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Proceedings

Educational Forum on Adolescent Health

Youth Bullying

May 3, 2002

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The AMA PIPPAH project is addressing *Healthy People 2010's* 21 critical adolescent objectives through its Educational Forum sessions. Each session considers a single issue that is directly related to one of the 21 critical adolescent objectives and one of the ten Healthy People leading health indicators. The May 3, 2002 Educational Forum featured a discussion of bullying which is related to the reduction of physical fighting (Objective 15-38) which is included in the Injury and Violence leading health indicator.

Missy Fleming, PhD
Program Director, Child and Adolescent Health
American Medical Association

Kelly J. Towey, MEd
Child and Adolescent Health
American Medical Association

Susan P. Limber, PhD, MLS
Institute on Family & Neighborhood Life
Clemson University

Richard L. Gross, MD
American Academy of Child and Adolescent Psychiatry

Marcia Rubin, PhD, MPH
American School Health Association

Joseph L. Wright, MD, MPH
American Academy of Pediatrics

Susan M. Anderson, MLS
Information Consultant

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"We are all either bullies, bullied, or bystanders."

Richard L. Gross, MD
American Academy of Child and Adolescent Psychiatry

Youth Bullying
An Overview

Bullying is a pervasive, serious problem with long lasting consequences; it's not just a natural part of growing up.

It happens in schools which means that parents, teachers, students, and administrators must be aware of the problem and ways to handle it.

Bullying can be direct or indirect and is different for girls and boys.

Regardless of the gender or the form, bullying has long-term effects for the bully and the bullied.

For the bully:

- Other antisocial/delinquent behaviors such as vandalism, shoplifting, truancy, and frequent drug use
- This antisocial behavior pattern will continue into young adulthood
- More apt to drink, smoke, and perform poorly in school
- One in four boys who bully will have a criminal record by age 30

For the bullied:

- Short-term problems can include depression, anxiety, loneliness, difficulties with school work
- Long-term problems can include low self-esteem, depression

We are still working on solutions. One excellent program, the Olweus Bullying Prevention Program, is discussed in this volume. We do know that solutions must be system- and community-wide. Policies of zero tolerance, "three strikes", mediation, and short-term fixes just don't work.

What physicians, health educators, and other professionals can do:

Be vigilant in clinical practice

- Ask patients about their experiences with bullying
- Look for potential victims, such as disabled patients.

Answer important research questions

- What is the psychopathology of bullying?
- What are the cues parents and teachers can use that signal the need to make a referral?
- What are the protective factors? (eg, relationships, school administrators, good academic skills)

Promote sound research

- Collect data on occurrence
- Design tools to measure bullying
- Develop risk management techniques
- Create screening questionnaires
- Outline responses to screening

Education

- Integrate into medical school curricula
- Develop continuing professional education opportunities
- Disseminate research findings

Support community efforts

We are all involved as bullies, bullied, or bystanders. This Educational Forum highlights the problems, some solutions, and areas for further research.

Introduction

American Medical Association
Educational Forum on Adolescent Health
Youth Bullying

May 3, 2002

Missy Fleming, PhD

I would like to welcome you to the first session of the American Medical Association's (AMA) Educational Forum on Adolescent Health. We are very excited about today's program. Those of you who attended our meetings the last several years may remember that we typically had a number of speakers who addressed one topic. We have switched to a new structure that includes a featured speaker and panelists who react to the speaker's remarks.

I would like to begin by recognizing our sponsor, the Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau, Office of Adolescent Health. Today's program is sponsored, in part, by our Partners In Program Planning for Adolescent Health (PIPPAH) project.

A number of our current and former partners are here today and I would like to recognize them.

- Karen Howze from the American Bar Association;
- Sheila Clark and Tracy Whitaker from the National Association of Social Workers;
- Mary Campbell from the American Psychological Association;
- Marcia Rubin from the American School Health Association, one of our panelists; and
- Shahla Ortega from the American Nurses Foundation

Most of us witnessed the violence epidemic of the 1990s. During that time, as we discussed many times during our previous five years of meetings, arrests for serious violent crimes increased by close to 50%. Homicide rates doubled between 1984 and 1994.

The search for solutions to this epidemic has become a national priority; many of us are involved in that search. One solution for addressing the violence epidemic of which we are all aware, is the strategy of building more prisons. In fact, we probably invested more resources in building prisons than we have in primary prevention. That is something we want to talk about today.

Today we want to begin thinking about injury and violence which is one of the *Healthy People 2010's* leading health indicators. Our speaker, Dr. Susan Limber, and our three panelists are going to discuss the pervasive issue of bullying, its impact on young people, and how we, as health care professionals, can better understand and address this issue.

I want to tell you briefly about some AMA activities that address injury and violence. The AMA and its partners on the *Commission for the Prevention of Youth Violence* have identified bullying and being bullied as warning signs for violence. I hope that everyone will take a copy of our excellent report that was sponsored jointly through medicine, nursing, and public health. (Commission for the Prevention of Youth Violence. *Youth and Violence. Medicine, Nursing, and Public Health: Connecting the Dots to Prevent Violence. December 2000. 44p* **www.ama-assn.org/violence**)

Other AMA efforts include an article published in the April 25, 2001 issue of *The Journal of the American Medical Association (JAMA)* on bullying behaviors among youth in the United States. In June 2001, the American College of Preventive Medicine and American Academy of Child and Adolescent Psychiatry, both of whom are represented here today, submitted a resolution to the AMA House of Delegates that was passed and adopted as policy to support research on bullying. The AMA is also represented on the HRSA's task force on bullying.

Please join me in welcoming our featured speaker and panelists who are going to lead today's discussion of bullying.

Susan P. Limber, PhD, MLS
Associate Director
Institute on Family and Neighborhood Life
Clemson University
Clemson, SC

Dr. Susan Limber is associate director of the Institute on Family and Neighborhood Life. She is also an associate professor of psychology at Clemson University. Dr. Limber is a developmental psychologist who completed her training and education at the University of Nebraska in Lincoln. Her research and writing have focused on both legal and psychological issues related to youth violence, child protection, youth participation, and child rights.

Dr. Limber has directed the first wide-scale implementation and evaluation of the Olweus Bullying Prevention Program in the United States. She coauthored the *Bullying Prevention Program,* one of the model programs in the Office of Juvenile Justice and Delinquency Prevention (OJJDP) *Blueprints for Violence Prevention,* as well as many other articles on the topic of bullying.

In recent years, Dr. Limber has consulted with numerous schools around the country on the reduction of bullying among school children.

Addressing Youth Bullying Behaviors*

Bullying among children is not a new phenomenon. Indeed, the experience of children being systematically harassed by their peers has been documented in literary works for hundreds of years. (Recall, for example, the torture that classmates exacted on Tom Brown in the 19th century classic, *Tom Brown's School Days*). It was not until fairly recently, however, that bullying was on the radar screens of researchers or the general public.

Strong societal interest in the phenomenon of bullying began in Scandinavia in the late 1960s and early 1970s. Efforts to systematically study bullying also emerged in Scandinavia and were led by the pioneering research of Dan Olweus and colleagues in Sweden and Norway during the 1970s. In the early 1980s in Norway, public attention was captured by the suicides of three young boys who took their lives after being persistently bullied by some of their peers. This horrific event triggered a chain of events that resulted in a national campaign against bullying in the Norwegian schools and the development of the Olweus Bullying Prevention Program which is now an international model (Olweus, Limber, & Mihalic, 1999).

Here in the United States, it has only been in the last several years that public attention has focused on bullying. Columbine and several subsequent school shootings likely were our wake-up calls causing us to pay attention to the experiences of bullied children in American schools and communities. Early anecdotal reports that emerged from the investigations in Littleton, Colorado suggested that the troubled teens who went on a shooting rampage had been the subjects of bullying by their peers. A subsequent investigation by the U.S. Secret Service of 41 school shooters involved in 37 incidents (including Columbine) revealed that two-thirds of the perpetrators described feeling persecuted, bullied, or threatened by their peers (Dedman, 2000). Another recently-published study in *The Journal of the Medical Association,* which examined all school-associated violent deaths in the United States between 1994 and 1999, found that homicide perpetrators at school were twice as likely as homicide victims to have been bullied by peers (Anderson et al., 2001). In the last several years, the air waves and print media have been filled with stories about bullying. What do we really know about the nature and prevalence of bullying and the experiences of victims and their perpetrators?

Before we launch into reviewing the numbers, the data, the statistics, the research, and what we know about bullying, I would like to make sure that we put a face on bullying. I think it is important that we keep at the forefront of our minds a clear image of the children who are involved as victims, as bullies, or as bystanders to bullying. I am going to show you a five-minute clip from a February 2002 ABC News special with John Stossel called, "The 'In' Crowd and Social Cruelty." (**http://abcnews.go.com/onair/2020/stossel_020215_popularity.html**) You are going to see footage of children on a playground. You will hear from kids who have been bullies, from kids who have been victimized, and as you watch this, I would like for you to think to yourselves, "Do you recognize these children from your schools and from your communities?" (Video clip)

Do any of those kids look familiar from your communities or maybe your personal memories? The video showed a number of different types of bullying that kids experience and in which they engage, but let's make sure we have a common understanding of what bullying is and a common understanding of the term.

* This paper is based in part on research conducted for the HRSA's Maternal and Child Health Bureau (MCHB) in development of a national Bullying Prevention Campaign.

Bullying defined

The most common definition of bullying used in the literature was formulated by Dan Olweus, who is widely recognized as the father of bullying research. According to Olweus (1993a), bullying is aggressive behavior that: (a) is intended to cause harm or distress, (b) occurs repeatedly over time, and (c) occurs in a relationship in which there is an imbalance of power or strength. It is important to note that bullying, as a form of peer abuse, shares many characteristics with other types of abuse, namely child maltreatment and domestic violence.

Traditionally, many members of the general public think of bullying as being physical and overt (eg, hitting, kicking, shoving another child). However, bullying also may involve words or other non-verbal, non-physical means (see Table 1). Moreover, although bullying behaviors may involve direct, relatively open attacks against a victim, bullying frequently is indirect, or subtle, in nature.

The prevalence of bullying

The most comprehensive study of bullying was conducted by Olweus (1993a) in Norway and Sweden, with 150,000 students in grades one through nine. In this sample, 15% of students reported being involved in bully/victim problems "several times" or more often within a three-to-five month period. Approximately 9% reported that they had been bullied by peers "several times or more", and 7% reported that they had bullied others. About 2% of all students reported both bullying and being bullied by their peers.

Studies elsewhere in Europe and in the United States typically have revealed higher rates of bullying among children and youth. For example, in a study of 6,500 4th to 6th graders in rural South Carolina, 23% reported being bullied "several times" or more during the previous three months, and 9% reported being the victim of very frequent bullying—once a week or more often. One in five reported bullying other students "several times" or more during that same period (Melton et al., 1998). Similar rates of bullying were found by Nansel and colleagues (2001) in their nationally-representative study of 15,600 6th to10th graders. Seventeen percent of their sample reported having been bullied "sometimes" or more frequently during the school term and 19% reported bullying others "sometimes" or more often. Six percent of the full sample reported both bullying and having been bullied.

Age trends Most studies have found that rates of victimization decrease fairly steadily through elementary grades (Melton et al., 1998; Olweus, 1991, 1993a), middle school (Nansel et al., 2001; Olweus, 1993) and into high school (Nansel et al, 2001). For example, in a recent study of over 10,000 Norwegian school children, Olweus (personal communication,

Table 1. Common Forms of Bullying

	Direct bullying	Indirect bullying
Verbal bullying	Taunting, teasing, name-calling	Spreading rumors
Physical bullying	Hitting, kicking, shoving, destruction or theft of property	Enlisting a friend to assault someone for you
Non-verbal/ Non-physical bullying	Threatening, obscene gestures	Excluding others from a group, manipulation of friendships, threatening e-mail

Source: Adapted from Rigby (1996). See also Olweus, (1993a).

The majority of studies show that the most common type of bullying experienced by both boys and girls is verbal (Olweus, 1993a; Melton et al., 1998; Unnever, 2001).

February 23, 2002) found that rates of victimization were twice as high in 4th grade compared with 8th grade, and lower still in 10th grade. Similarly, Nansel and colleagues in the United States (2001) found that although about one-quarter of 6th graders reported being bullied during the current school term, less than one-tenth of the 10th graders reported similar experiences during the same period of time.

Although self-reported victimization decreases with age, the picture is not as clear for age trends in self-reported bullying. In the study of 6th to 10th graders in the United States, Nansel and colleagues (2001) found that older students were less likely to bully their peers than were younger students. However, other studies (eg, Melton et al., 1998; Olweus, 1993a) have found no marked age differences, suggesting that older children who bully tend to find younger children to target (Olweus, 1993a).

Gender differences There are some interesting (and perhaps predictable) gender differences in bullying experiences. By self-report, boys are more likely than girls to bully other students (Duncan, 1999; Melton et al., 1998; Nansel et al., 2001; Olweus, 1993a). The picture is less clear with regard to gender differences in victimization experiences. Some studies (Boulton & Underwood, 1992; Nansel et al., 2001; Olweus, 1993a; Perry, Kusel, & Perry, 1998; Rigby & Slee, 1991; Whitney & Smith, 1993) have found that boys report higher victimization than girls. Other studies, however, have found either no gender difference or marginal differences (Boulton & Smith, 1994; Chrach, Pepler, & Ziegler, 1995; Duncan, 1999; Hoover, Oliver, & Hazler, 1992; Melton et al., 1998). What is clear is that girls report being bullied by both boys and girls, whereas boys typically are bullied only by other boys (Melton et al., 1998; Olweus, 1993a).

There are some marked differences in the kinds of bullying that boys and girls experience. Boys are more likely than girls to report being physically bullied by their peers (Harris, Petrie, & Willoughby, 2002; Nansel Overpeck, Pilla, Ruan, Simons-Morton, & Scheidt, 2001). Girls, on the other hand, are more likely than boys to report being the targets of rumor-spreading and sexual comments (Nansel et al., 2001). Recognizing that girls are bullied by both girls and boys, Olweus (February 23, 2002, personal communication) studied the nature of same-gender bullying (the bullying of girls by girls) and found that girls are more likely than boys to bully each other through social exclusion.

Bullying in urban, suburban, and rural communities Bullying often is viewed as a problem of urban schools. In fact, recent findings from a nationally-representative study of 6th to10th graders found that youth from urban, suburban, town, and rural areas in the United States were bullied with the same frequency (Nansel et al., 2001). Very small differences were found in students' reports of bullying others. Youth in rural areas were 3% to 5% *more likely* than youth in towns, suburban areas, or urban areas to admit bullying their peers.

Conditions surrounding the bullying

Recent research has focused on better understanding the conditions surrounding bullying incidents, namely the number of perpetrators and the location of the bullying.

Number of perpetrators Children who are bullied most commonly report that they have been bullied by one other child or by a very small group of peers. It is much less common for children to be bullied by large groups (Melton et al., 1998; Unnever, 2001).

Location of bullying Although the locations where children are bullied vary somewhat from survey to survey, several general trends are consistently noted. Bullying is much more common at school than on the way to and from school, such as on the bus, at the bus stop, or elsewhere in the community (Harris et al., 2002; Melton et al., 1998; Nansel et al., 2001; Olweus, 1993a; Rivers & Smith, 1994; Whitney & Smith, 1993; Unnever, 2001). Common locations for bullying at school include the playground (for elementary school children), the classroom (both with and without the teacher present), the lunchroom, and the hallways.

Children who bully

What is known about children who regularly bully their peers? A significant body of research on antisocial behavior among children indicates that such behavior is the result of an interaction between the individual child and his or her family, peer group, school, and community (Olweus, Limber, & Mihalic, 1999). Similarly, research specifically focused on bullying behavior suggests that there typically is no single cause of bullying. Rather, individual, familial, peer, school, and community factors may place a child or youth at risk for bullying his or her peers.

Common characteristics of children who bully Researchers have identified several general characteristics of children who bully their peers regularly (ie, admit to bullying peers more than occasionally).[1] These children tend to have impulsive, hot-headed, dominant personalities; are easily frustrated; have difficulty conforming to rules; and view violence in a positive light (Olweus, 1993a; Olweus, Limber, & Mihalic, 1999). Boys who bully tend to be physically stronger than their peers (Olweus, 1993a).

Risk factors for bullying Research also has identified a number of risk factors within the family environment that are common to children who bully (Espelage, Bosworth, & Simon, 2000; Loeber & Stouthammer-Loeber, 1986; Olweus, 1980, 1993a; Olweus, Limber, & Mihalic, 1999). These include a lack of warmth and involvement on the part of parents; overly permissive parenting (with a lack of clear limits for the child's behavior); a lack of parental supervision; and harsh, corporal discipline. Recent studies also point to links between the experience of child maltreatment (physical and sexual abuse) and bullying behavior (see eg, Shields, & Cicchetti, 2001).

Peer and school risk factors for bullying In addition to individual risk factors for bullying, the research literature has identified significant risk factors for bullying within the peer group and the school environment. Children who bully their peers are more likely than children who do not bully to have friends who have positive attitudes toward violence and who also tend to bully other children. Finally, there are school-related risk factors for bullying, as some schools have significantly higher rates of bullying than others. Bullying tends to thrive in schools in which there is a lack of adequate adult supervision (particularly during breaks) and where teachers, other staff, and students have indifferent or accepting attitudes toward bullying (Olweus, Limber, & Mihalic, 1999).

Common myths about children who bully Despite the significant increase in our understanding of bullying in recent years, several "myths" about bullies are common among educators, practitioners, and the general public. Correction of these myths may be important in the development of appropriate bullying interventions.

1. "Children who bully are loners." In fact, research indicates that children who bully are not socially isolated (Cairnes, Cairnes, Neckerman, Gest, & Gariepy, 1998; Nansel et al., 2001; Olweus, 1978, 1993a). Nansel and colleagues found that in their sample, 6th to 10th graders who bullied their peers reported having an easier time making friends than their peers. Olweus (1978, 1993a) has found that bullies are average or somewhat below average in popularity among their peers, but they have at least a small group of friends (a.k.a. "henchmen") who support their bullying behavior. These findings suggest that effective interventions must focus not only on bullies but on bystanders who support the bullying (whether actively or passively).
2. "Children who bully have low self-esteem." Contrary to the assumptions of many, most research indicates that children who bully have average or above average self-esteem (Olweus, 1993a; Rigby & Slee, 1991; Slee & Rigby, 1993; but see Duncan, 1999; O'Moore & Kirkham, 2001). Children who bully also are no more likely than their peers to be characterized as anxious or uncertain (Olweus, 1984, 1993a). These findings have implications for bullying interventions and confirm the experience of many that efforts that focus solely on improving the self-esteem of

[1] Although research has identified these as common traits of children who bully, it should be emphasized that individual children may not exhibit any or all of these characteristics.

children who bully may help create more confident bullies but may have no effect on their bullying behavior.

Bullying and its relation to other antisocial behavior Frequent or persistent bullying behavior commonly is considered part of a conduct-disordered behavior pattern (Olweus, 1993a; Salmon, James, Cassidy, & Javoloyes, 2000). Researchers have found bullying behavior to be related to other antisocial behaviors (Melton et al., 1998) such as vandalism, fighting, theft (Olweus, 1993b), drinking alcohol (Nansel et al., 2001; Olweus, 1993b), smoking (Nansel et al., 2001), truancy (Byrne, 1994; Olweus, 1993b), and school drop-out (Byrne, 1994). In addition, a recent study of 5th through 7th grade students in rural South Carolina found that students' reasons for gun ownership were linked with rates of bullying (Cunningham, Henggeler, Limber, Melton, & Nation, 2000). High-risk gun owners (those who owned guns to gain respect or frighten others) reported higher rates of bullying than did low-risk gun owners (those who owned guns to feel safe or to use in hunting or target-shooting) or those who did not own guns.

Finally, bullying behavior also may be an indicator that boys are at risk for engaging in later criminal behaviors (Loeber & Dishion, 1983; Olweus, 1993a). For example, in a longitudinal study in Norway, 60% of boys who were identified as bullies in middle school had at least one conviction by the age of 24, and 35-40% had three or more convictions. Thus, bullies were three to four times as likely as their non-bullying peers to have multiple convictions by their early 20s. Similar patterns may also hold true for girls, but as of now, the longitudinal studies have examined only boys (Olweus, 1993a).

Children who are victims of bullying

Children who are bullied by their peers tend to be characterized in the literature either as "passive victims" or as "bully-victims" (also referred to as "provocative victims") (Olweus, 1993a). Although estimates vary somewhat, bully-victims comprise a smaller subset of victims than do passive victims. For example in their nationally-representative sample of 6th to10th graders, Nansel and colleagues (2001) found that 6% of the sample were bully-victims, compared to 11% of the sample who were passive victims. What characterize these two groups of victimized children?

Common characteristics of "passive victims" Passive victims tend to be cautious, sensitive, insecure children who have difficulty asserting themselves among their peers (Olweus, 1993a). They frequently are very socially isolated (Nansel et al., 2001; Olweus, 1993a) and report feeling lonely (Nansel et al., 2001). This social isolation places children at particular risk for being bullied because the presence of friends helps to buffer children from bullies. Boys who are bullied frequently are physically weaker than their peers (Olweus, 1993a). Finally, children who have been victims of child maltreatment (neglect, physical, or sexual abuse) are more likely to be victimized by their peers (Shields & Cicchetti, 2001).

It is important to note that some characteristics of passive victims may be seen as both contributing factors as well as consequences of victimization (Olweus, 2001). For example, if a child feels insecure, his or her behavior may signal to others that he or she is an "easy target" for bullying. Here, the child's insecurity may be viewed as contributing to the abuse.[2] However, a child who is bullied regularly also is likely to have his or her confidence further shaken by the bullying experience. So, in this sense, insecurity may also be a consequence of bullying.

A common misperception is that children are victimized because of external characteristics that make them stand out among their peers (eg, thick glasses, freckles, red hair). Such characteristics typically are not as significant as those noted above (eg, insecurity) in eliciting bullying. However, emerging research on children with disabilities does suggest that children who have particular disabilities such as stammering (Hugh-Jones & Smith, 1999), cerebral palsy, muscular

[2] In noting that particular behaviors of children may contribute to bullying, one must be careful not to blame the victim. It should be emphasized that no children deserve to be bullied, and they are not responsible for the bullying they receive.

dystrophy, or hemiplegia (Dawkins, 1996; Yude, Goodman, & McConachie, 1998) may be more likely targets of bullying. Educators, parents, practitioners and other adults must be particularly vigilant to possible bullying of children with disabilities.

Common characteristics of "bully-victims" Bully-victims display many of the characteristics of passive victims, but they also tend to be hyperactive (Kumpulainen & Räsänen, 2000; Kumpulainen, Räsänen, & Puura, 2000) and have difficulty concentrating (Olweus, 1993a). These children (often referred to as provocative victims) tend to be quick-tempered and try to fight back if they feel insulted or attacked. When these children are bullied, many students (and sometimes the whole class) may be involved in the abuse. Although provocative victims are frequent targets of bullying, they also may tend to bully younger or weaker children (Olweus, 1993a).

Recent research suggests that there is particular reason to be concerned about bully-victims (Anderson et al., 2001; Haynie et al., 2001; Kumpulainen & Räsänen, 2000; Nansel et al., 2001; Smith & Myron-Wilson, 1998), as they frequently display not only the social-emotional problems of victimized children but also the behavioral problems of bullies. For example, in their study of middle and high school youth, Nansel and colleagues (2001) found that bully-victims reported more loneliness and problems with classmates, but also poorer academic achievement and more frequent alcohol use and smoking than their peers. In their study of school-associated violent deaths in the United States, Anderson and colleagues (2001) speculated that the violent youth in their study who had been bullied by their peers "may represent the 'provocative' or 'aggressive' victims described in recent studies on bullying behavior, who often retaliate in an aggressive manner in response to being bullied" (p. 2702). Clearly, particular attention needs to be paid to this high risk group of children by researchers and those designing prevention and intervention strategies.

Warning signs of victimization What behaviors or other signs may signal that a child is being bullied by peers? Possible warning signs of bully victimization include those below:[3]

- Returns from school with torn, damaged, or missing articles of clothing, books or belongings;
- Has unexplained cuts, bruises, and/or scratches;
- Has few, if any, friends;
- Appears afraid of going to school;
- Has lost interest in school work;
- Complains of headaches, stomach aches;
- Has trouble sleeping and/or has frequent nightmares;
- Appears sad, depressed, or moody;
- Appears anxious and/or has poor self-esteem;
- Is quiet, sensitive, and passive.

If a child exhibits any of the characteristics above, follow-up investigation is warranted with the child and his or her parents to discern whether the child may be bullied by peers and to help address whatever problems the child may be experiencing (whether ultimately related to bullying or not).

Coping with bullying

How do victimized children cope with the bullying that they experience? Some recent studies have focused on the various ways that children react to the bullying that they experience.

Reporting bullying experiences Despite the high prevalence of bullying and the harm that it may cause, substantial numbers of children indicate that they report their victimization neither to adults at school nor to their parents. For example, studies of children

[3] From Olweus, Limber, & Mihalic (1999)

in England revealed that less than one quarter of those who had been bullied with some frequency had subsequently reported the incidents to teachers or other school staff (Boulton & Underwood, 1992; Whitney & Smith, 1993). Somewhat higher reporting was found in a study of fourth to sixth graders in the United States (Melton et al., 1998), in which approximately half indicated that they had told a teacher or another adult at school about their experience. Not surprisingly, reporting of bullying varies by age and gender. Older children and boys are particularly unlikely to report their victimization (Melton et al., 1998; Rivers & Smith, 1994; Whitney & Smith, 1993).

Children are somewhat more likely to inform family members about their bullying experiences. For example, in a British study (Boulton & Underwood, 1992), 42% had reported their bullying to a parent. Olweus (1993a) found that 55% of bullied children in primary grades reported that "somebody at home" had talked with them about their bullying experiences. In secondary/junior high grades, this percentage had decreased to 35%. Studies suggest that a relatively small yet worrisome percentage of children (14 to17%) do not discuss their experiences with anyone (Harris et al., 2002; Naylor, Cowie, & delRey, 2001).

For many children, their reluctance to report bullying experiences to school staff likely reflects their lack of confidence in their teachers' (and other school authorities') handling of incidents and reports. For example, in a survey of high school students in the United States, 66% of those who had been bullied believed that school personnel responded poorly to bullying incidents at school, and only 6% felt that school staff handled these problems very well (Hoover et al., 1992).

In another study (Harris et al., 2002), ninth grade students were asked what happened after they did tell someone about their experiences. Only one quarter felt that things got better as a result.

Other coping strategies Reporting bullying is perhaps the most common strategy that children use to cope with bullying, but it is not their only strategy. In a study of 11- to 14-year-olds, Naylor and colleagues (2001) found that other strategies included ignoring or simply enduring the bullying (27%), physically retaliating against the bully or bullies (7%), trying to manipulate the social context by seeking out protection from other peers without telling them about the bullying, avoiding bullies at school (5%), and planning revenge (2%). Nine percent of the children reported that they simply were not coping with the bullying.

Effects of bullying on its victims

Bullying may seriously affect the psychosocial functioning, academic work, and the physical health of children who are targeted. Bully victimization has been found to be related to lower self-esteem (Hodges & Perry, 1996; Olweus, 1978; Rigby & Slee, 1993), higher rates of depression (Craig, 1998; Hodges & Perry, 1996; Olweus, 1978; Rigby & Slee, 1993; Salmon et al., 2000; Slee, 1995), loneliness (Kochenderfer & Ladd, 1996; Nansel et al., 2001), and anxiety (Craig, 1998; Hodges & Perry, 1996; Olweus, 1978; Rigby & Slee, 1993). Victims are more likely to report wanting to avoid attending school (Kochenderfer & Ladd, 1996) and have higher school absenteeism rates (Rigby, 1996). Although more research is needed to assess health-related outcomes of bullying, researchers have identified that victims of bullying were more likely to report experiencing poorer general health (Rigby, 1996), have more migraine headaches (Metsähonkala, Silanpaa, & Tuomien, 1998), and report more suicidal ideation (Rigby, 1996) than their non-bullied peers. For example, in a study of Australian school children, those who reported being bullied at least once a week were twice as likely as their peers to "wish they were dead" or admit to having a recurring idea of taking their own life (Rigby, 1996).

Some consequences of bullying may persist into early adult years. In a longitudinal study of males in their early 20s, Olweus (1993a) found that those who had been bullied in school (during grades six to nine) were more depressed and had lower self-esteem than their non-bullied peers. These results were observed even though as young adults they were no longer victims of bullying and no longer exhibited other signs of victimization.

Bystanders to bullying

Both research and experience suggest that most bullying incidents do not merely involve a single bully and his or her target (Craig & Pepler, 1997; Olweus, 1993a). For example, a study by Craig and Pepler (1997) conducted on an elementary school playground revealed that other children were involved in 85% of bullying incidents. Their involvement ranged from joining in the bullying, to observing passively, to actively intervening to stop the bullying.

When students are asked what they usually do if they witness bullying, many (50% or more) admit that they do not try to intervene. For example, a study by Melton and colleagues (1998) found that 38% of fourth through sixth graders reported that they "did nothing" when they observed bullying because they felt it was none of their business. An additional 35% reported that they tried to help, and 27% admitted that they were conflicted about intervening—they did not help *but felt that they should.* Likely reasons for children's inaction include fears of reprisal from bullies ("If I tell an adult or try to help out, maybe *I'll* be targeted next time") and uncertainty about how best to intervene without making the situation worse for the bullied child.

Adults as witnesses to bullying

Adults play critical roles in bullying prevention and intervention, particularly in light of the reluctance of many children to intervene when they witness bullying. Unfortunately, adults within the school environment dramatically overestimate their effectiveness in identifying and intervening in bullying situations. Seventy percent of teachers in one study (Charach et al., 1995) believed that teachers intervene "almost always" in bullying situations, while only 25% of the students agreed with their assessment.

These findings suggest that teachers are simply unaware of much of the bullying that occurs around them (likely because much of the bullying is difficult to detect and because children frequently are reluctant to report bullying to adults). Observational studies reveal that teachers miss much of the bullying that occurs not only on the playground but also in their own classrooms. For example, Atlas and Pepler (1998) observed that teachers intervened in only 18% of the bullying incidents that took place in their elementary and middle school classes.

Many children also question the commitment of teachers and administrators to stopping bullying. For example, in a recent study of 136 ninth grade students (Harris et al., 2002), only 35% believed that their teachers were interested in trying to stop bullying. Forty-four percent reported that they did not know if their teachers were interested in stopping bullying, and 21% felt that their teachers were not interested. Fewer students still (25%) believed that administrators at their school were interested in stopping bullying.

Prevention and intervention

Despite the pessimism of students, today, increasing numbers of educators, practitioners, parents, and other adults who interact with children understand the seriousness of bullying among children and youth and the importance of bullying prevention and intervention. The old refrains of "Kids will be kids!" or, "Kids have to figure out how to deal with bullying on their own–it builds character" are less common, as we come to better understand the toll that bullying can exact on victims, bystanders, and bullies themselves.

Perhaps not surprisingly, schools have taken the lead in the implementation of bullying prevention and intervention strategies. The most effective strategies are very comprehensive in nature, involving the entire school as a community to change the climate of the school and the norms for behavior (eg, Olweus, 1993a; Olweus, Limber, & Mihalic, 1999). The Olweus Bullying Prevention Program, which is being implemented in several hundred schools world-wide, is the best researched of the comprehensive programs, and has been identified as one of the national model or "Blueprint" programs for Violence Prevention by the Center for the Study and Prevention of Violence at the University of Colorado, and as an Exemplary Program by the Center for Substance Abuse

Prevention (Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services).

Unfortunately, a number of more questionable intervention and prevention strategies also have been developed in recent years:

"Zero tolerance" or "three strikes" policies A number of schools and school districts have adopted "zero tolerance" or "three strikes and you're out" policies towards bullying, in which children who bully their peers are suspended or even expelled from school. Such policies raise a number of concerns. First, they may cast a very large net (recall that approximately 20% of elementary school children admit to bullying their peers with some frequency). Even if policies are limited to forms of physical bullying, the numbers of affected children is not insignificant. Second, such severe punishments also may tend to have a chilling effect on the willingness of students and school staff to report bullying (Mulvey & Cauffman, 2001). Finally, children who bully are in great need of prosocial role models, including classmates and adults at their school. Although suspension and expulsion may be necessary in a small minority of cases in order to maintain public safety, zero tolerance policies cannot be considered an effective bullying prevention or intervention strategy.

Group treatment for bullies Other interventions for children who bully involve group therapeutic treatment, which may focus on anger management, skill-building, empathy-building, or the enhancement of bullies' self-esteem. Experience and research confirm that these groups are often ineffective at best even with skilled and committed adult facilitators. In the worst cases, students' behavior may further deteriorate, because group members may serve as role models and reinforcers for each other's bullying and antisocial behavior. Moreover, therapeutic efforts that are designed solely to boost the self-esteem of bullies (whether done in group or individual settings) likely will not be effective in reducing children's bullying behavior. Such efforts are premised on the assumption that low self-esteem is at the root of bullying behavior among children. As noted above, most evidence suggests that children who bully do not particularly lack self-esteem (Olweus, 1993a). Thus, such interventions may help to create more confident bullies but may have no effect on bullying.

Mediation for bullies and victims Other interventions have focused on reducing conflict among children who bully and their victims. A common strategy is the use of peer mediation programs to deal with bullying problems. Although peer mediation may be appropriate in cases of conflict between students of relatively equal power, it is not recommended in bullying situations (see eg, Cohen, 2002). First, bullying is a form of victimization; it should be considered no more a "conflict" than child abuse or domestic violence. As a result, the messages that mediation likely sends to both parties are inappropriate ("You're both partly right and partly wrong." "We need to work out the conflict between you."). The appropriate message to the child who bullies should be, "Your behavior is inappropriate and won't be tolerated." The message to children who are victimized should be, "No one deserves to be bullied and we're going to do everything we can to stop it." Not only may mediation send inappropriate messages, but it also may further victimize a child who has been bullied. Because of the imbalance of power that exists between bullies and their victims, facing one's tormenter in an attempt at mediation may be extremely distressing.

Simple, short-term solutions to bullying As educators and members of the public are increasingly recognizing the need to focus on bullying prevention, many are (quite understandably) searching for simple, short-term solutions. However, as Bob Chase, President of the National Education Association recently noted, "a single school assembly won't solve the problem" (2001); nor will a curriculum that is taught for six weeks by the health teacher. What is required to reduce the prevalence of bullying in our schools is nothing less than a change in the school climate and in the norms for behavior (see Mulvey & Cauffman, 2001). To do so requires a comprehensive, school-wide effort that involves the entire school community.

Conclusions and recommendations for health care professionals

Although much bullying takes place in school, bullying clearly is not solely a "school" problem or just a problem for educators. Health care professionals (in their roles as practitioners, educators, and researchers) and other professionals also play important roles in bullying prevention and intervention. I will note just a few.

- *As practitioners,* health care professionals should be vigilant for possible signs of victimization or bullying behavior among children and youth, particularly among high-risk youth such as children with disabilities or children who display characteristics of bully-victims. Health care professionals should ask children about their experiences with bullying and discuss possible concerns with parents. They should be prepared to make referrals to appropriate mental health professionals within the school or community.
- *As researchers,* health care professionals should continue to promote solid research on bullying. Although research on bullying has exploded in recent years, there is still very much that we need to learn about topics such as the physical and psychological effects of bullying on victims.
- *As educators,* health care professionals should promote training and continuing education for other health professionals on bullying, its characteristics, its effects, and effective interventions to reduce bullying.
- *As community members,* parents, and professionals committed to promoting the health and well-being of children and their families, health care professionals should support effective school-based and community-based bullying prevention efforts and public information bullying prevention campaigns. Effective bullying prevention programs require a great deal of effort on the part of school staff. These efforts are greatly enhanced with support from parents and other committed members of the community.

Efforts are also underway to raise the awareness of the public about problems associated with bullying through public information campaigns. Health care professionals, together with other professionals, can play important roles in helping to craft the messages of these campaigns and develop appropriate resources to complement these campaigns.

In conclusion, we have come a long way in recent years in the United States in raising the consciousness of children, the general public, educators, and other professionals about problems of bullying. To ensure that this is not just a "blip" on the radar screen, there is a great deal of work to be done to promote quality research, education, and interventions. Health care professionals will have important roles to play in this critical work to help ensure that children are not belittled, harassed, or excluded.

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Panelist remarks

Richard L. Gross, MD
American Academy of Child and Adolescent Psychiatry

Dr. Richard Gross is a child and adolescent psychiatrist, recently retired from private practice. He currently devotes his professional time to consulting and teaching. Dr. Gross is a clinical professor at The George Washington University School of Medicine and Health Sciences and a member of the American Psychiatric Association's School Health Committee.

I want to thank Dr. Limber for her wonderful talk. I learned a great deal reading and hearing more about it. I was struck by several things, especially how each of us can identify with somebody in those videotapes.

We are all either bullies, bullied, or bystanders.

I had the good fortune of not being bullied as a child because I was as big in sixth grade as I am now and was also athletic and a good student. But I can remember being a bystander and not wanting to intervene for fear that I somehow would lose my status if I intervened to protect the bullied person. I imagine all of us have been in one of those three roles in the past.

I was also struck by this. In the Stossel video, most, if not all, of the bullies showed an inability to empathize. The young lady talked about how she enjoyed bullying, how it didn't bother her. It is reported that bullies are unable to put themselves in the role of the bully to have any feeling for what it is like to be bullied. That's something about which we should all be aware.

I am a child and adolescent psychiatrist and in my private practice over the years, the ratio of bullied to bullies in children I have seen must be at least 10 to 1 of bullied children. I can't remember very many bullies that came into my practice. I suspect it has something to do with the lack of insight, but also that they are not referred to mental health services as often. When some event happens, bullies are more likely to get into the juvenile justice system than the mental health system. The children I have seen who are the bullies are "bully victims", or children with attention deficit hyperactivity disorder (ADHD) who tend to get bullied and then, in turn, bully younger children.

I think it would be an interesting study: in children receiving mental health treatment, how many are bullies, how many are bullied?

Diane Rehm on National Public Radio hosted Rachel Simmons, the author of a book called *Odd Girl Out: The Hidden Culture of Aggression in Girls,* a book about girls who are bullied. (April 29, 2002, **www.wamu.org/dr/shows/drarc_020429.html**) It is a call-in show; there were so many telephone calls, both from mothers of bullied daughters and people who remembered being bullied. One caller who was 19 or 20 talked about being bullied from ages 5 to 14 because she was overweight.

Bullying and harassment, long considered an inevitable part of the school milieu, are beginning to be viewed as pathological behaviors, pathological behaviors that are indicative of a disorder that may have a profound effect on those victimized. Bullying is a manifestation of aggression and youngsters who engage in bullying others are at a risk of becoming violent later.

Conversely, students who are habitually bullied or harassed because they are different from their peers may retaliate in a violent manner to get revenge.

I concur with the definition Dr. Limber presented and the description of bullying as direct or indirect. When listening to the call-in show I mentioned, I was particularly struck by how often bullying is ostracization, particularly among girls. I have seen that a great deal in my practice over the years including girls who are ostracized or who have rumors circulated about them. I think it is a very common occurrence and certainly much less likely to come to the attention of school personnel. It may come to light if there is at least a decent relationship at home to parents; daughters will talk with their mothers about being ostracized or rumored about by others.

Because bullying occurs predominantly at school, it is incumbent upon all of us to do something about it. Although I have not found any research to support it, I have a feeling that bullying is more likely to occur in larger schools than in smaller schools. In small schools, the staff know the children better, are more likely to intervene, and there is a sense of community. Someone bullying another person would less likely be tolerated by peers or by the school personnel.

I would like to comment on the common characteristics of the "bully victims" and their tendency to be hyperactive. In any child and adolescent psychiatric practice, for better or for worse, a lot of our patients are ADHD children. It has been my experience that they often are both bullies and bullied.

The hyperactive boy has a short fuse, is impulsive and especially overreacts, so it is fun to tease and bully him and watch the results as he makes a fool

of himself because he loses control and runs wild. The audience, or bystanders, who will watch, enjoy seeing the child make a fool of himself.

Then, in turn, the hyperactive boy may bully younger children. It seems better to get negative attention than to get no attention at all, and I think this is what happens very frequently with ADHD children. I think it is very sad about our society, or societies throughout the world, that victimized children do not report their victimization. I hear from child patients, and remember from my own childhood, that there is a concern about being identified as a tattletale. I think teachers often would say, "don't be a tattletale" or "stand up to him, stand up for yourself." I particularly remember coaches on athletic teams and physical education teachers who, if you reported being bullied, would consider you a wimp and make light of your complaints about being bullied or say "well, hit him or take care of him yourself."

Children also are concerned that if they tell their parents or talk to the teacher, it will identify them even more as a loser, a wimp, or someone who can't handle themselves, so they are much more likely to either keep it to themselves or ask their parents not to intervene to call the school or the parent of the bully for fear of worse retribution.

It is my experience that a very important component of bullying is that bullies require an audience. It is my impression that there isn't much satisfaction in bullying unless the bully has an audience to see what he is doing and to give him some of the gratification he seeks. A bystanding audience facilitates the bullying and can intensify the misery and humiliation of the victim, whose weakness and despair are displayed before the "applauding bystanders." The incident promotes an intense grandiosity with heightened feelings of personal power in the bully. Bystanders may mastermind or provoke the bullying so that they can enjoy it vicariously. I think that happens not infrequently.

Another issue to consider is how many bullies come from homes in which there is domestic violence, where violence is a way of dealing with the issue that the children learned at home. I believe that to reduce violence and bullying in schools, we must reduce domestic violence.

It needs to be emphasized again and again that changes to bullying behavior require a comprehensive school and community-wide effort.

Professional groups have also responded to youth violence. The American Academy of Child and Adolescent Psychiatry and the American College of Preventive Medicine jointly introduced Resolution 413 which was amended and adopted at the AMA 2001 Annual Meeting. In June 2002, a paper on bullying behavior among youth will be presented to the Council on Scientific Affairs (CSA) of the AMA House of Delegates. (Editor's note: CSA report was approved June 2002, **www.ama-assn.org/go/csa**).

One section of the paper addresses the role of peers. A child's peer group can have a key role in the development and maintenance of bullying and other antisocial and deviant behaviors. The presence of a peer audience is positively related to relentlessness during bullying episodes. In studies of playground bullying, peers are substantially involved, whether as active participants or bystanders who are unable or unwilling to intervene. Participants typically involve assistants who physically help the bully, "reinforcers" who incite the bully, outsiders who remain inactive and pretend not to see what is happening, and defenders who provide help for the victim and confront the bully.

By their presence, peers may give power to bullies by giving them popularity and status. While these peers can be a negative influence, they can also be a positive influence through friendship and acting on behalf of victims. Peers who witness bullying, however, may remain silent or be reluctant to intervene. Silence may result from denial, a psychological defense against anxiety evoked by the situation, as well as from lack of trust that telling someone will not result in retaliation. Failure of peers to act on behalf of victims is likely to reinforce bullies who may interpret ambivalence or inaction as condoning the bullying behavior.

Consequences of bullying are outlined in the CSA report. Chronic bullies can maintain their behaviors into adulthood, which may adversely affect their

ability to develop and maintain positive relationships. As adults, childhood bullies may experience more alcoholism, antisocial personality disorders and need for mental health services. Unfortunately, I'm not sure how many of them get to mental health services. As I mentioned before, in my practice I see the bullied rather than the bullies. Childhood bullies are also at increased risk for criminal convictions and involvement in serious recidivist crime in adulthood. The victims experience more physical and psychological problems than peers who are not chronically harassed by other children. Repeatedly victimized children experience real suffering that can interfere with social and emotional development and academic performance. They may suffer humiliation and develop a fear of going to school. Chronically victimized children can display symptoms similar to those of victims of chronic domestic violence.

A pattern of bullying can begin at an early age, even before the child enters school. Preventive action should be started at home before a child enters school. Parents and other care givers have the important task of preparing children to fit into the world socially. By the time they start school, children should have been taught responsible levels of aggression and impulse control.

The Olweus Bullying Prevention Program has been widely used in schools. The strategy involves school staff, students, and parents in efforts to raise awareness about bullying, improve peer relations, intervene to stop intimidation, develop clear rules against bullying behavior, and support and protect victims. In addition to explicit anti-harassment policies, the program was designed to improve the social awareness and interaction of students and staff. Instructional materials include a series of exercises that help students see problems from the victim's perspective and raise consciousness about the role of bystanders in encouraging the bully. Seeing problems from the victim's perspective is especially important related to the lack of empathy in bullies.

Olweus reported that over a 20-month study period of 2,500 youth, grades one to nine, in 42 schools, students' self-reports indicated that the program led to a 50% or greater reduction in bullying across all grades.

The AMA CSA report also discusses the implications for physicians identifying at-risk individuals, screening for psychiatric comorbidities, counseling families about the problem (including prevention and intervention), and advocating for violence prevention. There are suggestions, eg, helping children avoid being victimized by a bully, preventing children from becoming bullies, and screening questions for health care providers.

In closing, I commend to your attention, a book that came out in 2001 by Mo Shafii called, *School Violence, Assessment, Management and Prevention.* It also includes a discussion of bullying.

Panelist remarks

Joseph L. Wright, MD, MPH
American Academy of Pediatrics

Dr. Joseph Wright is medical director of Advocacy and Community Affairs at Children's National Medical Center in Washington, DC. He is an associate professor of pediatrics, emergency medicine, and prevention and community health at The George Washington University Schools of Medicine and Public Health. He practices pediatric emergency medicine in the Emergency Medicine and Trauma Center at Children's. Administratively, Dr. Wright is founder and director for the Center of Prehospital Pediatrics in the Division of Emergency Medicine at CNMC, and he also serves as the state EMS medical director for pediatrics within the Maryland Institute for Emergency Medical Services and Systems. His major areas of academic interest include injury prevention and the evolution of emergency care environments as appropriate for health settings. He has received several federal grants to study various aspects of emergency care for children and is currently developing a comprehensive program for pediatric, prehospital research in the District of Columbia.

I am a pediatric emergency physician, and I work at a very busy urban trauma center. I would like to talk about and react to Dr. Limber's very comprehensive review from the perspective of being "downstream." I take care of the victims and the perpetrators, and I would like to talk about some of the take-away messages and questions that came to mind as I went through Dr. Limber's paper.

At Children's National Medical Center we see about 65,000 children annually in our emergency department. The most common injury we see in kids is falls. But with regard to intentional injury, we have an extremely high rate of assault injuries. We still have epidemic proportions of intentional injuries happening in our urban centers; clearly it is no time to relax.

As I was reading Dr. Limber's paper, I had an idea of an idyllic playground where kids are playing then, in contrast, we saw the Stossel videotape. Earlier in the week there was a piece in the *Washington Post* about school crowding. The description was of one of our suburban high schools during a change of class periods. Things are tight; space is tight; bodies are tight. In her paper, Dr. Limber mentioned opportunities and locations in the school setting for bullying. Clearly, the hallway between classes seems like an ideal location and opportunity for kids who are intent on carrying out bullying behaviors.

I always return to the time-tested traditional public health model when trying to frame approaches and issues of prevention. What struck me as we moved through Dr. Limber's paper was the prevalence, the epidemiology of bullying. As Dr. Limber mentioned, the Nansel paper described an almost 30% prevalence; these are figures from Dr. Limber and her group's work in South Carolina. These are remarkable rates of bullying. If this were a medical issue, for example an infectious disease in my pediatrics practice, we would have the Epidemic Intelligence Service (EIS) people from the Centers for Disease Control and Prevention investigate it. The prevalence and epidemiology of bullying is striking.

Given its pervasiveness, how normative is this? Is this what kids do all the time? It was mentioned that bullying has been around a long time. Along a continuum of normative behavior, we understand that there are well known developmental and maturational risk factors that we accept from the cognitive development of young people that put them at risk for injury. If we think about them, the antecedents are not only developmental but also environmental, psychological, and sociocultural. However, this does set up a recidivist cycle. In our emergency departments, we refer to frequent fliers, those young people that we see over and over again for intentional injury.

If you think about points of intervention in the context of this model and in the context of bullying, when is it that we can intervene during the maturational and developmental processes that are normative, and through which all kids will proceed?

To get to behavior change and get out of that vicious cycle and back up to what contributes to risk behavior, you have to drill backwards. In my practice, I am dealing with the trauma and the recovery. But, to go upstream and really deal with the contributing elements that lead to behavior, that lead to injury risk in the first place, is where I believe this research is headed.

Unpublished work at the National Institute of Child Health and Human Development (NICHD) by Mary Overpeck, Peter Scheid, Denise Haynie and their group is very provocative with regard to the association of the bullying with what I'm seeing downstream and the intentional injury behavior risk in which kids I take care of are involved. This is actually an international study conducted in 29 countries using the World Health Organization (WHO) Health Behaviour in School-aged Children survey with 120,000 respondents which was incidentally, I believe, the same survey database used for the Nansel study.

I want to show qualitatively, we won't get into the rates where the United States ranks in relation to this question: "How often have you been bullied in this term in school?" This is a school-based survey. The United States falls mid-range. When the question is asked: "How often have you taken part in bullying other students?", the United States again is mid-range compared to other countries.

You might conclude that this behavioral data suggests that US adolescents are engaged in bullying no more often than those in other countries. Yet, this survey also asked about fighting behavior. Again, the United States is right in the middle. But look at our homicide rates relative to other countries. This is a discussion for another educational forum but one of the well-documented risk factors that I believe contributes to homicide rates is the high rate of penetrating injuries and the lethality of the firearm, the weapon of choice for assault in this country.

In looking at the data I thought, "Well, we have information from the Youth Risk Behavior Survey (**www.cdc.gov/nccdphp/dash/yrbs/**) about what's going on relative to fighting behavior, aggression, and weapon carrying. Those rates have been falling through the 1990s." Note: the YRBS doesn't specifically address bullying. Similarly, homicide rates have been falling and, notably, nonfatal rates have been falling as well. In emergency departments across the country over the last part of the 1990s, rates for nonfatal firearm assaults in youths have been falling. However, what is the contribution or the attribution of bullying as part of this? Clearly, we don't have the breadth and the length of data to let us know what trends are, but I think it would be very interesting to relate what might be happening with bullying behavior relative to what is happening with fighting aggression and morbidity and mortality down the line. There is also the vexing question of risk and resilience, and what factors contribute to bullying. As I read the risk factor section of Dr. Limber's paper, I see overlap with regard to those risk factors that put kids at high risk for being victims or perpetrators of violence and bullying behavior.

Work that we conducted at our center as part of a city-wide injury surveillance system looks at some of these factors. We interviewed victims and perpetrators of intentional injury that came through our emergency department to see what would fall out as significant. Not surprisingly, although these may seem somewhat intuitive, there were a number of factors that did not fall out. I think it is incumbent upon us to try and figure out the factors that confer resilience to those kids on the playground who are not involved in bullying behavior. What factors are protective? Actually, the Nansel and the Overpeck study I mentioned are the only wide-scale surveys that, to my knowledge, specifically asked the bullying question.

With regard to the risk factor issue, from my vantage point in the emergency department, it would be useful to know what questions to ask and how to ask them. We could participate and be a repository of or collection site for information and data. We could administer instruments to collect this information. We are one center that treats 65,000 kids. One emerging opportunity is that the community of pediatric emergency medicine has been awarded funding through HRSA to develop a research network, the Pediatric Emergency Care Applied Research Network (PECARN). That network will allow for pooling pediatric emergency departments to conduct large-scale studies.

To return to the public health approach, I was also impressed with developing and emerging interventions. The Olweus Prevention Program was absolutely true to the public health model in terms of defining the problem and moving ahead with a comprehensive approach. To quote from the *Commission for the Prevention of Youth Violence,* from the AMA, and others, "The answer is rooted in a public health approach." It is about *prevention* and not, as was mentioned at the outset, about building more prisons and school suspensions. As we move ahead in designing and evaluating interventions, we should stay true to the public health model. The Olweus Prevention Program is the only one that has been comprehensively evaluated, has shown efficacy, and is available now. Its one of the *Blueprints for Violence Prevention* (**www.ncjrs.org/html/ojjdp/jjbul2001_7_3/contents.html**).

One thing I would like to see in my setting is an instrument that could be easily administered in an acute care setting. We are developing some risk tools at the American Academy of Pediatrics. I believe that we have an opportunity to capture young people as subjects for research, even if they are not admitted to the hospital.

With regard to screening and monitoring for violence risk, the Office for Juvenile Justice and Delinquency Prevention (OJJDP) has funded the launch of our Violence Intervention and Prevention Program (VIPP). We would like to see -in the office setting- anticipatory guidance and the use of a screening risk classification to identify problems, not a comprehensive behavioral assessment but a screening and risk assessment tool. If you have a high-risk category you could drill down and ask about issues that might fall into a mental health category and referral. Dr. Gross mentioned the importance of referral to mental health services. If we can get this to work, it would truly make for a more robust health maintenance role for practicing community-based practitioners.

Work has already been done in a pilot form by Bob Saggi and colleagues at Tufts, where they have developed a screening tool for patients who present with obvious violence-related injuries. I personally would like to move this into the emergency department setting. Dr Howard Spivak is the principal investigator on that project. And one of their parent tip cards is on bullying (**www2.mms.org/pages/tip_bully.asp**); I particularly like it. The role of the bystander is included, and that's a very important part for parents in terms of intervening and counseling their kids. At the American Academy of Pediatrics, we have just reaffirmed our policy statement on the *The Role of the Pediatrician in Youth Violence Prevention in Clinical Practice and at the Community Level (RE9832).*

Panelist remarks

Marcia Rubin, PhD, MPH
American School Health Association

Dr. Marcia Rubin has served as Director of Research and Sponsored Programs for the American School Health Association since 1995. In that capacity Dr. Rubin has overseen grant-funded projects including the Guidelines for Protecting Confidential Student Health Information, the Substance Abuse and Mental Health Services Administration's Achieving Coordinated Mental Health Programs in Schools, and a *Journal of School Health* special issue, which was published in May 2000.

I would like to bring some distinctions to the discussion that we have had this morning. We are beginning to interchange a lot of terminology and beginning to think about the bully and the bullied in similar ways, and I would like to tease out that language a little bit, because Dr. Limber and several of the other speakers have mentioned that children who bully tend to exhibit very classic indicators of mental illness and mental health problems. We tend to gloss over that point and begin to talk about other kinds of issues.

However, I would like to return to that, because I think if we take a mental health approach to these children, we wind up in a different place than if we take a socialization orientation to these issues. I think part of the challenge is that there is a blurring in our society about what is appropriate and acceptable behavior, and what is illness. I think that if we take a mental health perspective, looking at a person who bullies, I think we deal with one set of issues. However, if we consider children who are victimized, we are talking about something entirely different.

If we look at a child who is hyperaggressive, indications of pathology occur very early in those children's lives, much the same way a child with ADHD begins to exhibit certain symptoms early in life. If we were able, and I don't think we are able yet in our understanding of mental illness, to have some cardinal indicators of when aggressive behavior is pathological, we would respond to these children differently and much sooner. The fact is that boys begin to exhibit aggressive behaviors early and, in our society, being an aggressive male is okay and an advantageous thing to be. Therefore, we tend to let hyperaggressive behavior in young boys go on much longer than it should in terms of early intervention.

The work of Hawkins and Catalano in Seattle with the social development program has established that if you intervene early with young children who show hyperaggressive behaviors, either in preschool or in first, second, or third grade, and you work with them intensively, you can help those children learn how to deal with their aggression in ways that are more prosocial and avoid winding up in emergency rooms either as perpetrators or victims of violence, homicide, and gun injury.

I believe we need better research about what is pathological aggressive behavior. We need to educate both parents and teachers in preschool and the primary grades about what cues they should be looking for to refer these children early for extensive evaluation and diagnosis. I don't think we yet are at that place where we can say, when do we need to intervene? When is it not just boys being boys or girls acting out in inappropriate ways?

The other side of that, though, is this victimization issue that I think we need to handle, and that is a whole societal issue. We tolerate kids being picked on. If we are going to address that, we need a whole school approach, and I think the Olweus program is one that looks not only at the culture of a school, but also at the environment.

We have emerging research that says elementary schools, when they get larger than 600 kids, are fomenting problems. The evidence is beginning to emerge that high schools can't be any larger than 1200 kids. So, the physical size of the environment is a factor, but the other issue is the culture of that environment, and that's where principals, school board members, and superintendents need to be very clear. Research coming out of the Office of Juvenile Justice and Delinquency Prevention, Gottfredson's work, is saying that the adults in that environment need to set very clear expectations for behavior, not just for academic performance but for behavior. There need to be clear rules so that everyone understands that verbal put-downs, physical touching, or inappropriate touching are simply not acceptable. Suspension and expulsion from school is not the answer, but there have to be expectations that are clearly communicated.

Other beginning evidence is that there are some curriculum-based programs that promote social and emotional learning. Although these programs are not going to fix the problem, they may be helpful in generating a school climate. We all know that if it is important, you spend time on it in schools. If it is not important, you don't study it. These researchers argue that unless you have initiatives in the school that help children to learn to be prosocial, then we are missing an opportunity to establish a culture that

permeates throughout the entire school. This is especially important if children are not learning this at home and we know there are many families that don't have good socialization processes for their children. This culture and climate must be established by principals and all the adults in school and complemented by specific curricula that talk about prosocial and emotional development of children from the bottom up. The children realize that it is important to learn to be a good neighbor, it is important to learn how to cooperate and communicate effectively with their classmates.

We are beginning to obtain a body of knowledge that will be useful, but we are not quite there yet in terms of knowing how to fix this problem, and I am afraid it is going to be years before we can fine tune this well enough to really see an impact on the demographic statistics that were presented earlier.

Participant discussion and questions

Audience member First, thank you all for the comprehensive presentations. It is excellent information. To any of the panelists, what kind of information or insight would you share around the cultural context of this phenomena related to racial/ethnic populations, as well as the social context? I am thinking that this issue may be defined and perceived differently in various communities. Communities may have different feelings about how they are able to access systematic resolutions, whether it's talking to someone, whether you have access and responsiveness by teachers, etc. Are there other contextual issues related to what may be vulnerabilities for children? For example, what about communities in which children are in foster care because their parents have been incarcerated? Other kids know about these situations and may pick on children because of the social things in their family that are common knowledge in the community.

Dr. Limber I think the context issue is critical. And, boy, did I learn that in working to adapt a Norwegian prevention program to rural South Carolina. I think we know from research that bullying exists in all communities and in all cultures. I think that the Nansel, et al., study didn't find overwhelming ethnic/racial differences in bullying. This is a community issue for many communities, but I think your point is well taken, we need to look to adapting intervention and prevention strategies to be consistent with the cultural context. To be perfectly honest, I think we are just beginning to do that. Do the others want to add to that?

Audience member I don't think there is any question that there is a tremendous disparity in terms of access to medical care or mental health care among different populations in this country. If we are talking about early intervention, then clearly access is a critical factor. As long as we have general disparities in our health system access, I don't think we are going to be able to address this problem across all different groups.

Audience member Thank you very much for the great presentation. My name is Stephanie Bryn. I am with the Maternal and Child Health Bureau of HRSA. We have launched a national campaign which includes a media campaign. I am going to ask Jason Smith from Widmeyer Communications to follow-up with comments.

Most of you have seen the initial flier we have published about the campaign. The goals of the campaign are very exciting because we have a two-year window to plan, launch, execute, and evaluate the campaign on reducing bullying. Our target audience is "tweens", aged 9 to 13 years, and those who influence their lives, which really means everyone. Dr. Limber asked, "Who are the players in the school setting?" and as Dr. Wright and Dr. Rubin mentioned, "In the community, everybody is a player."

We want you to know that partnerships are key to this campaign. Jason, will you tell us about the time frame and the focus groups with tweens?

Audience member I am Jason Smith, a vice president at Widmeyer Communications. We are the contractor for HRSA, Maternal and Child Health Bureau. I can tell you briefly about ways in which we are involving the community in this campaign. First, on partnerships, we will be having a partner summit in October 2002 when we will be convening organizations like yours to describe more about the campaign and what our plans are. Our launch will be in September of 2003; as Stephanie Bryn (HRSA, Maternal and Child

Health Bureau) said, we have two years to develop this appropriately. We have been conducting focus groups for the past three months; we are learning a lot. We haven't come to any conclusions yet, but we do know that the children confirm what we have heard today. Adults and teachers don't necessarily respond appropriately. Adults don't know where to go yet, and they don't necessarily have the strategies. We will be helping them with that. We are also convening a group of advisors. These tweens will be coming to talk to us for about a year on a regular basis so that we can have some continuity in our advice. If you have any questions, I would be happy to answer them.

Audience member I have a couple of questions. One, are there any studies done on children either as victims or bulliers who have alternative lifestyles, such as sexual orientation? Are they picked on more than other youngsters? We do know that they are at risk for suicide.

Second question, I am a pediatrician and as Dr. Wright mentioned, we all know how little time we all have in a visit. We need to think about how, given the time constraints in managed care, we can get this inserted into an extremely busy practitioner's office or an extremely busy emergency room.

Audience member Let me tackle the back end of that. Howard Spivak has been persistent on this issue. One of the advantages of having this project come through the American Academy of Pediatrics is that it provides not only the credibility, but it also will provide the evidence that this can be done, and the practice community is involved in the development. There is also the question of reimbursement. Reimbursement issues for the value of providing this level of screening and monitoring is something that is happening simultaneous to the development of the actual tools that will be used as part of the project.

Panelist Dr. Wright I think that we undersell the opportunity in the emergency department setting. There is down time for individual patients. I think it is not living up to your obligation as an academic medical center for patients to come in with injuries and not to have intervention beyond the medical intervention, even a simple screen to assess risk. This is truly a mindset shift that has to happen in the emergency care environment, but I think that with enough pushing, it can happen.

Audience member I think we need to learn a lot more about bullying of kids with alternative lifestyles. Some surveys have asked about bullying using sexual language but haven't really teased out enough information. Anecdotally, and from talking with teachers and students, the language that kids use to bully is very sexual. "Fag" is probably one of the most common terms that kids use to bully. I think it is a huge concern. Whether or not the kids are using it to single out kids with different lifestyles or whether it is just the language and the culture, I think it can be extremely damaging.

Audience member I would like to make one brief comment. I was thinking the same thing as the previous person. In the practice of a private pediatrician, or primary care physician, we are adding all these things, which we should, even as the HMOs and the insurance companies and hospitals are demanding less time per patient. It is incredible to me how we are going in opposite directions, with suicide and violence and bullying and sex education, etc. There are the same time demands on schools. I say this partly because my wife is a teacher. We are adding all these things to the schools as we are putting more kids in classes and cutting budgets. It is a problem; I don't know the solution.

Audience member I am Tracy Whitaker, and I am the director of program, policy and practice at the National Association of Social Workers. I have an observation and also a question. My observation is that as we struggle with observing social phenomena, I think more and more the general public and professionals, we are becoming the bystanders. Even videotaping children being bullied but not intervening removes us one more step. I was just thinking about the proliferation of talk shows and the media where the national audience becomes the confidant, where children begin to talk about their bullying experiences on national television with all kinds of entertainment value, audience participants harass and berate children and this has become acceptable.

Yet we wonder why we can't manage it in the school system. My question is, to any of the panelists, I would be interested in your thoughts, about the school risk factors. Not from the perspective of the culture and the climate of the school, but in terms of what kinds of opportunities are available for children to compete successfully in a variety of ways? I wonder if bullies learn that behavior in school, not from students, but possibly from teachers and administrators. I am also wondering if there are any studies about the onset at the age of bullying, "do children aggressive in day care become bullies in school?" And I wonder about the achievement rates of children who will be categorized as children who bully. Because one of the kids in the video said, "I needed attention." I wonder who is getting the attention and is it being shared? Are there more opportunities for that?

Dr. Limber You raise a number of good points and questions, and I think the school context issue is an important one. I have had an ongoing debate with Dan Olweus who, from his research in Norway, for example, did not find that school size made a difference. But when asked, "How big are your biggest schools in Norway?", they are in a different league than ours. And as one of my colleagues mentioned, we don't know, for example, the effect of these tight quarters or school size on bullying. My guess is that in larger schools, kids can be invisible.

Audience member I am not sure I have the number correct but I heard this at the meeting where the school violence book originated. Denmark has a law that says schools or high schools may not be larger than, I think, 600 students.

Audience member I am Charlie Irwin. I am a pediatrician and I direct the National Adolescent Health Information Center at the University of California San Francisco. It is funded by the HRSA, Maternal and Child Health Bureau. A couple of comments and questions. I would like to put them in three levels.

First, as a pediatrician, my feeling is that physicians, nurses, and other primary care clinicians aren't going to do any screening unless there is an intervention. The real issue is, if we have questions, they have to know what to do when they get a positive response. And I'm not clear we have a response for the screening. We have done a fair amount of work within managed care systems in getting doctors and systems to change what they do. And they are pretty effective in changing what they do in very short periods of time. But generally there is an opportunity for them to do something once they get a positive response. Unless there is an algorithm, they don't like wasting their time unless they can do something. Docs and nurses, and I hope I am not offending anyone, because I am a physician, are pretty concrete. They are fixers, so I think we have to be clear on the identification process and then what the outcome is going to be. And I'm not certain we are there yet.

Second, I am the parent of a 13-year-old and I have been on a lot of boards at schools. I'm overwhelmed at teachers' and administrators' expectations for kids to come forward regarding reporting bullying experiences. Schools and teachers don't seem to assume any ownership for what is happening. I feel we have a lot of work to do on educating teachers and school boards and parents and organizations on how to intervene and what to do. I feel that the victims are being asked to come forward and disclose when, in fact, they become more victimized by disclosing. I have seen this repeatedly in schools that are small, private schools with lots of resources. So not just at the upper end of school size. Size is important, and there is a lot of data on size, but I would say that it's not just size.

The third comment: we participated on Wednesday (May 1, 2002) in a briefing on Capitol Hill on violence. It attempted to highlight materials that work in violence prevention. As we have identified risk factors, we see that there are a whole series of protective factors. In spite of kids doing X, Y, and Z, or coming from horrific families, in spite of all of this, there really are protective factors such as parents who have high expectations for their kids, teachers and administrators who have expectations for the kids that attend their schools, a connectedness the kids felt to the school. Sometimes I think maybe we ought to concentrate on the protective factors. The risk factors always seem to be impossible to diminish, but there is a whole litany on protective factors. It was quite

interesting to see these data presented. What was fascinating to me was the level of decrements in violence when kids have all these risk factors of having witnessed violence, having used substances, having had suicide attempts, etc. When the protective factors were there, they outweighed the risk factors and actually led to decreases both in poor kids on Medicaid and kids who weren't on Medicaid by equal amounts. It wasn't just the kids with resources who had decrements.

Panelist Dr. Rubin May I respond to the first part about having pediatricians and other primary care physicians screen? We do have programs that are effective. The primary care mental health project has been around for 25 years and has consistently demonstrated and provided longitudinal data that early intervention doing specific kinds of things will make a major difference. Hawkins and Catalano's work is longitudinal data.

The problem is, and this is always true, we have efficacious treatment, but it isn't disseminated to the practice level. We know how to do it, but we lack the will to make sure that those programs are in place as safety nets for kids across the country.

It would be wonderful if we could do the primary care mental health care project. It does not rely on expensive professionals but can be done with paraprofessionals and trained individuals which makes managed care happy. We could do that program, but we haven't disseminated it, it is not widely known, and even if it were widely known, it is no guarantee that people are going to implement those programs in the way that they should be implemented. I think we have good data on how to fix some of these problems, but we don't follow through and do it.

The second statement is about being a parent and feeling frustrated about what teachers know: I am very sympathetic to teachers because so much is put on them. We have such little time, and there is so much pressure to improve test scores. And the priorities in schools are not health priorities. Fortunately, we are beginning to get good data that says early success in school, in and of itself, not only predicts academic success but also is a protective factor for the diminution of some of the health risk behaviors. If we can help kids learn to read, if we can help kids socialize to school routines, those kinds of interventions have multiple benefits that accrue to those kids. If kids do not succeed in school, for whatever reason, they turn to alternatives that help them to survive in schools, whether it's substance abuse, bullying, or any other acting out behavior. They are trying to survive as best they can in that environment. Helping kids succeed in school is our first priority, and if it takes smaller schools, if it takes more tutoring, more intensive intervention to help these kids learn to read, that money will be extremely well spent in the return in later years.

Audience member May I add one point to that? I agree. I think our response, whether it is clinical or in terms of school responses to concerns about bullying, is very sketchy right now. I frequently get calls from parents who feel like they are at their wits end, trying to get the administration's attention regarding these issues. Other schools are undertaking really heroic efforts and see the importance of changing that climate. I think clinically the same thing is true; it is very frustrating. There is a recent case in Canada where the parents went to court to sue their schools to try to help change, or to recognize the importance of the social climate of the school to support the academic learning environment. I have second grade teachers who tell me, "I understand it's a part of this program. It's important, for example, to put the books away once a week and to talk to kids about peer relations and bullying. We get that. But I don't have time to do it." That is a horrible thing to think about, that in second grade there is not 30 minutes once a week to talk with kids about their concerns.

Audience member I am Isadora Hare and I am with HRSA, Maternal and Child Health Bureau, Office of Adolescent Health. In relation to school climate and the whole context within which bullying occurs and other violent behaviors, I am wondering if any of the research has looked at the relationship between schools that still practice corporal punishment and the prevalence of violence, including bullies.

I don't know the latest statistics, but I do know that up to about 10 years ago, there were only four or five states in this country that had actually banned corporal punishment. Since that time more states have banned it, but it seems to be one of the hidden things that exist in our society. There is a small group of researchers who consistently focus on this. But the topic doesn't seem to be integrated with any of the other conversations that we are having about more violence in schools. I find that fascinating. Could you comment on that?

Dr. Limber That's an interesting point. One of the first schools I consulted with to implement a bullying prevention program said, "Okay, we get the importance of consistent sanctions for bullying." Their number one sanction was the paddle. That was how they anticipated they would deal with bullies, and, so, we had to take a few big steps backwards to work through that. In South Carolina, for example, corporal punishment is quite prevalent in many schools. Just as we talked about harsh corporal punishment being a family risk factor, I wouldn't be surprised if that atmosphere within a school setting couldn't contribute to that climate, as well. I don't know that we have research specifically focused on that, but it's a concern of mine. It is the messages that we are sending to kids.

Audience member Hello. I am Dr. Louise Peloquin. I am with the Center for Mental Health Services, which is part of the Substance Abuse and Mental Health Services Adminsitration (SAMHSA). I would like to talk about the issue of dissemination. I am a psychologist and a school counselor and worked with the AMA for many years. I realized when I went to the government that there is so much great stuff out there through associations and governments, but it is not being disseminated. In working with Stephanie Bryn (HRSA, Maternal and Child Health Bureau), we are utilizing social marketing techniques to try to get this information out. HRSA will be doing a national campaign at the Center for Mental Health Services. We are adapting Dr. Olweus' material for parents. It is all going to be public domain and on the Web for downloading. We are going to have public service announcements and prime time specials. Because it is in the public domain you can use all this material and put your own logos on it. That will go a long way in really helping to move this forward, because we need to deal with all levels. We also worked with the Center for Substance Abuse Prevention (CSAP) and just completed a training of trainers so people will know how to get these programs. We are looking at social marketing techniques to get this out to people.

Audience member A brief comment on the issue about principals and teachers in schools and about dissemination. It is my impression that we need to disseminate that information to schools of education, because I believe teachers aren't being taught much about bullying and violence and areas of learning disabilities. I have the impression that schools of education may not be sharing current research findings with their students.

Audience member Well, they also don't understand social marketing and how to use these same techniques to really market an issue. Social marketing includes a collaboration around any social issues which is a concept with which I agree.

Areas for future research

- What is pathological aggressive behavior? When do we need to intervene? We need to educate both parents and teachers in preschool and the primary grades about cues that suggest that children should be referred for extensive evaluation and diagnosis. (Rubin)
- Among children receiving mental health treatment, how many are bullies, how many are bullied? (Gross)
- What are the factors that confer resilience to those kids on the playground who are not involved in bullying behavior? What factors are protective? What factors contribute to bullying? (Wright)
- There are protective factors such as parents who have high expectations for their kids, schools that have expectations for their students, and a connectedness the kids feel to their school. The risk factors always seem to be impossible to diminish, but there is a whole litany of protective factors. (Irwin)
- We need survey instruments that can be evaluated. We need an instrument and risk tool that can be easily administered in an acute care setting. (Wright)
- What is the correlation between corporal punishment in schools and bullying? (Hare)
- It would be very interesting to relate what might be happening with bullying behavior relative to what is happening with fighting, aggression, morbidity, and mortality. (Wright)
- Adapt intervention and prevention strategies to be consistent with the cultural context. (Limber)
- Are there studies on children either as victims or bulliers who have alternative lifestyles, such as sexual orientation?
- We have to discuss the ethics of this type of research; if we watch/observe bullying and don't intervene, aren't we just bystanders?
- Our findings must be disseminated—to practitioners, schools, parents, and schools of education.

Bibliography

This list represents suggestions by our speaker and panelists and recommendations from professionals in the field. It is not intended to be an exhaustive list on the topic of bullying, aggression, or violence.

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Resources

This list is presented as a starting point and is not intended to be exhaustive.

American Medical Association, Child & Adolescent Health
Bullying Resource page
www.ama-assn.org/ama/pub/category/7830.html

American Academy of Child and Adolescent Psychiatry (AACAP)
Bullying, Facts for Families© fact sheets, No. 80, March 2001
www.aacap.org/publications/factsfam/80.htm

American Academy of Pediatrics (AAP)
www.aap.org

- *Aggressive Behavior (AAP)*
  www.medem.com/MedLB/article_detaillb.cfm?article_ID=ZZZ986OWQ7C&sub_cat=21
- *Anger (AAP)*
  www.medem.com/MedLB/article_detaillb.cfm?article_ID=ZZZPZO9TA7C&sub_cat=21
- *The Role of the Pediatrician in Youth Violence Prevention in Clinical Practice and at the Community Level (RE9832), AAP*
  www.aap.org/policy/re9832.html

US DHHS, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau
National Bullying Prevention Campaign
A multi-year public awareness and prevention campaign for tweens
Information: Stephanie Bryn, **sbryn@hrsa.gov**

Juvenile Justice Bulletin
www.ncjrs.org/html/ojjdp/jjbul.

Center for the Study and Prevention of Violence (CSVP)
www.colorado.edu/cspv.

Massachusetts Medical Society
Bullying—It's Not O.K. tip card, October 2001
www2.mms.org/pages/tip_bully.asp

School Mental Health Project
Conduct and Behavior Problems: Interventions and Resources
http://smhp.psych.ucla.edu/pdfdocs/conduct/CONDUCT.pdf

Quit it! A Teacher's Guide on Teasing and Bullying for Use with Students in Grades K-3

Merle Froschl, Barbara Sprung, and Nancy Mullin-Rindler with Nan Stein and Nancy Gropper. 1998. 128p.
www.edequity.org/featuremain.htm

Preventing Bullying (ERIC Digest)

March 2002
ERIC Clearinghouse on Educational Management
http://ericcass.uncg.edu/virtuallib/bullying/bullyingbook.html

Child and Adolescent Violence Research at National Institute of Mental Health (NIMH)

www.nimh.nih.gov/publicat/violenceresfact.cfm

Bullying and Your Child

www.kidshealth.org/parent/emotions/behavior/bullies.html
Created by The Nemours Foundation's Center for Children's Health Media

National Education Association

National Bullying Awareness Campaign
www.nea.org/issues/safescho/bullying/

National PTA

Safeguarding Your Children at School—Helping Children Deal with a School Bully
www.pta.org/programs/sycsch.htm

Committee for Children

Information on Bullying and Sexual Harassment
www.cfchildren.org/bully.html
Committee for Children, Seattle, WA, is a not-for-profit organization dedicated to promoting the safety, well-being, and social development of children.

International Education and Resource Network

www.bullying.org/
The International Education and Resource Network is a non-profit global telecommunications community of over 5,000 primary and secondary schools and youth organizations in over 95 countries.

National School Safety Center (NSSC)

www.nssc1.org/
America's Safe Schools Week, October 20-26, 2002
School bullying and victimization. NSSC resource paper. Westlake Village, CA: National School Safety Center. July 1999.

National Resource Center for Safe Schools

Recognizing and preventing bullying. Fact sheet No. 4. Washington, DC: National Resource Center for Safe Schools. Winter 1999.

Safe Schools Healthy Students Action Center Clearinghouse

www.sshsac.org/

Appendix: A

American Medical Association
Educational Forum on Adolescent Health
Youth Bullying

May 3, 2002
Washington, DC

Speaker and panelists

Susan P. Limber, PhD, MLS
Institute on Family & Neighborhood Life
Clemson University

Richard L. Gross, MD
American Academy of Child and Adolescent Psychiatry

Marcia Rubin, PhD, MPH
American School Health Association

Joseph L. Wright, MD, MPH
American Academy of Pediatrics

Attendees

Michael Barry
American College of Preventive Medicine

Audrey Rhodes Boyd, MD
American Academy of Family Physicians

David Brenner
Institute for Youth Development

Stephanie Bryn, MPH
US DHHS, Health Resources and Services Administration (HRSA)
Maternal and Child Health Bureau

Mary Campbell, MS
American Psychological Association

Elvia Chavarria, MPH
American Medical Association

Sheila Clark, MSW
National Association of Social Workers

Mary Crosby
American Academy of Child and Adolescent Psychiatry

Arthur Elster, MD
American Medical Association

Ted Feinberg, EdD
National Association of School Psychologists

Michael Fishman, MD
American Psychiatric Association

Missy Fleming, PhD
American Medical Association

Marcela Gaitan, MA, MPH
National Association for Hispanic Health

Bonnie Gance-Cleveland, PhD, RNC, PNP
National Association of Pediatric Nurses and Practitioners

Isadora R. Hare, LCSW
US DHHS, Health Resources and Services Administration (HRSA)
Maternal and Child Health Bureau

Denise L. Haynie, PhD, MPH
Society for Research on Adolescence

Karen Howze, JD
American Bar Association

Charles E. Irwin, Jr., MD
National Adolescent Health Information Center

Jennifer Jimenez
US DHHS, Health Resources and Services Administration (HRSA)
Maternal and Child Health Bureau

Woody Kessel, MD
US DHHS Office of Disease Prevention and Health Promotion (ODPHP)
Office of Public Health and Science
Office of the Secretary

Sue Martone, MPH
US DHHS Office of Disease Prevention and Health Promotion (ODPHP)
Office of Public Health and Science
Office of the Secretary

Jeannine Nielsen
Office of Population Affairs

Shahla Ortega
American Nurses Foundation

Louise Peloquin, PhD
Center for Mental Health Services (SAMHSA)

Sara Roschwalb, MSW
Association of Maternal and Child Health Programs

Nancy Sheehan, MD, MPH
American College of Preventive Medicine

Becky J. Smith, PhD, CHES
American Association for Health Education

Jason Smith
Widmeyer Communications

Darcy Steinberg, MPH
American Academy of Pediatrics

Mary Tierney, MD, MPH
American Institutes for Research

Kelly Towey, MEd
American Medical Association

Deidre Washington, MPH
National Assembly on School-Based Health Care

Vicky Weill, MSN, CRNP
American Nurses Association

Tracy Whitaker, MSW
National Association of Social Workers

Audrey Yowell, PhD
US DHHS, Health Resources and Services Administration (DHHS)
Maternal and Child Health Bureau

Susan M. Anderson, MLS
PIPPAH Information Consultant

Project Steering Committee

Michael A. Barry
Deputy Director
American College of Preventive Medicine

Janet Chapin, RN, MPH
Director, Division of Women's Health Issues
American College of Obstetricians and Gynecologists

Mary Crosby
Deputy Executive Director
American Academy of Child and Adolescent Psychiatry

Darcy Steinberg, MPH
Director
Division of Child and Adolescent Health
American Academy of Pediatrics

Appendix: B

The American Medical Association Adopts Policy Recommendations to Address Bullying Among Children and Adolescents

June 2002

Bullying can take place almost anyplace where children are present, but typically occurs at school or on the way to and from school. If not addressed early, bullying is an antisocial behavioral that can extend into adulthood. Such behavior is recognizable in all social, economic, and racial strata. Bullying occurs in many forms and may involve teasing, physically hitting or attacking, ignoring, socially isolating others, and calling others names. Bullies are deliberate in their intents to harm their victims physically or psychologically. Children who are victims of bullies may be repeatedly harassed, lose their personal property, have rumors spread about them, or be publicly or privately humiliated and embarrassed.

Typically, bullying is insidious and hidden from direct adult scrutiny. As a consequence, adults may underestimate its prevalence and effects. Students often remain silent about their bullying experiences because they fear that bullies will retaliate by intensifying their abuse of victims who bring it to the attention of authorities. The tendency to remain silent must be counteracted by efforts to educate children and adolescents about the importance of reporting incidents to proper and responsive authorities. Children must be assured that bullies will not be allowed to continue (or increase) their abusive behavior after incidents are reported.

Parents, teachers, and health care professionals must become more adept at and sensitive to identifying possible victims and bullies in order to understand the severity of this problem and intervene appropriately. Early-intervention approaches that feature social and cognitive skills training and development, problem-solving techniques, and anger management, are recommended components of anti-bullying programs. Effective prevention places special emphasis on helping families improve their parenting skills. Parent training can help reinforce the need for adequate nurturing, supervision, appropriate discipline practices, and modeling of positive social behaviors including development of a strong value system that considers bullying unacceptable. Expanding school health and mental health services to reach troubled students and assist them before their problems become severe is critical in addition to comprehensive evaluations by a child psychiatrist or other qualified mental health professional.

Physicians and other health professionals need to be alert to possible warning signs so they can intervene appropriately to minimize immediate and potential long-term effects in bullies and victims. Children and adolescents should be asked about bullying experiences when they present with unexplained psychosomatic and behavioral symptoms; when they experience problems at school or with friends; when they express thoughts of suicide or other deliberate acts of self-harm; or if they begin to use tobacco, alcohol, or other drugs.

The Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB)'s "Bullying Prevention Campaign" is designed to engage families, schools, students, and communities in reducing the impact of bullying, teasing, and harassment by youth. This issue also is being addressed by the AMA's National Advisory Council on Violence and Abuse, the AMA Alliance's national violence prevention and awareness campaign, and the AMA Partners In Program Planning for Adolescent Health (PIPPAH) project's emphasis on professional education and youth development.

In June 2002, the AMA House of Delegates adopted the following policy statements to stimulate national action against this problem:

- The AMA recognizes bullying as a complex and abusive behavior with potentially serious social and mental health consequences for children and adolescents. Bullying is defined as a pattern of repeated aggression with deliberate intent to harm or disturb a victim despite apparent victim distress and a real or perceived imbalance of power (eg, due to age, strength, size), with the more powerful child or group attacking a physically or psychologically vulnerable victim.
- The AMA will work with appropriate federal agencies, medical societies, the Alliance, mental health organizations, education organizations, schools, youth organizations, and others in a national campaign to change societal attitudes toward and tolerance of bullying, and advocate for multifaceted age and developmentally appropriate interventions to address bullying in all its forms.
- The AMA advocates federal support of research (1) for the development and effectiveness testing of programs to prevent or reduce bullying behaviors, which should include rigorous program evaluation to determine long-term outcomes; (2) for the development of effective clinical tools and protocols for the identification, treatment, and referral of children and adolescents at risk for and traumatized by bullying; (3) to further elucidate biological, familial, and environmental underpinnings of aggressive and violent behaviors and the effects of such behaviors; and (4) to study the development of social and emotional competency and resiliency, and other factors that mitigate against violence and aggression in children and adolescents.
- The AMA urges physicians to (1) be vigilant for signs and symptoms of bullying and other psychosocial trauma and distress in children and adolescents; (2) enhance their awareness of the social and mental health consequences of bullying and other aggressive behaviors; (3) screen for psychiatric comorbidities in at-risk patients; (4) counsel affected patients and their families on effective intervention programs and coping strategies; and (5) advocate for family, school, and community programs and services for victims and perpetrators of bullying and other forms of violence and aggression.
- The AMA advocates federal, state, and local resources to increase the capacity of schools to provide safe and effective educational programs from which students can learn to reduce and prevent violence. This includes: (1) programs to teach, as early as possible, respect and tolerance, sensitivity to diversity, and interpersonal problem solving; (2) violence reduction curricula as part of education and training for teachers, administrators, school staff, and students; (3) age and developmentally appropriate educational materials about the effects of violence and aggression; (4) proactive steps and policies to eliminate bullying and other aggressive behaviors; and (5) parental involvement.
- The AMA advocates expanded funding of comprehensive school-based programs to provide assessment, consultation, and intervention services for bullies and victimized students, as well as provide assistance to school staff, parents, and others with the development of programs and strategies to reduce bullying and other aggressive behaviors.
- The AMA urges parents and other caretakers of children and adolescents to (1) be actively involved in their child's school and community activities; (2) teach children how to interact socially, resolve conflicts, deal with frustration, and cope with anger and stress; and (3) build supportive home environments that demonstrate respect, tolerance, and caring and that do not tolerate bullying, harassment, intimidation, social isolation, and exclusion.