Tackling Bullying: Grounds for Encouragement and Sustained Focus

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With the growing recognition over the past 2 decades regarding the harm caused by school bullying on a child's physical and emotional health, a variety of measures to reduce bullying has been put in place. Given all these efforts, is school bullying trending upward (as many might fear) or downward (as we hope)? What are the current rates of bullying? And, beyond a singular focus on the occurrence of bullying episodes, is the climate in schools improving?

The large-sample, 10-year longitudinal study of school bullying by Waasdorp et al[1] in this issue of *Pediatrics* addresses these questions, and does so with commendable rigor. For instance, they used a standard definition of bullying, specifying the attributes of intention, repetition, and power imbalance; the use of this standard definition is not always routine in studies of bullying, making comparisons across studies usually problematic. They also examined a broader age range of students than in other research, improving the generalizability of the findings. Finally, they used a sophisticated longitudinal design that takes into account a number of covariates to better understand trends in bullying and related behaviors over this 10-year period.

The good news from the Waasdorp et al study[1] was that bullying perpetration and victimization appear to be decreasing over time. Over the course of 10 years, there were substantial decreases in all forms and modes of victimization (physical, relational, and cyber) and in bullying perpetration. In addition, many more youth feel that adults are now helping to prevent bullying than 10 years ago (rising from 39% to 71%), with the vast majority of youth reporting that they feel safe in school (88.5% in the last year of the study).[1]

This encouraging news notwithstanding, the sobering reality is that schools across the country continue to have a large bullying problem: 48% of youth still report that bullying is a problem and upwards of 40% still indicate that they are witnessing bullying behaviors. In addition, the complexity and impact of bullying may be hard to judge from only examining prevalence rates.[1] For instance, even though the frequency of cyber-bullying and victimization is relatively small (4%),[1] the impact of this behavior can be quite traumatic, because youth bullied through this modality have reported that not only are the words or images transmitted instantly to many people, but that they may retraumatize themselves by being drawn to and repeatedly viewing the harmful words or pictures. In sum, although we should not be pessimistic about our abilities to reduce bullying, we must also be relentless in seeking additional improvements, both in encouraging schools to mount antibullying programs and in supporting individual pediatric clinicians responding to patients who report bullying.

For schools, we cannot emphasize enough the importance that school personnel choose wisely when selecting a bullying prevention program for implementation in

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their school and community. What do we mean by "wisely?" The programs that have demonstrated the greatest impact are typically empirically based, whole-school intensive approaches in which students, teachers, and parents are engaged.[2] These programs often try to build skills in youth problem-solving abilities, empathy, perspective-taking, and how to be a positive bystander.[3] But these programs are only helpful when they are implemented as intended.[4] School officials therefore need to think through the match of the program to their school's specific needs and capabilities of program implementation. The good news is that when schools choose programs wisely, that is, select from among the whole-school prevention programs that have strong empirical evidence of effectiveness and that are feasible to implement in their setting, they are likely to experience important and sustained beneficial effects.

For pediatric clinicians, we need to remain constantly vigilant for the possibility that a child is being affected by bullying, given that bullying remains one of the largest influences on child development and health, academic learning, and feelings of safety at school.[5,6] In cases where patients demonstrate signs of anxiety, depression, or social withdrawal, clinicians should routinely ask screening questions as to whether their patient is the perpetrator or victim of bullying, because these symptoms often accompany peer victimization.[7] We recommend asking whether one is being bullied at school (treated aggressively by peers repeatedly) and, if so, in what manner (eg, physically, verbally, socially). Learning about the impact of the bullying and who the patient has reported this to at home or at school are also extremely important.

Based on children's responses, clinicians must determine whether they should provide anticipatory guidance, resources, or referral to a mental health professional. We recommend stressing several key points to youth and parents, which include: (1) establishing a point person at school so that the youth has someone who can help him or her navigate the difficult school environment; (2) recognizing that bullying often happens in unstructured school contexts, such as in the lunch room, hallways, or recess yard[8]; (3) supporting ongoing dialogue between the youth and his or her parents; (4) improving communication and collaboration between school and home; and (5) helping to support at least 1 peer friendship, because this has been found to be a strong buffer against peer victimization.[9]

Tackling bullying remains a priority for efforts to improve child well-being. Although the notable improvements over the past 10 years in rates of bullying should provide us with encouragement, we need to sustain our focus to continue the decrease of bullying and victimization in schools across the nation.

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