

Role of Emergency Physicians in Identifying Bullying in the Emergency Department

An Information Paper

Bullying is an important public health issue for children and adolescents. Prevalence rates for bullying vary widely depending on methodology and sample, but most large-scale surveys indicate that 1 in 3 youth are involved as a bully perpetrator, victim, or both.¹ Although bullying has been studied extensively, there is limited discussion of it in the Emergency Medicine literature. Emergency Departments (EDs) are potential venues for identifying bullying. Since children and teenagers may present with non-specific behavioral symptoms and may not provide information regarding their bullying experience, this makes the detection of bullying problematic and very challenging. ED staff should therefore be vigilant for clues, which may help identify bullying in the ED. ED staff thus have a unique opportunity to make a positive impact on the lives of those children who are victims of bullying.

Bullying is a complex issue which is influenced by individual, peer, family and social factors. It can affect children of any age. What separates bullying from other forms of peer conflict is the power differential between the bully and the victim. All forms of bullying can be potentially harmful. It has significant health impacts on those who are bullied, those who bully, and may even affect those who witness bullying. Those involved in bullying, at any level, may experience academic difficulties, mental health challenges, and physical injuries. Bullying is also associated with an increased risk for substance abuse, suicidal ideation, and/or suicide attempts.²⁻⁴ Unfortunately, these difficulties can persist into adulthood.

Since bullying is common, ED physicians should consider screening for signs and symptoms of bullying. An additional screening tool may be arduous, as the ED is already inundated with government mandates and challenged with patient overcrowding. Many of these issues lead to time constraints that make additional screening for bullying both challenging and difficult. ED physicians already provide the initial assessment and stabilization for patients who may be victims of domestic violence, sexual assault and child abuse. It is important to understand, however, that through effective screening, counseling and referral we may protect victims of bullying and facilitate better physical and mental health outcomes. Increased state legislative attention has resulted in 44 States and the District of Columbia introducing legislation to address bullying in children.⁵

Definition of the Problem

The Centers for Disease Control and Prevention (CDC) defines bullying as any unwanted aggressive behavior(s) by another youth, or group of youths, that involves an observed or perceived power imbalance and is repeated multiple times, or is highly likely to be repeated.⁶ Bullying can be verbal, physical or relational. Verbal bullying can include insults, teasing, taunting and name-calling. Physical bullying includes pushing, pinching, spitting, hitting, fighting, etc. Relational bullying is an insidious form of bullying. It manifests itself in passive ways that usually involve peer and group behavior. Typical examples include the silent treatment, such as ignoring and exclusion. Bullying can also occur via text message(s), e-mail(s), and social media. These electronic forms of bullying are known as cyber-bullying.

Prevalence

School children in all age groups are at risk for bullying. In an ED-based study, 24% of children who presented with behavioral symptoms reported bullying.⁷ In a 2001 national survey of students in grades 6-

10, 30% of respondents reported being involved in bullying, with 13% as bullies, 11% as victims, and 6% as both.⁸ According to the Indicators of School Crime and Safety 2013 report by the Bureau of Justice Statistics (BJS) and National Center for Education Statistics Institute of Education Sciences (IES), approximately 28% of students ages 12–18 reported being bullied at school during the school year.⁹ Most bullying occurs in unstructured areas such as playgrounds, cafeterias, hallways, and on buses.¹⁰⁻¹¹ In addition to children and adolescents with disabilities, lesbian, gay, bisexual, transgender and questioning (LGBTQ) children report a higher rate of bully victimization.¹²⁻¹³

With childhood access to personal electronic devices at increasingly younger ages, it is not surprising that these devices have become a means of bullying. The 2011 Youth Risk Behavior Surveillance Survey reported 16% of high school students (grades 9-12) were electronically bullied in the past year.¹⁴ Children can be exposed to traumatizing messages even while at home. This aggression is conducted by electronic means, such as the Internet, e-mail, or mobile devices. Electronic aggression can occur almost anywhere at any time 24 hours a day. Additionally, it allows a larger number of people to witness the bullying.

Early Detection

Bullying represents a unique challenge to the medical provider because there is no clearly defined and objective screening tool. The recognition of bullying depends on a high index of suspicion for its occurrence. This is the same challenge that providers face when screening for other issues such as domestic violence or child abuse. Unless a history of bullying is offered by the patient, family, legal guardian, teacher or eyewitnesses, ED staff should ask whether bullying is, or has been, a part of the child's history. This will be more obvious in cases of trauma or emotional crisis (depression, suicidal thoughts, anger outbursts, etc.) where the need to determine a mechanism of injury is already a part of good routine ED care. As in many other instances, it is often prudent to interview children separately from their parents to obtain more accurate information. Inquiring about recent experiences may be helpful in developing a comprehensive plan and targeted interventions.¹⁵ Literature supports that adolescents will discuss sensitive topics with physicians when confidentiality is ensured.¹⁶

Tools that can be utilized in the Emergency Department

It is important to remember that children may not report bullying and identifying the warning signs for bullying may help to focus attention on children who are at risk (Table 1).¹⁷ Asking parents about certain signs such as school avoidance, decline in academic performance, withdrawal, loss of friendships, torn clothes, bruises, unhappiness, physical complaints, changes in eating or sleeping habits and frequent loss of personal belongings, may also be helpful. For ED purpose, there are no brief tools exist to identify bullying, however the provider may consider asking the questions in the tables 2 and 3. Questions should include inquiring about events that take place in school, at school-related locations (bus-stops, social settings, after-school activities) and in sports-related activities. Questions should also address the child's behavior, including aggression, peer interaction, changes in behavior, eating or sleeping habits, school grades, changes in personality, etc.

Many tools are available to assess bullying, delineating bullying occurring in the child's environment, the forms it takes, and the effects it has on vulnerable children. Although, many of these tools do not assess all aspects of bullying (repetition, power imbalance, and various forms of aggression) these tools can provide important information for screening. Also, most of these tools are available in Spanish. Additionally, these

tools are long and may not be suitable for the ED settings necessitating the development of screening tools appropriate for acute care environment.

1) The Bully Survey¹⁸

The Swearer Bully Survey allows critical stakeholders to understand the characteristics of the bullying behaviors that are occurring in the child's environment. It consists of 4 sections which address the following: victims, bystanders, bullies and attitudes towards bullying.

2) Olweus Bullying Questionnaire¹⁹

The OBQ is a standardized, validated, multiple-choice questionnaire designed to measure a number of aspects of bullying problems in schools. It consists of forty-two questions designed for students in grades 3 through 12.

3) Peer Relations Assessment Questionnaires-Revised (PRAQ-R)²⁰

This questionnaire is designed to obtain the perceptions and judgments of bullying in schools from three different sources: teachers, parents and students.

4) Peer Relationship Survey (PRS)²¹

The PRS is designed to identify the bullying status and behavior patterns of each participating child.

5) The Personal Experiences Checklist (PECK)²²

The PECK tool provides a multidimensional assessment of the personal experience of being bullied and that covers the full range of bullying behaviors, including covert relational forms of bullying and cyber-bullying.

6) California Bullying Victimization Scale (CBVS)²³

The CBVS measures the intention, repetition, and power imbalance elements of bullying victimization without using the term “bully” in the scale.

Role of Emergency Physicians in Detecting Bullying

ED physicians should assume the role of identifying bullying if it exists, intervene immediately for the safety of the child, and help establish ongoing management and referral to appropriate resources. Once suspected, the safety of the child should be the first priority. A complete physical evaluation should be performed to determine physical injuries. If the child is deemed to be a possible danger to others, or to himself or herself, then an urgent psychiatric evaluation should be requested. The initial evaluation may involve multiple providers and ED staff members. This includes physicians and nursing staff, caring for acute medical needs, social service staff assessing family and other environmental dynamics, and mental health professionals, as needed, to ensure stability and good follow-up. (In a vast majority of cases of SI or HI, patient should be admitted to a mental health facility after being medically cleared, therefore such an evaluation is extremely important for ED disposition.) Each member of the team should have knowledge not only of his or her own role, but those of the other providers.

Step 1: Stabilization / Resource Mobilization

- 1) Stabilize the child against any life-threats (suicidal ideation/action, physical trauma related to bullying, etc.)
- 2) Recognize bullying (victim or bully) as the primary cause of, or a significant contributing factor to, the child's ED presentation
- 3) Consider: Does the child need urgent mental health evaluation or admission to a mental health facility?
- 4) Ask: How informed or involved are the child's caregivers and how much support can they offer?

Step 2: Establish Rapport

Establish rapport with the child or caregivers and create a non-judgmental atmosphere where the child or caregivers feel safe and comfortable discussing these issues. This involves all ED personnel, from triage throughout the care in the ED. It is important to provide reassurance to the child or caregiver that within legal limits, he or she has full control over what will happen with the information they will reveal. When interviewing a child, use age appropriate interviewing techniques, allow free narrative, ask non-leading and non-suggestive questions and use language appropriate for the child's developmental age. Consider opening a conversation more broadly by asking if bullying is a problem in his or her school or environment.

Step 3: Screen for Psychological Conditions and Assess the Risk for Aggressive Behavior

All persons involved in bullying are at increased risk for mental health problems.²⁴ Increased risk of suicidal ideation and suicide attempts have been reported in children who had been victimized by their peers.²⁵⁻²⁹ A suicidal screening tool may potentially be helpful to assess the risk (Table 4: Suicidal Screening Tool). If required, a psychiatric consultation or outpatient referral may be helpful in the evaluation of children presenting with significant emotional or behavioral concerns.

Step 4: Identify Resources and Develop a Plan

EDs should have a plan for addressing bullying. ED staff can receive training in how to use screening tools and should be familiar with available local resources such as local interest groups and advocacy centers. With proper training, a nurse, or a mid-level provider can screen for bullying and provide counseling. Social services can also provide counseling and supportive care. In addition, school staff can also be important collaborators.

EDs should engage resources regarding follow-up, counseling, social service involvement and local community resources. Some children may require mental health evaluation and assessment. The child crisis service and child or adolescent outpatient psychiatry (where available) can be used to provide these services. An important step is to encourage the ED to help identify a community liaison to notify specific school personnel.

Step 5: Provide Resources/Referrals for Bullying Prevention

There is no one-size-fits-all anti-bullying strategy. The ED staff should provide referrals for counseling and treatment resources when necessary. Many organizations and federal agencies have developed bullying prevention programs. Many municipalities have confidential anti-bullying hotlines to report bullying, such as the Be BRAVE (Building Respect, Acceptance and Voice through Education) Against Bullying campaign hotline, in New York City.³⁰

Conclusion

ED physicians and staff are in a unique position to identify and treat children who are the victims of bullying. Acute care for physical and emotional trauma should be rendered immediately. Beyond the traditional acute care role of ED providers, a plan to stop the bullying and mitigate its effects can be initiated through a multidisciplinary approach in the ED. This will improve outcomes and prevent further harm to these vulnerable patients. ED staff should be diligent in determining who needs further assessment by other services. Screening tools should be used as part of the assessment process. ED's may choose to modify the screening tools provided, based on their individual needs and circumstances. We have a substantial and essential opportunity to make a difference in the lives of those children who are victims of bullying.

Summary of Key Points

- Bullying is a serious public health issue with a very high prevalence rate.
- Bullying results in serious health issues, including depression, substance abuse, physical abuse, and death.
- It is often challenging to detect the victims of bullying.
- Early detection can improve outcomes and potentially save lives.
- ED Staff have an important role and unique opportunity to help bullied victims in need.
- ED Staff should:
 - Maintain a high index of suspicion for bullying.
 - Know the warning signs for bullying.
 - Ensure that the child gets the necessary help in a timely fashion.
 - Determine what resources are available in the local community to help the victims of bullying. If adequate resources are lacking, it may be necessary to work to improve those resources.
 - Utilize the screening tools provided to help identify children involved in bullying.
 - Involve the child's parents or legal caregivers in the process.

Useful Resources

www.stopbullying.gov

<http://brnet.unl.edu>

<http://gse.buffalo.edu/albertcenter>

www.violencepreventionworks.org

www.aacap.org/cs/Bullying

<http://cyberbullying.us>

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