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Assessment and Management of Bullied Children in the Emergency Department

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Abstract

Bullying is an important public health issue in the United States. Up to 30% of children report exposure to such victimization. Not only does it hurt bully victim, but it also negatively impacts the bully, other children, parents, school staff, and health care providers. Because bullying often presents with accompanying serious emotional and behavioral symptoms, there has been an increase in psychiatric referrals to emergency departments. Emergency physicians may be the first responders in the health care system for bullying episodes. Victims of bullying may present with nonspecific symptoms and be reluctant to disclose being victimized, contributing to the underdiagnosis and underreporting of bully victimization. Emergency physicians therefore need to have heightened awareness of physical and psychosocial symptoms related to bullying. They should rapidly screen for bullying, assess for injuries and acute psychiatric issues that require immediate attention, and provide appropriate referrals such as psychiatry and social services. This review defines bullying, examines its presentations and epidemiology, and provides recommendations for the assessment and evaluation of victims of bullying in the emergency department.

Keywords

bullying; bully victim; bullied children; interpersonal violence; peer victimization; peer harassment; aggressive behavior

CASE

A.K., a 14-year-old female adolescent, presents to the emergency department (ED) at 3 PM on a Thursday afternoon transported from school by ambulance and escorted by paramedics and 2 police officers. The paramedics report to the triage nurse that a fight had broken out at school after A.K. had teased another girl. A.K. was identified as the instigator of the altercation. She is in handcuffs and is disheveled, her shirt is torn, and she has been crying.

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She is arguing with the triage nurse, stating that “I’m not sick and I don’t need to be in the hospital. I want to go home.” She paces and appears agitated in the triage area.

BULLYING: DEFINITIONS, PRESENTATIONS, AND EPIDEMIOLOGY

What Is Bullying?

Bullying is characterized by 3 elements: repeated acts of verbal or physical intimidation, coercion, and aggression.¹ There is generally a power differential between the bully and the bully victim, who is weaker in terms of physical size or possesses less psychological or social power.^{1–3} To be considered bullying, acts of conflict, harassment, teasing, taunting, or intimidation between children must go beyond what might be expected in youth-peer relations and be repeated both inside and outside school. Bullying exists in many forms and can be either direct or indirect.^{4,5} Direct forms include physical bullying, such as hitting and kicking, and verbal bullying, such as name calling and teasing. Indirect forms of bullying (also referred to as relational bullying) include social exclusion and the spreading of rumors. The rapid incorporation of computers, cell phones, and other electronic devices into the daily lives of children has created a new means of bullying. Cyberbullying or electronic bullying refers to bullying that occurs through e-mail, texting, instant messaging, social networks, chat rooms, and so on.^{5–7} Cyberbullying has unique features that may make it more troubling than traditional bullying.⁷ For example, cyberbullying can occur at any time and any place, as long as victims and perpetrators are connected to the Internet or have access to a cell phone; messages can be distributed almost instantly to very large audiences; the perpetrators can remain anonymous or disguised behind a nickname; and the effects of the aggression on the victim can remain hidden to the perpetrator and to others.

Bullying can escalate to violent acts leading to injury and trauma that requires assessment in the ED.⁸ Bullying others and being bullied have been implicated as a cause of violence-related behavior for both boys and girls⁹ and are also associated with key violence-related behaviors including weapon carrying and fighting injuries. Many injured youth have been in a conflict before presenting to the ED with injuries.⁴ Emergency departments across the country evaluate a large number of victims of violence each year.^{5,6} In 1 study, 3% of the ED visits were due to violence-related injuries.⁶ With the rising prevalence of bullying and the increasing public awareness of it, more children are being referred from schools directly to EDs.^{7,10,11}

There is a small literature demonstrating that both bullies and bully victims are increasingly being brought to EDs for emergency psychiatric evaluation in addition to physical injuries. Because being bullied is a distressing experience, emergency physicians need to be prepared to respond to children who present with both physical and emotional trauma. This problematic behavior affects academic achievement, social skills, and psychological well-being of both victims and perpetrators.¹² In general, there has been an increase in the prevalence of ED visits for psychiatric conditions.^{13–18} Lee and Korczak¹⁹ demonstrated that, of the children referred to a pediatric crisis center by pediatric emergency physicians, 17% experienced ongoing bullying. Another study reported that children involved in bully/victim problems were more likely to be referred for psychiatric evaluation.²⁰

In the United States, rising violence among youth is alarming; acts of violence at schools across the country require EDs to be prepared for potential multiple victims. According to an American College of Emergency Physicians policy statement, emergency physicians are ideally situated and have the responsibility to affect the health of the public by being leaders in injury prevention and control.⁹ Emergency departments are rapidly becoming a new arena for assessment and intervention for bullying behavior.^{13–16}

What Is the Prevalence of Bullying?

In a 2001 national survey of grades 6 to 10 students, 30% of respondents reported being involved in bullying, with 13% as bullies, 11% as bully victims, and 6% as both.²¹ In the ED, the prevalence has been reported to be 24% among children with behavioral issues.¹⁰ However, verbal bullying (including taunting, teasing, and name calling) had the highest prevalence. In 1 study, prevalence of having been bullied or having bullied others at school at least once in the last 2 months was reported as 11.6% for physical and 52% for verbal form of bullying.²² In the past few years, as the rising importance of technology in youth social lives has become evident, researchers have included cyberbullying or electronic bullying into the mix of types of bullying.^{12,23–25} These studies have found that bullying through electronic means, although prevalent, ranks third after verbal bullying and physical bullying.²⁵

Where Does Bullying Occur?

Bullying has traditionally been framed as a schoolyard issue, and thus schools have been the primary arena for studying bullying.^{26,27} Research has shown that bullying and victimization in schools most often occur in unstructured areas such as playgrounds, cafeterias, hallways, and buses.^{28,29} These locations are conducive to bullying because of the low levels of adult supervision, high levels of student activity, and frequency of interaction with peers.

What Are the Risk Factors for Bullying?

Risk factors for bullying exist at the levels of the family, the social environment, and the individual. Exposure to violence and emotional trauma may contribute to violent and aggressive behavior.^{30,31} Bullying is also associated with key violence-related behaviors including weapon carrying and fighting injuries.^{32,33} There are certain risk factors that represent the characteristic qualities that may attract bullies to their victims³⁴ (Table 1).

Demographics

Research has shown that boys are more often bullies.^{21,35,36} For boys, verbal bullying and physical bullying were common, whereas girls experienced verbal bullying and relational bullying (rumors and social exclusion) more often.^{37,38} Different types of bullying victimization have been found to co-occur.³⁹ When considering race/ethnicity, in 1 study, Hispanic youth's involvement as bullies was found to be marginally higher than youth of other races/ethnicities.²¹ Later studies that focused more specifically on ethnic/racial minority students of low socioeconomic status, however, reported estimates similar to those

reported for national studies.⁴⁰ Bullying occurred with greater frequency in middle school.⁴¹ It has been reported to decline with increasing age.^{21,42}

Domestic Violence

At the level of the family, domestic violence has been identified as one of the strongest predictors for the development of bullying.^{34,43–45} Bullying is also regarded a strong predictor for future antisocial and delinquent behavior.^{46–49} In homes with poor family functioning (ie, emotional distance between family members, lack of warmth, and inconsistent discipline) and violence, children may develop low empathy toward others and bullying behavior.⁵⁰ Another study reported that exposure to family conflict and parental psychological abuses were both significantly associated with youth violence and aggression in children.⁵¹ It has also been shown that children victimized in their own homes are likely to be targeted among their peers as bully victims.⁵²

Violence Exposure

At the level of the social environment, exposure to violence and conflict as well as association with aggressive friends has been shown to predict bullying behavior.⁵³ Children residing in inner-city neighborhoods are at particular risk, as they are exposed to higher levels of crime and poverty.^{51,54} In a study of more than 600 Hispanic children, association with a delinquent peer group and psychological abuse in intimate relationships were significantly associated with youth violence and aggression.⁵¹

Media Violence Exposure

School shootings have increased attention to evaluate the relationship between exposure to media violence and aggressive behavior in adolescents.⁵⁵ It has been shown that exposure to violence on television, video games, and social media increases aggression in youth.^{25,51,56–59} In this age, social media has become a risk. In addition, presence of anger and contact with delinquent friends appears to mediate this relationship between media violence exposure and bullying.⁶⁰

Poverty and Income Inequality

An association has been reported between income inequality and school bullying.⁶¹ It has been reported that children who reside in socioeconomic inequality are at higher risk of being bullied.⁶² In another study, behavioral problems were found more frequently in children living in socially disadvantaged neighborhoods.^{63,64}

Poor School Perception

Research has shown that children involved in bullying (as bullies, bully victims, or both) have less favorable views of school and feel less safe at school and less connected to their schools.^{65,66} Many studies have shown that negative school perceptions among children predict higher likelihood of involvement in high-risk behaviors including bullying.⁶⁷ In an other study, school perception was regarded as the strongest predictor for the involvement of violence.⁶⁸

Low Social Support and Isolation/Peer Rejection

Children with low levels of social support are more likely to be bullied. This may be due to their social isolation that attracts bullies to them.⁶⁹ Another study reported that children with high levels of social support from their friends were less likely to be bullied.⁷⁰ A reciprocal relationship is believed to exist between bullying and peer acceptance/rejection in the dynamic of peer relationship.⁷¹ Peer group rejection has been shown to result in reactive aggression toward others.⁷² Several studies have demonstrated that peer rejection is associated with aggression.^{73,74} Peer group association is a powerful context that shapes children's behavior both positively and negatively.⁷⁵

Special Health Needs/Conditions

At the level of the individual, many studies have shown that children with chronic illnesses and disabilities (ie, learning disorders, chronic diseases) are more likely to be bully victims.^{76–80} Children with cerebral palsy have been reported to be victims of social exclusion within the school context.⁸¹ It is important to pay particular attention to this population because of cumulative vulnerabilities resulting from existing health care needs and bully victimization. Children with mental health conditions and behavioral or emotional difficulties may also be at increased risk for victimization.^{82–85} The combined effect of intellectual disability and social exclusion may result in increased vulnerability to bullying.⁸⁶ Poor academic performance and reduced student involvement in educational activities (eg, lower rates of homework completion, lower grades, and school dropout) have been found to be associated with bullying, both as bullies and bully victims.⁸⁴

Physical Appearance and Body Image Dissatisfaction

One of the most common reasons provided by children for bullying was different appearance.⁸⁷ Being teased on the basis of appearance has been reported to be the most common reason for bullying in children and adolescents.^{87,88} Physical appearance, particularly overweight or obesity, has been reported to be a common reason for being bullied for both boys and girls.^{89–96} This weight-based teasing is a problem for all youth regardless of racial/ethnic origin.⁹⁷ Bullies often target individuals who are overweight and unattractive. Teasing has been found to be associated with significantly higher current levels of weight and shape concerns and body dissatisfaction.⁹⁸ Body image dissatisfaction is also reported to be associated with bullying.⁹⁹ Obese youths are at increased risk of social consequences attributable to their appearance, such as stigma and being discriminated against.¹⁰⁰ These overweight adolescents who are teased about their weight are at risk for psychological morbidities such as anxiety and lower self-esteem.¹⁰¹ The presence of bullying has also been evaluated in children who were referred for orthodontic treatment, and a significant relationship has been noted between bullying and malocclusion.¹⁰²

Sexual Orientation

Youth who report same-sex sexual orientation are at greater risk for being bullied.^{103–106} It is therefore important that lesbian, gay, bisexual, transgender (LGBT) youth be evaluated for the presence of victimization.^{107,108} The LGBT population is at greater risk than their peers

to attempt suicide.^{109–111} In 1 study, LGBT adolescents who experienced family rejection were at 8-fold greater risk for suicide.¹¹²

What Are the Protective Factors for Bullying?

Emergency physicians should be aware of protective factors that can be harnessed in developing interventions against bullying as well as the available social resources that can be leveraged. Many factors are described to protect against bullying mostly at the level of the family and social environment, specifically the school (Table 2).

Positive Family Interaction and Home Environment

At the level of the family, living with supportive parents has shown protection against bullying involvement.¹¹³ In addition, cohesive families have also demonstrated to guard against bullying.³⁴ Another study showed that warm relationships within the family were associated with both emotional and behavioral resilience to bullying victimization.^{114,115} These factors facilitate children's social and emotional well-being even in the presence of exposure to adversities such as socioeconomic deprivation.^{116,117}

Friendly Neighborhood Environment

Social environment is an important variable influencing the risk for bullying. Studies have demonstrated an increased prevalence of bullying in disadvantaged neighborhoods.^{111–118} Similarly, there is a higher risk of behavioral problems associated with unfavorable neighborhood conditions.⁶³ A higher level of social support in a friendly neighborhood may lower involvement in bullying.^{119,120}

Positive School Climate

At the level of the social environment, positive and supportive classroom and school cultures are associated with less bullying behavior.^{121,122} One of the most important markers of school climate is student perceptions of whether teachers care about students and treat them fairly. Children with positive perceptions about their teachers and school staff are less likely to be aggressive.¹²³ In another study, support from the school staff was regarded as a common reason for bullying to stop.¹²⁴

School Connectedness

There is increasing evidence that shows that, when children feel cared for by people at their school and feel like a part of their school, they are less likely to engage in violence.¹²⁵ Researchers have found that school connectedness, defined as children who like school and who have a positive relationship with teachers and peers, is an important variable in the dynamics of bullying.⁶⁵ It is believed that school connectedness functions as a buffer against violence and aggressive behavior.¹²⁶ Clearly, supportive relationships and safe environments are essential for healthy youth development. In interaction, they serve as buffers against children's exposure to violence^{121,127} and as key factors in engaging students in the prevention of and protection against bullying.¹²³

Peer Acceptance and Supportive Friends

Peer acceptance and friendship have been recognized as protective against bullying.¹²⁸ It is reported that children who have high-quality best friends are less likely to be victimized.^{129–131} Another study indicated that higher level of perceived support from friends was associated with decreased bullying and victimization.¹³² It is believed that friendship can contribute to resiliency against negative events in children's life.¹³²

What Are the Consequences of Bullying?

Being either a bully or a victim of bullying is associated with increased risk of a wide range of problems. Children who present to the ED after a bullying episode may present in the future with some of the consequences of bullying, such as depressive symptoms (Table 3). Being either a bully victim or a bully is associated with an increased risk of immediate and long-term negative social and psychological consequences.¹³³ Being bullied may result in difficulty concentrating, school absences, poor performance in school, depression, anxiety, and low self-esteem.^{23,134–137} Being the victim of a bully is also associated with school adjustment problems.^{134,138} Many bullied children express feelings of helplessness, loneliness, and feeling excluded.^{139,140}

A prospective study demonstrated an association between bullying and development of borderline personality symptoms as early as 11 years of age.^{141,142} Bully victims may feel unsafe, spend more time playing alone, have fewer friends, feel more isolated, and report recurrent memories of bullying.¹⁴³

Childhood bullying has been reported to be significantly associated with violence and substance abuse.¹⁴⁴ Studies have also demonstrated a link between bullying (either as perpetrators or victims) and suicidal ideation and/or attempts.^{109,145–149} In children, frequent exposure to bullying increases victims' risk of self-harm. Being a bully victim is also associated with emotional and behavioral difficulties, and children who bully are at risk for various mental disorders, including anxiety and depression.^{22,24–26,137,150,151} Bullies may continue to have psychiatric problems later in life, as involvement in bullying is a predictor of future psychological well-being.²⁰ This is important, considering 6% of US adults report a lifetime history of bullying others.¹⁵²

Bullying, in summary, should not be considered a transient, harmless part of the normal process of growing up, as it is associated with significant youth risk behaviors. The emergency physician has the opportunity to play a vital role in the assessment of children who are involved in bullying confrontations and should be aware of both the physical and psychiatric manifestations as well as some long-term sequelae.

ASSESSING AND EVALUATING BULLYING IN THE EMERGENCY DEPARTMENT

Screening and Recognizing Bullying

Given the high prevalence of bullying and the potential for injury and harm, emergency physicians should be vigilant and screen children who present with behavioral symptoms or

have other risk factors for presence of bullying (Table 4). It is important to recognize that bullying is an abnormal behavior that goes beyond the conflict and harassment that may be expected in youth-peer relations. To recognize this potentially dangerous behavior, the emergency physician should have a high index of suspicion when evaluating children presenting to the ED with unexplained injuries or abnormal behavior. Bully victims are at particular risk of being victimized, and thus are at risk of being severely harmed both physically and emotionally.¹⁵³

Assessment and Evaluation

Emergency departments can play a vital role in the assessment and management of children presenting with behavioral problems due to bullying. Safety considerations should be a priority, with special attention paid to preventing injury to other patients, which may include the victim and the ED staff. While in the ED, children with violent and aggressive behavior may require interventions to stop this behavior, including both physical and pharmacologic interventions. Many of these patients are angry because they have been escorted to the ED against their will, as shown in the case of A.K. at the beginning of this article. Every attempt should be made to diffuse the situation before it escalates by using strategies such as reflective listening and by clarifying responses to obtain information and convey understanding of the patient's perspective of the issue.¹⁵⁴

Children and adolescents brought to the ED because of violent and disruptive behavior in school, including bullying other children, must have a thorough medical and psychiatric evaluation. If the child is deemed to be a possible danger to others or to himself/herself, then he/she cannot be safely discharged, and an emergency psychiatric consultation must be obtained.

Many research tools are available to evaluate probully and provictim attitude (Table 5). These include the Olweus Bully/Victim Questionnaire,¹⁵⁵ the Peer Relations Questionnaire,¹⁵⁶ and Personal Experiences Checklist, which provides a multidimensional assessment of an individual's personal experience of being bullied.¹⁵⁷ Peer Interactions in Primary School Questionnaire has been used in the school setting to capture direct and indirect forms of bullying and victimization.¹⁵⁸ Although these instruments are well validated and standardized, they are time consuming and have multiple items, which limits their use and application in the clinical setting, particularly the ED. The College of Family Physicians of Canada has described a brief tool of questions to assess bullying exposure that includes questions targeted for the bully and the victim of bullying.¹⁵⁹

For the Bully

- (1) How often do you bully others?
- (2) How long have you bullied others?
- (3) Where do you bully others?
- (4) How do you bully others?

For the Victim

- (1) How often are you bullied?
- (2) How long have you been bullied?
- (3) Where are you bullied?
- (4) How are you bullied?

Bully victims are at risk for remaining unidentified, as they often present with unexplained injuries or nonspecific symptoms and as they may be reluctant to disclose being victimized. Emergency department staff must be especially attentive to physical and psychosocial symptoms related to bully victimization (Table 2). Bully victims may present to the ED with significant injuries. Once stabilized, it is very important to obtain a detailed history regarding the mechanism of injury from the child as well as from any witnesses, including family members, friends, and school staff. A history of any previous injuries should be obtained, and a thorough physical examination should be performed, assessing for signs of both acute and previous trauma. Old records should be reviewed, as they may reveal a previous history of injuries, which may indicate that the patient is being chronically abused by a bully.

Bully victims may present to the ED repeatedly for non-specific somatic complaints due to an underlying depression caused by bullying. When evaluating these children, it is important that the emergency physician considers this possibility and inquires specifically about it. Children who have chronic illnesses and disabilities may also have an exacerbation of their underlying medical problems when they are being bullied and may have additional difficulty expressing and describing the abuse they are experiencing. These possibilities should be considered by the emergency physician during the evaluation, and ED staff must look for relevant historical and clinical evidence.

Evaluating Suicidal Risk and Psychiatric Conditions

Behaviors related to bullying may often coexist with other psychiatric conditions. Emergency physicians should evaluate children involved in bullying for coexisting psychiatric problems. Children who are being bullied and those who are bullies are both at an increased risk of depression and suicide.¹⁶⁰ The need for psychiatric evaluation should be considered not only for victims of bullying but also for bullies.¹⁶⁰ A validated screening tool for suicidality could be implemented by ED staff.¹⁶¹ The screening tool is composed of the following questions:

- (1) Are you here because you tried to hurt yourself?
- (2) In the past week, have you been having thoughts about killing yourself?
- (3) Have you ever tried to hurt yourself in the past other than this time?
- (4) Has something very stressful happened to you in the past few weeks?

If any of the warning symptoms or signs of suicidal ideation is present, a psychiatric consultation should be obtained in the ED. If the patient is considered to be a possible suicide risk, he/she should not be allowed to leave the ED and must be closely observed. In

addition, exposure to bullying is a potential risk factor for posttraumatic stress disorder symptoms, such as intense fear, helplessness, flashbacks, or nightmares.¹⁶²

Management and Disposition Plan

A multidisciplinary approach is required for the management of a child who is physically injured or emotionally disturbed after a bullying experience. If after the assessment and evaluation the emergency physician suspects that a patient is involved in bullying behavior, this should be discussed with the family. Parents must realize that bullying is a serious problem. Children require the support and presence of parents to cope with this behavior. Emergency physicians should counsel parents to discuss coping strategies, such as refusing to support the bully and reporting bullying incidents. In addition, emergency physician can counsel the parents to provide close supervision, which may be helpful in protecting children from future episodes of bullying or victimization.

If the bully victim has been significantly injured, law enforcement should be contacted. If the bully victim or the perpetrator appears to be depressed and is a possible suicide risk, then an emergency psychiatric consultation should be obtained. If the bullying is occurring at school, school authorities should be notified. Social services should be involved if there is any evidence of ongoing risk to the child. Social services as well as mental health providers can undertake a comprehensive assessment of the larger social issues within the immediate family and evaluate the support structure of the child. Engaging social services and mental health workers in the ED may help avoid future episodes and help the child to develop coping mechanisms. The child and the family should be provided with information about available support services and community-based resources (eg, 24/7 access to toll-free help lines). The knowledge that there is help available provides both reassurance and practical assistance. If and when it is deemed safe for the patient to be discharged, the patient should be referred for appropriate outpatient follow-up for both physical and psychological issues related to bullying. Bully victims must always be discharged to a safe environment.

There may be challenges to the involvement of outside agencies. The parents or the child might want to deal with the situation “on their own.” They may resist outside involvement, viewing it as interference in what they may consider a personal matter. In this situation, the family should be counseled, educated, and encouraged to accept the services available to them rather than viewing them as outside interference. Emergency department staff should keep in mind that there may be situations when involvement of outside agencies is required regardless of the wishes of the family or the child. Providers thus should be familiar with the mandatory reporting laws for the state in which they practice. For example, there are state laws mandating reporting of certain crimes and injuries (eg, injuries involving knives or guns) as a matter of public safety. The family and the child should be informed of the mandatory reporting requirements, and ED staff should encourage their support and involvement in the process.

Follow-up Plans

Care of these children should not end at the discharge. Instead, a comprehensive and structured plan should be initiated. All follow-up arrangements and referral to available

resources should be carefully discussed with parents and care-givers. Behavioral therapy and counseling may be required for some victims of bullying. In certain situations, family counseling should also be considered.

Prevention

Bullying and peer victimization will continue unless its antecedent factors are addressed. The ED should identify intent to harm another student and intervene through crisis intervention. Many states have required that school boards develop bullying prevention programs.¹⁶³ However, the efficacy of many of these programs has not been formally evaluated, and there is no criterion standard approach established for prevention. Currently, there is no federal law that specifically applies to bullying. However, there are legislative initiatives in various states taken to ensure that every child is able to learn in a safe, secure, and bullying-free school environment. Some states require each school to have a comprehensive policy on anti-bullying and an antibullying coordinator and to define appropriate range of penalties (eg, school suspension). Emergency department staff should be familiar with the specific legislation related to bullying in the state in which they practice and inform the child and family of any legislative requirements.

CONCLUSIONS

Bullying is a common and serious problem in the United States. It has very serious consequences for all the children involved, as well as for their families, communities, and the entire nation. Emergency physicians play an important role in prompt identification, treatment, and referral of these children. It is important that emergency physicians are aware of this growing problem and know how to recognize and assess both the bullies and their victims. A multidisciplinary approach involving physicians, families, schools, social workers, and communities is needed to identify and intervene in this dangerous behavior. The recent attention on the sociologic phenomenon of childhood bullying creates a unique opportunity for emergency physicians assume a leadership position in effecting meaningful social change. In understanding the psychological, emotional, and social underpinnings of bullying, emergency physicians have an opportunity to bridge the gap between the acute, short-term clinical needs of the bullying victims and the greater social and cultural needs of the community.

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TABLE 1**Risk Factors for Bullying**

Bully Victim	Bully
Family	
Poor family functioning	Poor family functioning
Abuse (physical, psychological, or sexual)	Abuse (physical, psychological, or sexual)
Witness to domestic and/or interparental violence	Witness to domestic and/or interparental violence
Social environment	
Lack of close peers or friends	Peer pressure/delinquent peer association
Inner-city upbringing	Inner-city upbringing
Socioeconomic disadvantage	Socioeconomic disadvantage
Low connectedness to school	Low connectedness to school
Individual	
Physical traits, especially obesity, different appearance	Poor academic achievement
Chronic illnesses	Behavioral or emotional problems
Physical or learning disabilities	Criminal involvement
Sexual orientation (LGBT)	
Behavioral or emotional problems	

TABLE 2**Factors That May Protect Against Bullying**

Positive family interaction and home environment
Friendly neighborhood environment and social support
Positive school climate
School connectedness
Peer acceptance and support

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TABLE 3**Warning Signs Related to Bully Victimization**

Unexplained injuries
Repeated vague physical complaints
Fear of going to school
Fear of riding on school bus
Request to travel a different route
Loss of interest in school
Difficulty relating with peers
Poor school performance
Excessive feeling of isolation
Excessive feeling of rejection
Low self-esteem
Expression of violence in writing or drawing
Mood disturbances (sad, depressed, or withdrawn)
Behavioral manifestations (change in eating or sleep pattern)
Suicidal ideation or attempts

TABLE 4**Who Should Be Screened for Bullying**

Extremes of behavior: too aggressive or too withdrawn
Suspicion of domestic or family violence
Victim of violence
Children who look or act differently
LGBT
Children with special health needs
Special education children
Children with mental health conditions
Children with chronic medical conditions
Obese or overweight children

TABLE 5**Tools for Bullying Assessment**

Olweus Bully/Victim Questionnaire
Peer Relations Questionnaire
Personal Experiences Checklist
Peer Interactions in Primary School Questionnaire

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