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 out[19]), 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.[7,16,18–20,25,31,33–35] 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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REFERENCES

1. Juvonen J, Gross EF. Extending the school grounds?—bullying experiences in cyberspace. *J Sch Health*. 2008;78(9):496–505
2. Kowalski RM, Limber SP. Electronic bullying among middle school students. *J Adolesc Health*. 2007;41(6 suppl 1):S22–S30
3. Wang J, Iannotti RJ, Nansel TR. School bullying among adolescents in the United States: physical, verbal, relational, and cyber. *J Adolesc Health*. 2009;45(4):368–375
4. Williams KR, Guerra NG. Prevalence and predictors of internet bullying. *J Adolesc Health*. 2007;41(6 suppl 1):S14–S21
5. Schneider SK, O'Donnell L, Stueve A, Coulter RW. Cyberbullying, school bullying, and psychological distress: a regional census of high school students. *Am J Public Health*. 2012;102(1):171–177
6. Stopbullying.gov. State Anti-Bullying Laws & Policies. Available at: www.stopbullying.gov/laws/index.html#listing. Accessed October 22, 2012
7. Olweus D, Limber S. Bullying prevention program. In: Elliot DS, ed. *Blueprints for Violence Prevention*. Golden, CO: Venture; 1999
8. Nansel TR, Overpeck M, Pilla RS, Ruan WJ, Simons-Morton B, Scheidt P. Bullying behaviors among US youth: prevalence and association with psychosocial adjustment. *JAMA*. 2001;285(16):2094–2100
9. Carlyle KE, Steinman KJ. Demographic differences in the prevalence, co-occurrence, and correlates of adolescent bullying at school. *J Sch Health*. 2007;77(9):623–629
10. DeVoe J, Murphy C. Student Reports of Bullying and Cyber-Bullying: Results From the 2009 School Crime Supplement to the National Crime Victimization Survey. Washington, DC: US Department of Education National Center for Education Statistics; 2011
11. Due P, Merlo J, Harel-Fisch Y, et al. Socioeconomic inequality in exposure to bullying during adolescence: a comparative, cross-sectional, multilevel study in 35 countries. *Am J Public Health*. 2009;99(5):907–914
12. Radliff KM, Wheaton JE, Robinson K, Morris J. Illuminating the relationship between bullying and substance use among middle and high school youth. *Addict Behav*. 2012;37(4):569–572
13. Glew GM, Fan MY, Katon W, Rivara FP, Kernic MA. Bullying, psychosocial adjustment, and academic performance in elementary school. *Arch Pediatr Adolesc Med*. 2005;159(11):1026–1031
14. Olthof T, Goossens FA, Vermande MM, Aleva EA, van der Meulen M. Bullying as strategic behavior: relations with desired and acquired dominance in the peer group. *J Sch Psychol*. 2011;49(3):339–359
15. Sijtsema JJ, Veenstra R, Lindenberg S, Salmivalli C. Empirical test of bullies' status goals: assessing direct goals, aggression, and prestige. *Aggress Behav*. 2009;35(1):57–67
16. Vaillancourt T, Hymel S, McDougall P. Bullying is power. *J Appl Sch Psychol*. 2003;19(2):157–176
17. Janssen I, Craig WM, Boyce WF, Pickett W. Associations between overweight and obesity with bullying behaviors in school-aged children. *Pediatrics*. 2004;113(5):1187–1194

18. Puhl RM, Peterson JL, Luedicke J. Weight-based victimization: bullying experiences of weightloss treatment-seeking youth. *Pediatrics*. 2013;131(1). Available at: www.pediatrics.org/cgi/content/full/131/1/e1
19. Shemesh E, Annunziato RA, Ambrose MA, et al. Child and parental reports of bullying in a consecutive sample of children with food allergy. *Pediatrics*. 2012;131(1). Available at: www.pediatrics.org/cgi/content/full/131/1/e10
20. Wang J, Iannotti RJ, Luk JW. Bullying victimization among underweight and overweight U.S. youth: differential associations for boys and girls. *J Adolesc Health*. 2010;47(1):99–101
21. Branum AM, Lukacs SL. Food allergy among children in the United States. *Pediatrics*. 2009;124(6):1549–1555
22. Gupta RS, Springston EE, Warrier MR, et al. The prevalence, severity, and distribution of childhood food allergy in the United States. *Pediatrics*. 2011;128(1). Available at: www.pediatrics.org/cgi/content/full/128/1/e9
23. Lack G. Update on risk factors for food allergy. *J Allergy Clin Immunol*. 2012;129(5):1187–1197
24. Sicherer SH, Mahr T; American Academy of Pediatrics Section on Allergy and Immunology. Management of food allergy in the school setting. *Pediatrics*. 2010;126(6):1232–1239
25. Bugden E, Martinez A, Green B, Eig K. *Safe at School and Ready to Learn: A Comprehensive Policy Guide For Protecting Students With Life-Threatening Food Allergies*. Alexandria, VA: National School Boards Association; 2011
26. Juvonen J, Graham S, Schuster MA. Bullying among young adolescents: the strong, the weak, and the troubled. *Pediatrics*. 2003;112(6 pt 1):1231–1237
27. Juvonen J, Nishina A, Graham S. Peer harassment, psychological adjustment, and school functioning in early adolescence. *J Educ Psychol*. 2000;92(2):349–359
28. Kim YS, Leventhal B. Bullying and suicide. A review. *Int J Adolesc Med Health*. 2008;20(2):133–154
29. Newman ML, Holden GW, Delville Y. Isolation and the stress of being bullied. *J Adolesc*. 2005;28(3):343–357
30. Idsoe T, Dyregrov A, Idsoe EC. Bullying and PTSD symptoms. *J Abnorm Child Psychol*. 2012;40(6):901–911
31. Baumeister AL, Storch EA, Geffken GR. Peer victimization in children with learning disabilities. *Child Adolesc Social Work J*. 2008;25(1):11–23
32. Hightow-Weidman LB, Phillips G II, Jones KC, Outlaw AY, Fields SD, Smith JC; YMSM of Color SPNS Initiative Study Group. Racial and sexual identity-related maltreatment among minority YMSM: prevalence, perceptions, and the association with emotional distress. *AIDS Patient Care STDS*. 2011;25(suppl 1):S39–S45
33. Russell ST, Sinclair KO, Poteat VP, Koenig BW. Adolescent health and harassment based on discriminatory bias. *Am J Public Health*. 2012;102(3):493–495
34. Swearer SM, Turner RK, Givens JE, Pollack WS. 'You're so gay!': do different forms of bullying matter for adolescents males? *School Psych Rev*. 2008;37(2):160–173
35. Espelage DL, Aragon SR, Birkett M, Koenig BW. Homophobic teasing, psychological outcomes, and sexual orientation among high school students: what influence do parents and schools have? *School Psych Rev*. 2008;37(2):202–217
36. Janson GR, Hazler RJ. Trauma reactions of bystanders and victims to repetitive abuse experiences. *Violence Vict*. 2004;19(2):239–255
37. Janson GR, Carney JV, Hazler RJ, Oh I. Bystanders' reactions to witnessing repetitive abuse experiences. *J Couns Dev*. 2009;87(3):319–326
38. Committee on Injury, Violence, and Poison Prevention. Role of the pediatrician in youth violence prevention. *Pediatrics*. 2009;124(1):393–402
39. American Academy of Child and Adolescent Psychiatry Task Force for the Prevention of Bullying. Policy Statement: Prevention of Bullying Related Morbidity and Mortality. 2011. Available at: www.aacap.org/cs/root/policy_statements/policy_statement_prevention_of_bullying_related_morbidity_and_mortality. Accessed June 23, 2012
40. American Medical Association National Advisory Council on Violence and Abuse. Policy Compendium. *School & Youth Violence: H-60.943 Bullying Behaviors Among Children and Adolescents*. 2008:8–9
41. American Psychological Association. APA Resolution on Bullying Among Children and Youth. 2004:1–4
42. American Psychiatric Association. Joint AACAP and APA Position Statement on Prevention of Bullying-Related Morbidity and Mortality. March 2011
43. National Association of School Nurses. NASN Issue Briefs Full View. Role of the School Nurse in Violence Prevention. Revised August 21, 2012:169–170
44. National Association of School Psychologists. Bullying Prevention and Intervention in Schools [Position Statement]. Bethesda, MD: National Association of School Psychologists; 2012
45. Eisenberg ME, Neumark-Sztainer D, Story M. Associations of weight-based teasing and emotional well-being among adolescents. *Arch Pediatr Adolesc Med*. 2003;157(8):733–738
46. Twemlow SW, Fonagy P. The prevalence of teachers who bully students in schools with differing levels of behavioral problems. *Am J Psychiatry*. 2005;162(12):2387–2389
47. Faith MS, Leone MA, Ayers TS, Heo M, Pietrobelli A. Weight criticism during physical activity, coping skills, and reported physical activity in children. *Pediatrics*. 2002;110(2 pt 1). Available at: www.pediatrics.org/cgi/content/full/110/2/e23
48. Scanlan T, Lewthwaite R. Social psychological aspects of competition for male youth sport participants: IV. Predictors of enjoyment. *J Sport Psych*. 1986;8(1):25–35
49. Collot d'Escury A, Dudink A. Bullying beyond school: examining the role of sport. In: Jimerson S, Swearer S, eds. *The Handbook of Bullying: An International Perspective*. New York, NY: Routledge; 2010:235–248
50. Tinkler JE. "People are too quick to take offense": the effects of legal information and beliefs on definitions of sexual harassment. *Law Soc Inq*. 2008;33(2):417–445
51. Zimbroff J. Cultural differences in perceptions of and responses to sexual harassment. *Duke J Gend Law Policy*. 2007;14:1311–1341
52. Batson CD, Dyck JL, Brandt JR, et al. Five studies testing two new egoistic alternatives to the empathy-altruism hypothesis. *J Pers Soc Psychol*. 1988;55(1):52–77
53. Latané B, Darley JM. *The Unresponsive Bystander: Why Doesn't He Help?* New York, NY: Appleton-Century-Crofts; 1970
54. Pettigrew TF, Tropp LR. A meta-analytic test of intergroup contact theory. *J Pers Soc Psychol*. 2006;90(5):751–783

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