Bullying: A primary care problem
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Introduction

Bullying is a very important topic for pediatricians in our goal to aid not merely children’s physical ailments, but furthermore, their life. Bullying is a specific type of aggression in which the behavior is intended to harm or disturb, occurs repeatedly over time, and there is an imbalance of power, with a more powerful person or crowd attacking a less powerful one. There are multiple forms of bullying including verbal, physical, social, and cyberbullying. The American Academy of Child and Adolescent Psychiatry estimate that half of all children are bullied at some point during school years. Close to 10% are repeatedly bullied. Other bullying statistics show that about 77% of students have admitted to being the victim of one type of bullying or another. It is our role as pediatricians to help fight to minimize or eradicate bullying. However, for various reasons, pediatricians do not inquire or educate about bullying situations with their patients and are therefore unaware of the significant impacts bullying has on their health. My aim in this project was to educate pediatric residents at Palmetto Health for the purpose of more intentional and informed conversations with patients about bullying.

Methods

Initially, a survey was created and distributed to all current Palmetto Health pediatric residents via surveymonkey.com. The survey assessed the resident’s opinions on the importance of a comprehensive approach of anticipatory guidance, screening, and counseling about bullying during routine well visits and how often they do discuss such topics. This survey also inquired about the residents’ comfort levels screening children and teens for involvement with bullying, recognizing signs of bullying from children’s chief complaints during sick visits, and discussing and educating children and their parents about specific ways to handle bullying situations. Lastly, it assessed whether or not their comfort level in these discussions correlated with the amount of time they spend dedicated to bullying in well child visits. The residents also had an opportunity to free text what hinders them from being comfortable with discussions about bullying. Survey is found below. After analyzing the results of the survey, I created a comprehensive PowerPoint presentation about bullying and focused on the areas residents felt least comfortable. In the lecture, I addressed statistics about bullying, definition and types of bullying, and the common qualities that the victim or bully embody. I also taught how involvement with bullying affects well-being and social functioning and causes the development of somatic and psychological health problems. I then reviewed our role as pediatricians with these families and how specifically to advise kids as well as their parents when they are a victim of
bullying. In addition, there was a slide dedicated to how to counsel parents if their kids is the bully. Finally, a few resources were reviewed for parents and kids that we could recommend for these families. Following the lecture, the same survey was administered with the exception of questions 2, 3, 8, and 9. Again, survey is found below.

Results

The initial survey was completed by 33 out of the 36 total residents in the program, 11 from each of the classes. The post-lecture survey was completed by 22 of the 36 residents, 6 PGY1, 7 PGY2, and 9 PGY3. In the initial survey, when asked about the importance of these discussions, 55% and 39% of residents felt that it was very important or somewhat important, respectively.

In reference to the percentage of well visits that the residents inquire about bullying, a majority responded fifty percent of the time (42%). Three percent and 21% of residents responded that they either never ask or only ask twenty five percent of the time, respectively. Twenty one percent inquire seventy five percent of the time and 12% reported that they always inquire about bullying.
A majority of residents (81%) relayed that their comfort level does affect whether or not they spend time in discussions about bullying (39% somewhat, 39% quite a bit, 3% a great deal).

In the questions assessing the comfort of residents, initially, more residents were comfortable screening patients for involvement in bullying, but less were comfortable actually discussing and educating children and their parents about specific ways to handle bullying situations. In all questions related to comfort, there was a significant increase in the number of residents who felt somewhat or completely comfortable after the lecture was given. Specifically, 48% of residents pre-presentation and 86% post were either somewhat or completely comfortable screening patients for involvement with bullying. Thirty six percent pre and 91% post were somewhat or completely comfortable recognizing signs of bullying from chief complaints during sick visits. Eighteen percent pre and 91% post were somewhat or completely comfortable discussing and educating children about
specific ways to handle bullies. Fifteen percent pre and 91% post were somewhat or completely comfortable discussing and educating parents about specific ways to handle situations when their child is a victim of bullying.

![Bar chart showing comfort levels before and after intervention](image)

This figure displays the percentage of residents who felt either completely or somewhat comfortable in the situations listed at the left.

In response to the open-ended question about hinderences in comfortable discussions, most residents responded with similar answers to, “unsure of the best way to deal with bullying” or unaware of “proper suggestions” to give patients or parents. Other unique responses included, “knowing that my patients know I haven’t been where they are and I don’t know what it’s like,” afraid that “intervening may make the situation worse,” and unsure of proper coping mechanisms to teach children or resources to point them to.

**Discussion**

This study demonstrated that with more education about bullying and how to approach and handle situations with the victim, the bully, or their parents leads to more comfort in discussions within a primary care pediatric clinic. An assumption of the study was that more comfort in discussions would actually lead to more discussions. However, a weakness of the study was that this specifically was not measured. The ultimate assumption, though, is that more discussions and education for children and their parents would actually lead to less bullying in general and therefore a richer quality of life. Nevertheless, the amount and severity of bullying is not an entity that can be easily tracked and measured.
There were several advantages to the study. The survey was easy to administer and cost effective. It was easily replicated post-lecture to test the success of the intervention. Still, the study does have its limitations. There were 33 residents who completed the pre-intervention survey and only 22 who completed the post-intervention survey. It is unknown whether these 22 residents were ones who initially completed the survey. Also, surveys can always be limited by accuracy or honesty. Another potential, more specific weakness is that when asked, “how important do you believe it is to provide a comprehensive approach of anticipatory guidance, screening, and counseling about bullying during routine well visits,” approximately 6% of residents chose “very unimportant.” This choice appears to be an outlier; however, the data was still included as it is impossible to decipher whether the residents chose that purposefully or on accident.

All in all, resident comfort level did improve after the lecture was given; however, without continued education and the experience of discussions with children and their parents, residents cannot expect to remain confident in a pediatrician’s role in handling bullying.

In addition to continued education, it may also be helpful to provide brochures or handouts in clinic for families as another resource on how to handle bullying situations. In terms of future research, it would be beneficial to expand the project to multiple residency programs to increase subject number and hence obtain more accurate, statistically significant conclusions.
1. What is your level of training?
- PGY1
- PGY2
- PGY3

2. As a primary care physician, how important do you believe it is to provide a comprehensive approach of anticipatory guidance, screening, and counseling about bullying during routine well visits?
- Very unimportant
- Somewhat unimportant
- Neither important nor unimportant
- Somewhat important
- Very important

3. What percentage of well visits do you inquire about bullying?
- 0%
- 25%
- 50%
- 75%
- 100%

4. How comfortable are you screening children and teens for involvement with bullying as either the victim or as the bully?
- Completely uncomfortable
- Somewhat uncomfortable
- Neither comfortable nor uncomfortable
- Somewhat comfortable
- Completely comfortable

5. How comfortable are you in your skills to recognize signs of bullying from their chief complaints during sick visits?
- Completely uncomfortable
- Somewhat uncomfortable
- Neither comfortable nor uncomfortable
- Somewhat comfortable
- Completely comfortable

6. How comfortable are you discussing and educating children about specific ways to handle bullies?
- Completely uncomfortable
- Somewhat uncomfortable
- Neither comfortable nor uncomfortable
- Somewhat comfortable
- Completely comfortable

7. How comfortable are you discussing and educating parents about specific ways to handle situations when their child is a victim of bullying?
- Completely uncomfortable
- Somewhat uncomfortable
- Neither comfortable nor uncomfortable
- Somewhat comfortable
- Completely comfortable

8. How much does your level of comfort affect whether or not you spend time in discussions about bullying?
- Not at all
- Very little
- Somewhat
- Quite a bit
- A great deal

9. What hinders you from being very comfortable with discussions about bullying?
References

1. Arseneault, Louise et. al. Bullying Victimization Uniquely Contributes to Adjustment Problems in Youth Children: A Nationally Representative Cohort Study.


16. Ttofi, Maria M. and Farrington, David P. Effectiveness of school-based programs
