

Did the Ugly Duckling Have PTSD? Bullying, Its Effects, and the Role of Pediatricians

Draco Malfoy of *Harry Potter*; Nellie Oleson of *Little House on the Prairie*; Lumpy Rutherford of *Leave it to Beaver*; Amber Von Tussle of *Hairspray*; Nelson Muntz of *The Simpsons*; Regina George of *Mean Girls*; all 3 Heathers of the eponymous movie, and last but not least, pretty much all the ducks in the *Ugly Duckling*: regardless of one's generation, such bullies are a staple of child and adolescent life in literature, movies, and television. Throughout the media, bullied kids' "crimes" are varied: they may have a different race, religion, or sexual orientation; they may be too poor, too rich, too heavy, too short; they may suffer for their lineage, as do the magical children of Muggles in *Harry Potter*. Sometimes they are just the new kid in town. Sometimes they are the socially clumsy kid without friends, an easy target for a bully who wants to assert power and impress others. What happens to bullies in fiction, beyond driving the plot? Sometimes they get sent to the principal, sometimes they get a talking-to by an embarrassed parent, and sometimes they get a knowing wink and an at-a-boy from a parent when the principal is not looking. They often get their comeuppance in the end of the movie or book, having the tables turned on them or developing a newfound respect for their target.

Although the bully has been a stock character for years, something has recently changed in the United States. The bully has jumped off the page and out of the screen, and into everyday life and legislation and pediatric practice. The bully is no longer simply a representation of a moral lesson or a source of humor. We have come to recognize the bully as a real person with complex needs and motives who can inflict great harm on others, not to mention on his or herself. The rise of cyberbullying,^{1–5} with its potential for broad public humiliation, has highlighted the damage that bullying can cause. Since 1999, almost all US states have enacted antibullying legislation and have established requirements that school districts implement antibullying policies.⁶

In research studies, bullying is typically defined as intentional and repeated perpetration of aggression over time by a more powerful person or group against a less powerful person or group.^{7,8} In study after study, a substantial proportion of youth report having been bullied,^{3–5,8–13} with the prevalence peaking in middle school.^{4,8,10} Most studies find that at least 1 in 10 middle school students report being bullied in the previous year,^{4,8,10} and the proportions are much higher in some studies.^{3,4,8–12} The variation across studies may reflect differences in setting, timeframe, and specific questions asked. Research also shows that bullies, who are often perceived as popular by their peers, are motivated to denigrate others to attain a dominant social position.^{14–16} Moreover, bullies have a tendency to target others

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ABBREVIATION

PTSD—posttraumatic stress disorder

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who have stigmatizing characteristics, that is, attributes that are socially devalued and discriminated against (eg, being obese; being lesbian, gay, bisexual, or transgender).^{5,17}

This month's issue of *Pediatrics* includes 2 articles on bullying,^{18,19} both of which not only suggest that health issues are a consequence of bullying, but also reinforce that health issues can motivate bullying. The article by Puhl et al builds on previous research on bullying and obesity^{17,20} by documenting substantial weight-based victimization in a sample of children receiving obesity treatment at weight-loss camps.¹⁸ The study highlights an additional consequence of the growth in obesity rates in recent decades: the increase in the number of children at risk for being bullied. The second article, by Shemesh et al, calls attention to another health issue, food allergies, which provide a visible target for bullies. Some bullies even threaten allergic children with the food to which they are allergic (eg, by waving or throwing the food at them).¹⁹ Food allergies are becoming more common,^{21–23} and schools have adopted varying strategies to address them.^{24,25} Students who are not allowed to bring peanut butter to school because a classmate has an allergy might bully the classmate to gain popularity with others who resent the limitation. The potential for bullying underscores the importance of addressing food allergies in a way that protects but does not stigmatize children who have them.

Bullying can have immediate physical and emotional effects that warrant the awareness and involvement of pediatricians and other clinicians. But the effects of bullying do not necessarily stop when the bruises heal or the graffiti is sandblasted off the wall or the Ugly Duckling becomes the Swan. Bullying can have life-long health

consequences. It has been associated with stress-related physical and mental health symptoms, including depression, anxiety, posttraumatic stress, and suicidal ideation.^{8,26–34} When bullying is motivated by discrimination or an attack on someone's core identity (eg, their sexual orientation), it can have especially harmful health consequences.^{32–35} The effects of bullying are not limited to the bullied. Bystanders who witness bullying may experience mental health consequences (eg, distress) as well.^{36,37}

The American Academy of Pediatrics and other major professional organizations have issued policy statements recognizing bullying as a serious medical and public health issue that pediatricians and other clinicians should address jointly with parents, educators, and community organizations.^{38–44} Professional organizations recommend that clinicians take concrete steps to respond to bullying. For example, clinicians can incorporate bullying into anticipatory guidance for children and parents by describing bullying and its consequences, whether the child is bullying, being bullied, witnessing bullying, or all 3. In addition, clinicians can learn to recognize indicators of possible bullying such as unexplained bruises, cuts, and scratches, as well as school avoidance, social isolation, anxiety, depression, substance use, and chronic physical symptoms (eg, headaches, stomachaches). They should be particularly alert when patients have stigmatizing characteristics that could lead to bullying (eg, obesity, disabilities, gender nonconformity). Clinicians may also want to teach parents, who, are not always aware of bullying (as Shemesh et al point out¹⁹), how to recognize clues that bullying might be occurring.

We generally think of adults as part of the solution. They can teach children not to bully and help bullies identify and manage the challenges that may

lead them to bully. They can teach children what to do when they witness bullying. And they can comfort children who are bullied and help them figure out how best to respond. Parents, teachers, coaches, religious leaders, and pediatricians and other clinicians can all make a huge difference in the life of a child who is being bullied by providing an accepting and safe environment to discuss and address the situation. At school, where bullying often occurs, teachers and coaches can institute clear rules and implement swift discipline against bullying, which can undermine bullies' motivations for dominance, popularity, and social reward.

These same adults, however, can be part of the problem,^{18,45–49} sometimes serving as negative role models, ignoring the issue of bullying, failing to notice its signs, or actually bullying children themselves. For example, a clinician who is trying to motivate a child to lose weight might use language, tone, and facial expressions that are undermining, scolding, and even bullying. A parent or coach shouting at a boy, "You throw like a girl!" or "Don't be a sissy!" may not consider the impact on the child if he is gay or even if he is not; importantly, research finds that boys of any orientation who are bullied by being called "gay" show worse distress in comparison with boys who are bullied in other ways.³⁴ Clinicians have a role to play not only in monitoring their own actions when counseling children with stigmatized characteristics, but also in helping other adults, especially parents, to recognize and address their own aggressive and bullying behaviors.

Achieving broad cultural change and promoting public discourse on what is acceptable behavior may be the most promising ways to reduce bullying. Although there has been a rapid increase in antibullying laws and school

antibullying programs, we need a cultural evolution in awareness and repudiation of bullying. We have witnessed such a shift with sexual harassment, which was once considered to be acceptable and normative. Although sexual harassment has not been eradicated, the national reaction to it has markedly changed.^{50,51} The experience with sexual harassment can serve as a model for the kind of societal discussion that can benefit antibullying efforts. We need to create a dialogue on what bullying is and why bullying is not acceptable, even if it has been tolerated or applauded for decades or centuries.

The science of bullying is still young in the United States, although Europe has a longer tradition of studying and addressing bullying. Researchers can build on this previous work, which has helped to operationalize the concept of bullying; elucidate the health correlates of bullying among bullies, bystanders, and targets; and develop antibullying programs in schools.^{7,16,18–20,25,31,35–35}

This is a field that begs for multidisciplinary input by anthropologists, clinicians, educators, epidemiologists, research psychologists, sociologists, and others. There is a need for more methodological research, including longitudinal research that may help to disentangle the effects of bullying on long-term health problems from the effects of other factors, such as preexisting mental health issues. There is a need for descriptive studies that advance our knowledge of the types of children who bully and are bullied, with a particular focus on how to protect children with stigmatizing characteristics. It is also critical to explore the types of community, family, and individual-level factors that reduce involvement in bullying and that promote resilience among targets of bullying.

Perhaps most importantly, there is a need for research on how clinicians, parents, educators, and other advocates for youth can best tackle the issue. We need rigorously tested

interventions that use a solid theoretical basis to create norms for behavior toward the bullied,⁵² to prompt bystanders to take action when they witness bullying,⁵³ and to integrate stigma reduction strategies against prejudicial attitudes and discriminatory behaviors.⁵⁴ Interventions are also needed to help clinicians recognize signs of bullying and take steps to help children who are targets or witnesses address bullying. Having everyone who engages with children participate in shifting the culture of bullying provides our best hope for tackling this challenging problem.

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