Adv Dev Educ Psychol, 2022, 4(1): 143-146
DOI: 10.25082/ADEP.2022.01.002

COMMENTARY

Detection and first step intervention for child victims of bullying

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Received: February 16, 2022;
Accepted: March 21, 2022;
Published: March 22, 2022.

Citation: Saroyan, J. S., & Skaff, L. S. (2022). Detection and first step intervention for child victims of bullying. *Advances in Developmental and Educational Psychology*, **4**(1): 143-146.
https://doi.org/10.25082/ADEP.2022.01.002

Abstract: Bullying behavior towards young children and adolescents can occur in schools, neighborhoods and structured group activities, including sports teams or after school programs. While some children manage to avoid harmful negative contacts prompted by their peers, other children suffer repeated verbal abuse, physical assaults, gossip, harassment and/or group rejection. Ultimately this can affect their self esteem and social interactions. Such victims commonly develop symptoms related to depression and anxiety that are not easily observable to teachers and parents or other concerned adults. Family physicians and pediatricians may however carry the role as a child's trusted and caring support, to help uncover issues related to a child as a victim. They may provide opportunities for a child to open up and share personal problems related to bullying along with other related mental health concerns needing attention. Detecting victimization may be recognized after viewing initial prompts or questionnaires given at intake. The addition of a quantifiable instrument related to bullying may also aid in discerning whether a problem exists. Recognizing symptoms of bullied children provides an opportunity for physicians to further inquire about the emotional impact bullying has on the child. Children and parents should both experience support during this process. The addition of educational resources, group referrals and individual/family counseling should also be recommended with follow ups to review progress.

Keywords: bullying identifiers, childhood depression, core self, family physician, pediatrician

1 Introduction

Bullying among children is a current issue of grave concern. It is experienced among age groups spanning from early and middle childhood through late adolescence and is present in schools, neighborhoods and social media. Bullied children are undoubtedly affected emotionally, yet their symptoms can go undetected by parents or other significant adults in a child's life. Outside of teachers, who have regular contact with these children, pediatricians or family physicians may also have opportunities to identify child victims experiencing chronic peer harassment and bullying. These physicians are important resources since they may become instrumental in the detection of behavioral and emotional indicators of a bullying problem that may go unnoticed unless properly recognized and further explored. From the time a bullying problem is revealed, a referral to a child and adolescent psychiatrist and/or psychologist may be crucial.

2 Identifying bullying behaviors

Bullying is identified by the Centers for Disease Control (CDC) as producing a serious public health crisis due to its harmful outcomes on children's self-esteem, their sense of belonging, sense of control, and meaningful existence. It is defined as a power imbalance with unwanted aggression by another youth or youth group that is often repeated and directed toward someone less powerful (Kann et al., 2016; Underwood et al., 2020). When bullying behavior is overtly directed toward an individual, it can include intimidation, verbal assaults, and physical aggression. Other forms of bullying, such as relational aggression affect social relationships and may include provoking, communicating hate messages, spreading negative rumors, cyber harassment through social media and deliberate exclusion from peer groups. Cyber bullying through social media has increased significantly, impacting children and adolescents (Santre, 2022). It appears to occur individually as well as collectively among peers.

A bully's intentional behavior is considered proactive aggression in view of the fact that it is deliberately intended to hurt and control a peer through hostile acts that include verbal or physical assaults and threats as well as hurtful neglect and social rejection (Hawley, 2014). Bully-victims have similar behaviors but perpetuate bullying in response to being bullied themselves.

Bully-victims may also be children in emotional pain who have trauma or abuse histories, come from dysfunctional family systems or have significant loss issues (Herd & Kim-Spoon, 2021). These children may feel powerless and develop inappropriate coping mechanisms in reaction to feelings of inferiority.

Gender differences appear to exist when comparing types of bullying and frequency of the behavior. In the 2017 CDC Youth Risk Behavior Surveillance Survey (Kann et al., 2018), bullying victimization was more common among females than in males. Female bullying on school grounds was 22.3% compared to males who reported 15.6%. Cyber bullying was also higher for females and represented 19.7%, while males reported 9.9%. Regarding types of bullying behavior, males tended to use more physical aggression, while females were more likely to bully through rumors and sexual comments using relational/social aggression (Fox et al., 2014). Concerning frequency, bullying victimization was experienced more often in middle school than in high school, with a consistent year-to-year decline in bullying from ninth to twelfth grade (Kann et al., 2018).

3 Recognizing symptoms of bullied children

Child victims of bullying are frequently repeated targets. They may internalize peer taunting and experience lower self esteem when compared to their better adjusted peers. Also, research has shown that children with special health needs are at higher risk for bullying (Gage et al., 2021). For example, children with chronic illnesses, learning or physical disabilities, behavioral problems, LGBTQ+ and those who are under- or overweight are at higher risk (Hickner, 2017; McClowry et al., 2017). These children may struggle to fit in among peer groups and may produce a social approach or presentation labeling them as outsiders, commonly with a distinct or awkward communication style. They may also possess unique characteristics related to their temperament and Core Self, making it difficult for them to assimilate into peer groups or follow peer norms (Saroyan, 2019). Regardless of whether the bullying is verbal, physical or relational, the psychological effect significantly impacts the victim thus increasing the risk of maladaptive symptoms and coping strategies.

Troubled youths with emotional problems commonly experience negative occurrences produced by their environment and peer relations. These children often feel depressed or anxious with varying degrees of intensity. Specific risk symptoms can include sad affect and loneliness, school absenteeism, health complaints and injuries (Srabstein & Piazza, 2008). For some children, acting out behaviors are the obvious signs of an existing problem, requiring some sort of intervention. For other children, less noticeable dysfunctional behaviors may exist that should necessitate further investigation. For instance, some youths may avoid peer interactions, withdraw socially and isolate at home alone in their bedroom. Other signs can include poor verbalization of feelings or minimal sharing of personal experiences, anhedonia, and low motivation or drive in several areas of their lives. These accompanying symptoms may not be easily identifiable by parents or teachers, considering they may not have specific training or experience to recognize such symptomatology. A pediatrician or family physician has the opportunity to assess a child's emotional status through screening instruments and basic interview questions that highlight problem areas needing further inquiry.

4 Investigation and detection of a victimization problem

Basic questionnaire items can be incorporated into intakes or medical updates given to both younger and older children. Parental consent may be received at that time. Simple yes/no questions may suffice for younger children while options for open ended questions may follow for older children and adolescents. Questions such as "Have you felt picked-on or bullied by anyone this week?" can lead to a follow up inquiry if the child has answered "yes" to this question. Such a disclosure would prompt the physician to gently explore concerns in order to gain insight and assess whether there is a deeper, more pervasive problem. Another approach can include a list of identifiers related to victimization which can be easily checked off by a youth and then reviewed further should a bullying pattern or theme emerge. These identifiers might include subject matters such as: school avoidance, frequent injuries, unexplained items lost or taken such as money, lunch or school supplies, lack of friends or spending free time alone, somatization, fear of a particular peer or group of classmates, changes in mood through anger, sadness or anxiousness, nightmares, bed wetting, recent drop in school grades, aggressiveness with younger siblings, repeatedly teased or mocked by peers, self injurious behavior or mention

of self harm or suicidal ideation. Parents or primary caretakers may also complete a similar list of victim identifiers that can be compared to the child's responses for added information.

Outside of intake questions and survey lists, other assessment tools can be used to help determine types and frequency of bullying behavior, should they exist. Such instruments can provide useful information, especially when parents or other significant adults are unaware of the extent and emotional impact of bullying. Children may not always disclose it or it occurs when adults are not present. Assessments for bullying victimization should be brief and non-invasive, but should also cover issues that help describe problem areas requiring attention or intervention. Several measures assessing the constructs related to bullying already exist. A sample collection of these assessment tools can be found through the National Center for Injury Prevention and Control of the CDC (Hamburger et al., 2011). This compendium of assessments includes short item scales such as the Gatehouse Bullying Scale and Multidimensional Peer-Victimization Scale. A more comprehensive assessment for children to complete during an office visit is the My Life in School Checklist. This measure addresses events that can occur at a child's school with items specific to acts of bullying. These examples are useful tools to assess children who may experience bullying at various subtle or obvious levels.

5 Recommendations

Family physicians or pediatricians can follow the bullying screening process by communicating concerns and pursuing proper support and interventions. After the discovery of bullying as a problem, attention and care may be given through education for the child and parent(s) about bullying and its impact on the victim's emotional and behavioral effects in relation to mental health. Assertiveness skills and the support to report bullying behavior to significant adults, such as parents, caregivers and teachers, should be encouraged. This form of empowerment is an essential goal in taking action to stop bullying behavior as it occurs. Encouragement for the child to develop effective social skills is also important. Utilizing active support systems or building new ones can decrease hurt and feeling alone. A referral to a mental health provider who specializes in children and adolescents should be the next step in supporting the child. Parental involvement in the follow-up process is critical to assure the child receives the necessary care. Beyond individual psychotherapy, family counseling may be an essential adjunct to mental health treatment.

6 Conclusion

The high frequency of reported bullying has prompted the creation of numerous community and school based approaches that serve to intervene on several levels, be it with students, teachers, parents and counselors involved with administration. Though these approaches do show promising results, they are not always consistent when program studies are replicated and they do not always provide the necessary support that the victims need. Addressing victim issues individually is a starting point for decreasing harmful symptoms or negative behaviors for the child. It is also important to be aware that children may minimize their emotional pain due to the shame of being a victim. Physicians can help these children's emotional needs through gentle and supportive inquiry. Since victims of bullying do not always present with clear, overt symptoms related to depression and anxiety, interventions may not have been considered necessary. Since parents, teachers and other important adults in the child's life may not always observe the child's struggles with various forms of bullying and harassment, family physicians and pediatricians can help through their role as trusting and caring adults. They may uncover bullying and victimization issues and intervene appropriately.

Conflicts of interest

The authors declare that they have no conflicts of interest.

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