.
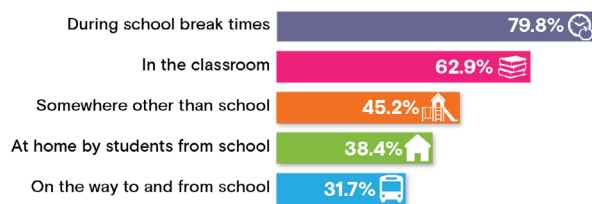
Location	Percentage
During school break times	79.8%
In the classroom	62.9%
Somewhere other than school	45.2%
At home by students from school	38.4%
On the way to and from school	31.7%

Fig 1: Speaking Out Survey 2019, Commissioner for Children and Young People, 2020

Risk and protective factors for bullying

Understanding and addressing risk factors while building protective factors is important in early intervention to prevent bullying behaviours. While several studies have been published relating to this, for various reasons there is limited clarity on what are the most important factors, including a reliance on cross-sectional studies and self-report (Kljakovic & Hunt, 2016). As such, several risk factors are proposed in the literature, but caution is needed given the limitations of the quality of the evidence available.

In a meta-analysis of longitudinal studies, Kljakovic and Hunt (2016) found the risk factors that most significantly predicted bullying victimisation in those aged 11–18 years were conduct problems, social problems, prior victimisation and internalising problems. No protective factors were found in this study. Conduct problems and social problems, as well as school problems (e.g. academic failure, low commitment to school), were also found to be risk factors for engaging in bullying behaviour.

Cook, Williams, Guera, Kim and Sadek (2010) conducted a meta-analysis of predictors of bullying victimisation and bullying behaviour in children and young people ages 3–18 years. They found that the most important predictors of victimisation were:

– peer status,[3]

– social competence;[4] and

– school climate.[5]

Based on analyses of all the significant predictors of bullying victimisation, these authors describe the 'typical *victim*' [as] one who is likely to demonstrate:

– internalising symptoms

– engage in externalising behaviour

– lack adequate social skills

– possess negative self-related cognitions

– experience difficulties in solving social problems

– come from negative community, family, and school environments; and

– be noticeably rejected and isolated by peers' (p. 76).

Rates of bullying victimisation are reported to be higher among vulnerable young people, such as those with disability, sexually diverse young people, and those who are overweight and obese (Eisenberg, Gower, McMorris, & Bucchianeri, 2015) and 'medically fragile' children and young people (Pittet, Berchtold, Akre, Michaud, & Suris, 2010). Vulnerable children and young people may also be at risk of higher rates of bullying behaviour, particularly being a bully-victim (Eisenberg et al., 2015).

[3] Defined as '…the quality of relationships children and adolescents have with their peers, including rejection, isolation, popularity, and likeability' (Cook, et al., 2010, p. 67)

[4] Defined as '….an overall evaluative judgment of an individual's social skills that enable him or her to interact effectively with others and to avoid or inhibit socially unacceptable behaviors' (Cook, et al., 2010, p. 67)

[5] Defined as '…the degree of respect and fair treatment of students by teachers and school administrators as well as a child's sense of belonging to school' (Cook, et al., 2010, p. 67)

Other research indicates that internalising problems can be both a risk factor and an outcome of bullying victimisation (Reintjes, Kamphuis, Prinzie & Telch, 2010). For example, a 2019 study using data across two waves of the Longitudinal Study of Australian Children (LSAC) indicated that the relationship between depressive symptoms, anxiety and peer victimisation may be bidirectional for children aged 10–13 years (Forbes, Fitzpatrick, Magson & Rapee, 2019). Meaning, bullying behaviours can lead to internalisation of distress, which results in targeting by bullies due to the associated symptoms of the distress, e.g. social withdrawal, fearfulness, crying.

Bullying in the pre-teen years

Bullying behaviours are traditionally thought of as occurring in the teenage years, and many resources addressing bullying are targeted at this age group. Evidence suggests, however, that bullying is common in the pre-teen years, and that there is a fairly steady downwards trend from the pre-teen years through the remainder of the school years (Smith, Madsen & Moody, 1999).
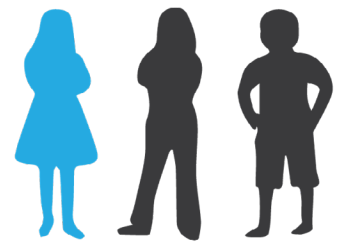
The Australian Covert Bullying Prevalence Study reported that, in a sample of almost 21,000 Australian students aged between 8–14 years, the highest prevalence rates of bullying occurred in children in Year 5 (age 10–11 years). The Childhood to Adolescence Transition Study also found that in a population-based sample of 1221 Australian children aged 8–9 years old, almost one in three (29%) reported experiencing regular bullying (at least once per week). Verbal bullying was most common (23%) but one in eight (14%) experienced physical bullying and 7% experienced both. Those who identified having a group of friends fared better in terms of emotional wellbeing, indicating this may be a protective factor against negative outcomes (Bayer, Mundy, Stokes, Hearps, Allen & Patton, 2018).

The Trends in International Mathematics and Science Study (TIMSS; 2015) also showed that younger students (Year 4; 56%) were more likely to be bullied monthly or weekly during the school year than older students (Year 8; 43%) (Thomson, Wernert, O'Grady & Rodrigues, 2017).

There are several theoretical explanations posed for this decline across ages. Carr-Gregg and Manocha (2011) note the contribution of developmental changes in the pre-teen years to increased incidence of bullying behaviours. They suggest that there is a peak mismatch of fundamental drives and self-regulation in the late primary and early secondary school years, characterised by difficulties in expressing thoughts and feelings, difficulties seeing another person's point of view and an inability to see the consequences of actions.

Pre-teen children are also increasingly concerned about their status in relation to their peers (Luthar & Ciciolla, 2016; Ryoo, Wang & Swearer, 2015), interactions become more complex (Luthar & Ciciolla, 2016), and friendship instability is common in early adolescence (Poulin & Chan, 2010). International research indicates that a decline in bullying behaviours across the school years may be related to younger students having less sensitivity to what constitutes bullying by definition (e.g. including 'general fighting' without consideration of whether an imbalance of power exist), resulting in greater disclosure, and that older students have improved social skills (Smith, Madsen & Moody, 1999).

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year 5 students affected by frequent bullying (10–11 yrs old)

(Australian Covert Bullying Prevalence Study (2019) of Australian students aged 8-14 years old).

Types of bullying

23% verbal bullying

7% experienced both

14% physical bullying

(Childhood to Adolescence Transition Study of Australian children aged 8–9 years old).

Impact of bullying in the pre-teen years

A rapid evidence assessment conducted by the Parenting Research Centre (Devine, 2019) highlighted the association between bullying victimisation in the pre-teen years (defined in the study as 10–12 years) and a range of negative health outcomes for pre-teens and adolescents (10–18 years). Nineteen international studies were identified on various forms of bullying victimisation, including verbal, physical, social/relational, individual, group and online.

All the studies found a statistical association between bullying victimisation in the pre-teen years and mental health problems during the pre-teen and/or teen years. Pre-teen bullying victimisation was associated with psychotic experiences, depression, anxiety, suicidal ideation and eating disorders. Pre-teens who

experienced more severe and/or chronic bullying victimisation and experienced it in multiple contexts (e.g. school and sibling bullying at home) had worse outcomes than those who experienced less frequent or severe incidences or in single contexts.

The findings of this rapid evidence assessment highlight the need for effective prevention and early intervention on bullying victimisation in the pre-teen years if we are to have a meaningful effect on mental health outcomes.

Bullying as a public health issue

There is a growing awareness that bullying is best addressed as a public health problem requiring a collaborative, community-based solution, and that prevention and early intervention approaches in the pre-teen years (and earlier) are needed for this purpose. In 2010, the World Health Organization (WHO; Srabstein & Leventhal, 2010) identified bullying as a problem that exists beyond schools and as such, one that requires the time and attention of people outside of the school system. Feldman, Hertz, Donato & Wright (2013) also call for an integrated approach to increasing protective factors including coping skills, but also social support and access to supportive adults in school, communities and home environments.

In particular, with increasing mobile phone use by children and young people bullying has become more broadly community-based (Dale, Russell & Wolke, 2014). The use of technology to engage in cyberbullying behaviours means that bullying can occur anytime and outside of a physical setting. Addressing bullying therefore demands a coordinated response from parents, educators, school administrators, health care providers, policy makers and others. This type of response recognises the range of contexts in which youth are embedded (National Academies of Sciences, Engineering and Medicine, 2016).

If we accept that the prevalence and nature of bullying in the pre-teen years justifies a response that extends beyond the education system, then it is important to identify other key social and community touchpoints that pre-teens utilise. Careful consideration is needed regarding the best sources of support and information on bullying for this age group.

The role of health services

Research on health service utilisation goes some way to informing us about one avenue of service touchpoints for this age group that might play a greater role in prevention and early intervention. Data from the LSAC shows a notable difference in frequency of annual visits to a GP across the primary school years (an average of 7.0 visits to a GP at 4–5 years compared to 4.5 at 10–13 years). However, those with peer problems were significantly more likely to see a GP at age 10–11 or 12–13 (74% and 71%) compared to children who were not experiencing peer problems (66%). Similarly, the percentage of children who had a consultation with a paediatrician in the previous 12 months was significantly higher among those with elevated conduct and peer problems, with the highest number of visits occurring at 8–9 years old (Warren, Quinn & Daraganova, 2020).

In 2018, a Royal Children's Hospital (RCH) Child Health Poll of more than 1,500 parents identified that half felt like they need more information or guidance about protecting their child from bullying, particularly parents of primary-school aged children.[6] While the preferred sources of this information were school (73%) or online (71%), a notable minority (22%) said they would prefer to get this information from their GP. Additionally, GPs were nominated by more than one in three parents (37%) as a source of potential help if their child was being bullied. Potential other sources of information in a health setting were identified as allied health professionals (e.g speech pathologists, physiotherapists), dentists and opticians – for example, children with a communication disability such as a stutter are at an extremely high risk of bullying (Speech Pathology Australia, 2016).

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parents say their GP could be a potential source of help if their child was being bullied.

37%

(Royal Children's Hospital Child Health Poll, 2018)

Children also indicate that they see primary health care professionals as having a role to play in identifying and responding to experiences of bullying. For example, findings from a study of 96 children by Dale et al. (2014) indicated that 93% of the children surveyed felt that GPs should be better able to recognise and help young people who were affected by bullying. Around half (55%) felt they would be comfortable being asked about bullying in an everyday consult with a GP. Additionally, 86% of parents of bullied children in this study thought it important that GPs should be able to recognise bullying.

[6] See the full report: https://www.rchpoll.org.au/wp-content/uploads/2018/08/childhood-bullying-how-are-parents-coping-report.pdf

Primary health care has a pivotal role in identifying and responding to bullying for several reasons. Disclosing bullying is a key step in getting help and support, but research indicates that 40% of children who are bullied don't disclose to parents (Scott, Dale, Russell & Wolke, 2016). To encourage the disclosure of bullying, it makes sense to be in a situation where there is 'no wrong choice' for a child in terms of who they choose to disclose to, including health care professionals. Hensley (2015) suggested that primary health care professionals should be an option for children to disclose to, given:

- the widespread prevalence of bullying;

- the adverse consequences of bullying;

- reluctance of some victims to seek help from parents or school authorities; and

- the limited effectiveness of school prevention programs.

McClowry, Miller & Mills (2017), in addressing family physicians in the US, agree that the impact of bullying demands a multifaceted approach '...that begins in your exam room.' (p. 83). Similarly, Leff & Feudtner (2017) call upon paediatricians to remain constantly vigilant to the possibility that bullying is occurring.

How might primary health care professionals respond?

Guidance and understanding on exactly what role primary health care providers can best play in identifying and responding to bullying, especially in the pre-teen years, is currently limited and poorly defined (Condon & Prasad, 2019). Primary health care professionals' own views on childhood bullying and their support for different approaches to identification and support also need better understanding, to guide training, responses and resourcing (Dale et al., 2014).

Stephens, Cook-Fasano & Sibbaluca (2018) call for an anticipatory guidance[7] approach at around age six for children and their parents.[8] This would draw attention generally to bullying as a problem, when and for whom, and empowers the family to seek additional support or information. The goal of anticipatory guidance would be to increase protective factors for the child (e.g. activities that promote confidence, seeking positive friendships, modelling how to treat others), as well as positive parenting skills.

Vaillancourt et al. (2017) suggested that the primary health care provider's role could incorporate screening, validation and advocacy, with special attention to the 'uniquely negative impact' of cyberbullying. Stephens et al. (2018) also offer clinical recommendations for physicians, based on limited evidence:

- Physicians should ask about bullying when children present with multiple somatic problems, school avoidance or incidents of self-harm.

- Physicians should use indirect, open-ended questioning to increase the identification of children who are bullying or being bullied.

- Questions about their online lives should be included in general history taking with children and adolescents.

- Patients who are being bullied or are identified as engaging in bullying behaviour should be screened for psychiatric comorbidities

Screening

McClowry, Miller & Mills (2017) suggest screening specifically for:

- high risk groups (e.g. children who identify as LGBTIQ+, are over/underweight or have special needs);

- children with risk factors for or whose complaints suggest they have been exposed to bullying (including mood disorders, psychosomatic complaints and/or behavioural symptoms); and/or

- children whose parents identify a behaviour or action that indicates bullying may be present, e.g. unexplained outbursts, unexplained physical injuries.

[7] Anticipatory guidance involves health care workers (e.g. doctors or nurses) providing parents with advice and information about issues that might arise between visits, in relation to promoting healthy lifestyles and disease/injury prevention, and is carefully timed to match the child's age. Read more: https://www.nhmrc.gov.au/about-us/resources/promoting-social-and-emotional-development-and-wellbeing-infants-pregnancy-and-first-year-life#toc__link__938

[8] The article originates in the US where a six-year-old 'well visit' occurs with a family physician.

The HEEADSSS[9] psychosocial screening tool is mentioned by a number of papers (Stephens et al., 2018; Carr-Gregg & Manocha, 2011). HEEADSSS allows a comprehensive psychosocial assessment of a young person aged 10–24 years and helps to elicit information about their functioning across a range of key domains, including school and home. A handful of questions refer to, or are related to, bullying behaviours, however, they are focused on bullying that occurs at school, e.g. 'Is your school a safe place? (Why?)', 'Have you been bullied at school?'[10] The tool is broad and long, and can take several sessions to complete, which appears challenging for the purposes of encouraging disclosure of bullying behaviours in a primary health care setting.

The absence of brief, good quality, validated screening tools for use in a healthcare setting was also mentioned as a barrier by Hutson Melnyk and Hensley (2019), with the conclusion that if paediatric health care providers do not have a simple and reliable screening tool for bullying behaviours, screenings are less likely to occur.

This gap has recently been filled by the development of the Child Adolescent Bullying Scale, which has been developed specifically for healthcare provider use, and is showing promise as a reliable and valid tool (Strout, Vessey, Difazio & Ludlow, 2018). The scale, however, comprises statements that directly ask about bullying. Given that there is some suggestion that open-ended questions and avoiding terms related to bullying are preferable (Stephens et al., 2018), other options for screening questions as well as suggestions for responding to disclosures are needed.

What do we know about how primary health care providers currently identify and respond to bullying behaviours?

For the purposes of this paper, a limited scoping review of studies was conducted in relation to primary health care workers and the identification of and support for bullying behaviours, in order to broadly scope current knowledge in this space.

Most studies considered for this paper were small scale, largely limited to qualitative data, and focused on the role of GPs. Few focused on the Australian context. A more rigorous review of the literature is needed to draw any definitive conclusions, and

to examine the role of other primary health care providers in identifying and responding to bullying behaviours. However, below are some examples of research findings that outline the experiences of primary health care providers in identifying and responding to bullying.

Current primary health care responses

A US study of 102 health care providers (Hutson et al., 2019) found that:

- 53% screened for traditional bullying, but only 27% for cyberbullying

- 33% intervened either frequently or very frequently when they suspected bullying was a problem, but 10% didn't intervene

- when intervention did occur, 91% of health care providers provided 'counselling' (though no detail is given about what this involved) and 95% referred patients to a mental health care provider; and

- 35% provided reading materials to the patient and family.

Other strategies less likely to be used included:

- advising parents to talk to the school or to consult bullying laws

- contacting school guidance

- screening for depression/suicidality

- referral to an internal service (e.g. psychologist, social worker); and/or

- telling the patient and family to go to the emergency department to document the harm from bullying.

[9] Home, Education/Employment, Eating and Exercise, Activities/Peer Relationships, Drug/Alcohol use, Sexuality, Suicide and Depression, Safety. For more information: https://www.contemporarypediatrics.com/view/heeadsss-30-psychosocial-interview-adolescents-updated-new-century-fueled-media

[10] See more: https://www.contemporarypediatrics.com/view/heeadsss-30-psychosocial-interview-adolescents-updated-new-century-fueled-media

In a UK study by Condon & Prasad (2019), interviews with 14 GPs showed that all could recall experiences where bullying was disclosed by children and/or young people. The GPs talked about remaining 'clinically vigilant' for signs of distress, uncertainty and non-verbal clues that might open up an opportunity for disclosure, and all were able to describe techniques for identifying bullying as a contributing factor to symptoms at presentation. This included the use of open-ended questions about school and friendships to provide opportunities for disclosure of bullying, as opposed to asking direct questions about bullying behaviours. All GPs in this study felt part of their role was to identify and manage cases of bullying.

Skills and confidence

In a survey of 128 UK GPs, Condon and Prasad (2019) found that a vast majority of GPs (92%) had never received formal training, resources or information to help children and young people (5–24 years) with bullying-related health problems. However, most (90%) had seen adult patients who they identified as having mental health symptoms related to childhood bullying.

In a UK survey of 206 young people (aged 11–26 years old) and 44 parents (Scott et al., 2016), both young people and parents were overwhelmingly in favour of GPs being better able to identify and support young people who are experiencing bullying, especially as they were outside of the school environment and there was often a pre-existing relationship between the GP and family. However, it was also felt that problems may exist for GPs in terms of the boundaries of their roles and time pressures.

Hutson et al. (2019) reported on the findings of a descriptive survey on the practices, attitudes, self-confidence and knowledge of US-based paediatric primary health care providers in relation to bullying. Of the 102 participants, 94% said they strongly agreed or agreed that health care providers should assess for bullying routinely, with 90% believing that bullying was a primary health care problem. Nurse practitioners were more likely to screen for bullying than paediatricians. However, only 37% of the participants felt confident that they could recognise the signs/symptoms of bullying, and 25% believed that bullying was 'part of growing up'.

Being knowledgeable about bullying alone did not lead to screening but attitudes regarding the importance of screening and belief in the practitioner's ability to screen did. This research indicated that changing attitudes towards bullying and self-efficacy is critical, alongside increasing knowledge and skills of health care providers (Hutson et al., 2019).[11]

Young people's willingness to disclose to primary health care professionals

There is limited data on young people's willingness to disclose bullying to primary health care professionals. In one study (Scott et al., 2016), young people felt more comfortable answering questions about experiences of being bullied via a questionnaire in the waiting room (49% completely comfortable, 11% not very or not at all comfortable) than direct questioning from their GP (18% completely comfortable, 23% not very or not at all comfortable), if they went to the GP for an everyday problem (e.g. headache, stomach ache). Some young people felt, however, that the questionnaire may be better filled in at home or online before the visit due to privacy concerns in the waiting room.

Both parents and young people in the Scott et al. (2016) study agreed they would more likely acknowledge incidence of bullying if they understood the reasons why the doctor was asking (i.e. the link between health outcomes and bullying). Confidentiality may be an issue, with some parents in the study wanting to know if and when the child disclosed bullying to the GP, however others recognised that if confidentiality was what it took for the child to disclose and gain support for bullying then that was acceptable. Many of the young people in this study expressed a preference for parents not to be present during discussions about bullying. This could be a particular problem for children in the pre-teen years who may not get an opportunity to speak alone with a health professional.

[11] An Emerging Minds survey of 27 practitioners in an Australian context similarly found that while most respondents said they understood the link between bullying behaviours and child mental health (80%), 53% rated their confidence in identifying and supporting bullying as lower than their understanding of this link.

Vaillancourt et al. (2017) suggested that if disclosure was not forthcoming, there was still merit in being aware of commonly reported symptoms for patients with a bullying history, so that practitioners can opt to raise and discuss concerns. Commonly reported symptoms of patients with a bullying history include physical symptoms (stomach ache, difficulty sleeping, headaches and fatigue) and psychosocial symptoms (depressed mood, anxiety, irritability, poor concentration, isolation and suicidal ideation) (Hutson et al., 2019).

Barriers for primary health care professionals in responding to disclosure

Several barriers may arise in relation to primary health care professionals' role in recognising and responding to bullying disclosure, including:

– Length of consultation

– Lack of guidance on:

  – asking the right questions to identify the contribution of bullying to presenting symptoms;

  – the impact of different types of bullying; and

  – referral pathways and specialist services for children and young people's mental health (Condon and Prasad, 2019).

Condon & Prasad (2019) note that national guidance in the UK on depression in children and young people suggested asking about, and recording information on, interpersonal relationships in notes, and that bullying should be enquired about. However, it is possible that the lack of guidance outside of depression guidelines means that health care professionals are unsure on how to embark on these conversations in situations where depression is not present or currently diagnosed.

Dale et al. (2014) identified lack of awareness and fear of embarrassing patients and their parents as barriers to enquiring about bullying behaviours. They also identified the length of the consultation and absence of clear clinical guidelines in the UK (and effective interventions) as a problem. While multiple paediatric organisations have policies or position statements on bullying, Hutson et al. (2019) noted they don't specifically discuss screening methods or offer evidence-based recommendations for treatment.

What could primary health care offer?

As mentioned, the limited literature and guidance on the role of primary health care professionals in identifying and responding to bullying behaviours tends to focus on encouraging disclosure and engaging in screening and assessment. There is less discussion on the 'what next' when bullying behaviours are disclosed to a primary health care professional. Where it is addressed, resources tend to focus on working with teenagers, and while actions may be similar for pre-teens it nevertheless highlights the lack of attention to developmentally-specific responses.

Guidelines in Australia

Australian Medical Association (AMA) guidance on bullying, published in 2012, covers background information and questions to elicit a young person's concerns about bullying. However, there is little information on interventions once the questions are asked, other than referral back to schools or other professionals in the community, such as psychologists, youth workers or social workers. The guidance nevertheless recognises the limitations in referring to schools due to varied success with school-based approaches and an inability to offer long-term counselling.

Similarly, clinical guidelines published by the Royal Australian College of General Practitioners (RACGP) are descriptive and informative in regard to prevalence and types of bullying, and recognise that bullying is a public health issue. The guidelines support initial recognition and acknowledgement of bullying, however, further and more concrete guidance about responses to a disclosure of bullying would be useful. The guidelines:

– outline physical and psychological symptoms that may be associated with bullying and encourage 'case finding' based on these;

– encourage a careful history taking, with a few suggested questions; and

– suggest following up with 'counselling and support'.

Support includes acknowledgement that:

– the young person has shown courage in disclosing bullying

– they don't have to face it alone

– it is not their fault

– all students have a right to a safe school environment

– they should not tackle the bully alone; and

– they should tell an adult.

Additionally, the GP is encouraged to advocate for the family and support them to take an active role in monitoring their children and engaging them in positive school and community activities.

While these guidelines are a good start, there is an emphasis on school-based solutions, e.g. a recommendation that health practitioners understand that school programs can be effective. This is unlikely to be helpful to the young person who is seeking help on the spot, who is only encouraged to tell an adult or someone in authority. Since the young person has, in this case, already disclosed to an adult in authority, this raises questions about the willingness and capacity of professionals to respond helpfully to the already difficult task of disclosure for a young person. Counselling responses are undefined in the RACGP guidelines, and parenting intervention in terms of monitoring behaviours is alluded to but not in terms of which services may be available to help.

Responses to disclosure need to explicitly acknowledge the link between mental health problems and experiences of bullying, and that referral to a specialist mental health service may be unwarranted at best and ineffective at worst, unless serious concerns are present. The development of consistent, effective and brief interventions that are tailored to the primary health care practitioner's context are needed, alongside effective and validated screening tools that are administered in youth-friendly ways. In the case of pre-teens, it is important to identify responses that the child can utilise that are not developmentally determined, for example 'fogging', i.e. agreeing with the bully in an offhand manner when they say offensive or negative things (M. Carr-Gregg, personal communication, May 11, 2020).

Carr-Gregg & Manocha (2011) also advocate for

referral to a psychologist if screening (e.g. Kessler Psychological Distress Scale (K10)) indicates the young person's mental health is at risk. The problem with referral, however, can be threefold – the suitability of the referral, the possibility of a long waiting list, and the cost of specialist services. Hutson et al. (2019) drew attention to the shortage of paediatric mental health care providers in the US and the historically long waitlists. Waiting times for child and youth mental health services have also been identified as an issue in Australia, particularly in rural and regional areas (Orygen, 2017).

Summary

There is strong evidence for a causal pathway between bullying behaviours and later mental health problems. For many years, the responsibility for addressing bullying behaviours has fallen to schools, with little to indicate that approach has been singularly successful.

It is important to consider the role of primary care in encouraging and responding to disclosure and identifying and managing the physical and psychological symptoms associated with bullying. This is especially true considering the protracted and trusting relationships that are often in place between families and health care services, meaning there is a significant opportunity for both anticipatory guidance and/or early intervention. In the primary school and pre-teen years, parents also need anticipatory guidance about bullying as they are often not a key target group for existing bullying initiatives.

There is generally a lack of quality guidance around best practice in identifying and responding to bullying in primary health care, and what little exists is usually heavily focused on victims of bullying, with little

attention paid to children who engage in bullying behaviours or who are victim/bullies. Primary health care practitioners have a role to play:

– as an alternate and reliably informed point of disclosure, particularly as they are identified as independent from school

– for screening and identification, when symptoms indicate bullying is a possibility

– treating the health impacts, including screening for and responding to early signs of mental health problems

– as an advocate and support in terms of liaising with schools and other community agencies; and

– as an effective referral point, to the right service or intervention.

It is recognised that this role needs to be considered alongside practitioner capacity, burden and expectations in short consultations. There needs to be manageable and actionable, evidence-informed responses when a disclosure does occur – a clear 'what next' that has a positive outcome for the young person.

In the pre-teen years, it is also important to consider the implications of this stage of development, as outlined earlier, and the potential for reluctance to disclose bullying if parents are present in consultations. Anecdotal evidence suggests that when disclosures occur, it is often the first time the parent is aware of the bullying behaviours,[12] meaning there is a particular need for skills in acknowledging and responding effectively to this likelihood.

Research outlined in this paper indicates that primary health care providers may hold attitudes towards bullying that predict whether assessment occurs or not, such as bullying being an inevitable by-product of growing up (Hensley, 2015). These attitudes may also be held by parents, alongside other factors such as shame regarding their child's behaviour. As a result, parents may justify or downplay the bullying or fear retaliation if the matter is pursued.[13]

It is no longer appropriate to see schools as the only avenue for identification and support for children involved in bullying behaviours. Primary health care providers have a role to play due to their perceived status in the community and their common and regular engagement with families with children. However, these providers need to be better equipped and given actionable advice about how to identify and respond to bullying behaviours, within the scope and existing challenges of their roles. There is an urgent need to further explore, address and standardise responses to suspicion or disclosure of bullying in primary health care settings.

Acknowledgements

[12] Dr Anthony Zehetner, personal communication, 8/10/19

[13] Dr. Michael Carr-Gregg, personal communication, 11/5/20.

References

Arseneault, L. (2018). Annual research review: The persistent and pervasive impact of being bullied in childhood and adolescence: implications for policy and practice. *The Journal of Child Psychology and Psychiatry, 59*(4), 405-421.

Australian Institute of Health and Welfare (2020). *Australia's Children*. Retrieved 27 July, 2020: https://www.aihw.gov.au/reports/children-youth/australias-children/contents/justice-and-safety/bullying

Bayer, J., Mundy, L., Stokes, I., Hearps, S., Allen, N., & Patton, G. (2018). Bullying, mental health and friendship in Australian primary school children. *Child and Adolescent Mental Health, 23*(4), 334-340.

Carr-Gregg, M., & Manocha, R. (2011). Bullying: Effects, prevalence and strategies for detection. *Australian Family Physician*, 40(3), 98-102.

Commissioner for Children and Young People 2020, Speaking Out Survey 2019. *The views of WA children and young people on their wellbeing – a summary report*, Commissioner for Children and Young People WA, Perth.

Condon, L., & Prasad, V. (2019). GP views on their role in bullying disclosure by children and young people in the community: a cross-sectional qualitative study in English primary care. British Journal of General Practice, Online First, Retrieved from <DOI: https://doi.org/10.3399/bjgp19X706013>.

Cook, C.R., Williams, K.R., Guera, N.G., Kim, T.E., & Sadek. S. (2010). Predictors of bullying and victimization in childhood and adolescence: A meta-analytic investigation. *School Psychology Quarterly, 25*(2) 65–83.

Copeland, W., Wolke, D., Angold, A., & Costello, E. (2013). Adult psychiatric and suicide outcomes of bullying and being bullied by peers in childhood and adolescence. *JAMA Psychiatry, 70*(4), 419-426.

Dale, J., Russell, R., & Wolke, D. (2014). Intervening in primary care against childhood bullying: an increasingly pressing public health need. *Journal of the Royal Society of Medicine, 107*(6), 219-223.

Eisenberg, M.E., Gower, A.L., McMorris, B.J., & Bucchianeri, M.M. (2015). Vulnerable bullies: Perpetration of peer harassment among youths across sexual orientation, weight, and disability status. *American Journal of Public Health, 105*, 1784–1791.

Feldman Hertz, M., Donato, I., & Wright, J. (2013). Bullying and suicide: a public health approach. *Journal of Adolescent Health, 53*(10). S1-S3.

Forbes, M., Fitzpatrick, S., Magson, N., & Rapee, R. (2019). Depression, anxiety and peer victimization: Bidirectional relationships and associated outcomes transitioning from childhood to adolescence. *Journal of Youth and Adolescence, 48*, 692-702.

Ford, R., King, T., Priest N., & Kavanagh, A. (2017). Bullying and mental health and suicidal behaviour among 14- to 15-year-olds in a representative sample of Australian children. *Australian and New Zealand Journal of Psychiatry, 51*(9), 897-908.

Government of South Australia. (2019). Connected, A community approach to bullying prevention within the school gates and beyond. Retrieved from https://www.education.sa.gov.au/sites/default/files/connected-community-approach-bullying-prevention.pdf.

Hutson, E., Melnyk, B., & Hensley, V. (2019). Childhood bullying: Screening and intervening practices of pediatric primary care providers. *Journal of Pediatric Health Care, 33*, e39-e45

Kljakovia, M, & Hunt, C. (2016). A meta-analysis of predictors of bullying and victimisation in adolescence. *J Adolesc. 49*, 134-145.

Leff, S., & Feudtner, C. (2017). Tackling bullying: Grounds for encouragement and sustained focus. *Pediatrics, 139*(6), https://pediatrics.aappublications.org/content/139/6/e20170504

Luthar, S., & Ciciolla, L. (2016). What it feels like to be a mother: Variations by children's developmental stages. *Developmental Psychology, 52*(1), 143-154.

Moses, B. (2019). *Addressing bullying behaviour in pediatric patients using a clinical practice guidelines*. Dissertation, Walden University, US

National Academies of Sciences, Engineering, and Medicine. (2016). *Preventing Bullying Through Science, Policy, and Practice*. Washington, DC: The National Academies Press. https://doi.org/10.17226/23482.

O'Brien, N. (2019). Understanding alternative bullying perspectives through research engagement with young people. *Frontiers in Psychology, 10*, 1984.

Orygen, The National Centre of Excellence in Youth Mental Health (2017). A better fit: Improving the access and acceptability of youth mental health services. Retrieved 29 June, 2020, from: https://www.orygen.org.au/Policy/Policy-Areas/Government-policy-service-delivery-and-workforce/Service-delivery/A-Better-Fit-Improving-the-access-and-acceptabili/Orygen_A_better_fit_policy_brief_public?ext=.

Pittet I., Berchtold A., Akre C., Michaud, P.A., & Suris, J.C. (2010). Are adolescents with chronic conditions particularly at risk for bullying? *Arch Dis Child, 95*, 711–716.

Poulin, F., & Chan, A. (2010). Friendship stability and change in childhood and adolescence. *Developmental Review*, 30, 257-272.

Reijntjes, A., Kamphuis, J. H., Prinzie, P., & Telch, M. J. (2010). Peer victimization and internalizing problems in children: a meta-analysis of longitudinal studies. *Child Abuse & Neglect*, 34, 244-252.

Ryoo, J., Wang, C., & Swearer, S. (2015). Examination of the change in latent statuses in bullying behaviours across time. *School Psychology Quarterly, 30*(1), 105-122.

Scott, E., Dale, J., Russell, R., & Wolke, D. (2016). Young people who are being bullied – do they want general practice support? *BMC Family Practice, 17*. Online: DOI 10.1186/s12875-016-0517-9

Smith, P., Madsen, K., & Moody, J. (1999). What causes the age decline in reports of being bullied at school? Towards a developmental analysis of risks of being bullied. *Educational Research, 41*(3), 267-285.

Speech Pathology Australia (2016). Inquiry into students with a disability or special needs in New South Wales schools. Retrieved from https://www.parliament.nsw.gov.au/lcdocs/submissions/57153/0125%20Speech%20Pathology%20Australia.pdf

Srabstein, J., & Leventhal, B. (2010). Prevention of bullying-related morbidity and mortality: a call for public health policies. Retrieved from: https://www.who.int/bulletin/volumes/88/6/10-077123/en/

Stephens, M., Cook-Fasano, H. & Sibbaluca, K. (2018). Childhood bullying: Implications for physicians. *American Family Physician, 97*(3), 187-192.

Strout, T., Vessey, J., Difazio, R., & Ludlow, L. (2018). The Child Adolescent Bullying Scale (CABS): Psychometric evaluation of a new measure. *Research in Nursing and Health, 41*(3), 252-264.

Takizawa, R., Maughan, B., & Arseneault, L. (2014). Adult health outcomes of childhood bullying victimization: Evidence from a five-decade longitudinal British birth cohort. *American Journal of Psychiatry*. Online https://doi.org/10.1176/appi.ajp.2014.13101401

Thomson, S., Wernert, N., O'Grady, E., & Rodrigues, S. (2017). TIMSS 2015: reporting Australia's results. Melbourne: Australian Council for Educational Research

Vaillancourt, T., Faris, R., & Mishna, F. (2017). Cyberbullying in children and youth: Implications for health and clinical practice. *The Canadian Journal of Psychiatry, 62*(6), 368-373.

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