Published in final edited form as:

J Pediatr Health Care. 2017 ; 31(5): 536–545. doi:10.1016/j.pedhc.2017.01.004.

“I Didn’t Even Know You Cared About That Stuff:” Youths’ Perceptions of Healthcare Provider Roles in Addressing Bullying

Judith A. Vessey, PhD, MBA, RN, FAAN,

Lelia Holden Carroll Professor in Nursing, Boston College, William F. Connell School of Nursing, 140 Commonwealth Avenue, Chestnut Hill, MA 02467, vessey@bc.edu, Work: 617-552-8817, Mobile: 781-974-8513, Nurse Scientist, Boston Children’s Hospital, 300 Longwood Ave, Boston, MA 02114

Rachel L. DiFazio, PhD, RN, PPCNP-BC, FAAN, and

Nurse Scientist, Boston Children’s Hospital, Instructor, Harvard Medical School, 300 Longwood Avenue, Boston, MA 02114, Mobile: 617-240-8287

Tania D. Strout, PhD, RN, MS

Director of Research, Department of Emergency Medicine, Maine Medical Center, Associate Professor of Emergency Medicine, Tufts University School of Medicine, 22 Bramhall Street, Portland, ME 04102, Work: 207-662-7049

Abstract

Introduction—Youth bullying is a critical public health problem with those exposed to bullying at risk for development of serious sequelae lasting into adulthood. The purpose of this study was to explore youths’ perceptions regarding the role that advanced practice nurses and physicians play in addressing bullying.

Method—A qualitative descriptive approach was employed; focus groups were used to generate study data. Twenty-four adolescents participated in focus groups centered on exploring healthcare providers’ roles in addressing bullying.

Results—Three themes emerged through qualitative analysis: 1) *not sure that’s part of their job*, 2) *that’s way too personal*, and 3) *they couldn’t help anyway*. Participants described a very limited role for healthcare providers in addressing bullying.

Discussion—Youths recognized a narrow role for healthcare providers in addressing bullying, characterizing bullying as a school- or-community-related issue rather than one influencing health.

Correspondence to: Judith A. Vessey.

Publisher's Disclaimer: This is a PDF file of an unedited manuscript that has been accepted for publication. As a service to our customers we are providing this early version of the manuscript. The manuscript will undergo copyediting, typesetting, and review of the resulting proof before it is published in its final citable form. Please note that during the production process errors may be discovered which could affect the content, and all legal disclaimers that apply to the journal pertain.

Disclosures: All authors report no financial interests or potential conflicts of interest

IRB approval: Institutional Review Board approvals have been obtained from Boston College, Boston Children’s Hospital, and Maine Medical Center.

Keywords

youth bullying; focus groups; health screening; adolescent-provider communication; nurse practitioners; advanced practice nurses

Youth bullying is a critical public health problem affecting approximately 20–28% of all middle school youths each year (Centers for Disease Control, 2014). Youth bullying is defined as “... *any unwanted aggressive behavior(s) by another youth or group of youths who are not siblings or current dating partners that involves an observed or perceived power imbalance and is repeated multiple times or is highly likely to be repeated*” (Centers for Disease Control, 2014). Youths who have been victimized by bullies experience a full range of short- and long-term academic and psychological health problems (Card & Little, 2006; Cook, Williams, Guerra, Kim, Sadek, 2010; Hawker & Boulton, 2000; Hepburn, Azael, Molnar, & Miller, 2012; Kim & Leventhal, 2008; Nakamoto & Schwartz, 2010; Reijntjes, Kamphuis, Prinzie, & Telch, 2010; Reijntjes et al., 2011). Bullied youths also experience an increased number of common physical health ailments and significantly higher levels of psychosomatic symptomatology when compared to their non-bullied counterparts (Due et al., 2005; Fekkes, Pijpers, Fredriks, & Verloove-Vanhorick, 2006; Gini & Pozzoli, 2009). Moreover, being bullied in childhood contributes to poorer psychological and physical health outcomes throughout adulthood (Copeland, Wolke, Angold, & Costello, 2013; Copeland et al., 2014; Takizawa, Maughan, & Arseneault, 2014). Due to the seriousness of bullying sequelae, numerous federal and state legislative remedies and public policy initiatives have been introduced and *HealthyPeople 2020* Objective IVP-35: Reduce bullying among adolescents has targeted a 10% reduction, from 19.9 to 17.9 percent, in the incidence of bullying by 2020 (Healthy People, 2012). To date, the emphasis has been placed on school-based programming designed to deter bullying. These programs, however, have resulted in only modest improvements in the school climate and student attitudes with little reduction in the actual amount of bullying behavior that occurs (Lee, Kim, & Kim, 2013; Merrell, Gueldner, Ross, & Isava, 2008; Ttofi & Farrington, 2011).

Despite bullying's omnipresence and its impact on health, routine surveillance is rarely initiated. Advanced practice nurses and other healthcare providers are on the ‘front lines’ and should be key players in identifying and assisting victimized youths (Hendershot, Dake, Price, & Larty, 2006; Lyznicki, McCaffree, & Robinowitz, 2004; Vessey, DiFazio, & Strout, 2013). Successful preventive healthcare relies in part on the relationship that nurse practitioners, pediatricians, school nurses, and other healthcare providers have with youths (Brown & Wissow, 2009; Jacobson, Richardson, Parry-Langdon, & Donovan, 2001). The failure for youths and healthcare providers to engage in discussions around bullying is unfortunate and represents a significant missed opportunity for intervention. Although youths may seek care for psychosocial and physical complaints resulting from bullying, neither the patient nor provider may be aware that bullying could be the root cause to the distress the youth is experiencing.

This lack of awareness is more profound for youths with chronic conditions. They are often targeted by bullies while simultaneously interfacing with healthcare providers who could

assist them in handling the bullying issues that they encounter (Faith et al., 2015; Sentenac, Arnaud, Gavin, Gabhainn, & Godeau, 2012; Shiu, 2004). Selected ‘provider-side’ barriers to screening include a lack screening mandates and appropriate screening tools, limited encounter time, cultural differences, poor reimbursement for psychological intervention, and provider discomfort discussing sensitive topics and identifying treatment options (Brown & Wissow, 2009; Cabana et al., 1999; Kautz, Mach, & Smith, 2008; Sege, Hatmaker-Flanigan, De Vos, Levin-Goodman, & Spivak, 2006; Van Hook et al., 2007).

Little is known, however, regarding the views youths hold regarding healthcare providers’ roles in addressing bullying. This study which assessed youths’ views of bullying and their view of the role healthcare providers play in addressing it, was the first phase of a larger NIH-funded study, *Development of the CABS: Child-Adolescent Bullying Screen* (R21HD083988). The purpose of the overall study is to develop a brief youth bullying screening tool for widespread use by healthcare providers during primary care and other visits (e.g., emergency department, chronic illness clinics, sports physicals, etc.) that provide screening opportunities.

Methods

Study Design

This study was conducted using a qualitative descriptive approach (Sandelowski, 2000). A focus group strategy was employed to gain a comprehensive description of youths’ perceptions of the roles that healthcare providers should play in addressing youth bullying. As bullying occurs within a social context, the focus group methodology was determined to be well-aligned with exploring this phenomenon and has previously been shown to be highly effective for this purpose (Horowitz, et al., 2004; Krueger & Casey, 2009). The study was approved by Institutional Review Boards at Boston College, Boston Children’s Hospital, and Maine Medical Center.

Study Setting and Recruitment

Purposive sampling was used in order to select participants who could provide in-depth information about the phenomenon of interest. Youths in middle or junior high school from diverse racial, ethnic, socio-economic, and geographic backgrounds were recruited from two states through fliers posted in the clinic areas, announcements on the hospital web page, or nomination by clinic staff.

For youths expressing interest in participating in the focus groups via telephone or email, eligibility initially was confirmed through a telephone discussion with their parent(s). Inclusion criteria required that the youths were between 10–16 years of age, fluent in spoken English, willing to share their expertise and experiences in a focus group, and had participated in school or community bullying prevention educational programs. Youths with significant cognitive or behavioral impairments resulting in disabling language comprehension or expressive problems as determined through the parental interview (e.g., use of Individualized Educational Plans, parental report, etc.) were excluded as they would

be unable to participate in group focus group activities. Data were collected September through November, 2015.

Study Measures

Two measures, a demographic form and moderator guide, were used during the study. The investigator-created demographic form collected key information about the study participants. The moderator guide was developed based upon group process principles and the study's purpose and objectives (Stewart & Shamdasani, 2014). Semi-structured interview questions and probes were designed in accordance with the study's overall aims, information culled from published multidisciplinary research findings, and informed by bullying theory and expert clinical opinion. Example questions can be found in Table 1.

Data Collection

An evidence-based approach for conducting successful youth focus groups on health-related topics was used in the focus group design (Horowitz et al., 2003; Morgan, Gibbs, Maxwell, & Britten, 2002). The groups, 1-½ hours in length, took place in private conference rooms within regional healthcare facilities. Prior to the start of the focus group, parental consent and child assent were obtained. The participants were then asked to complete the demographic form, were provided with snacks, and engaged in facilitated informal conversation. The focus groups were led by experienced moderators and were conducted in a semi-structured manner as this approach allowed for the collection of data from both individuals and the individual as part of a larger group. The moderator initially began by introducing herself and the recorder and by orienting the participants to the group's purpose and ground rules. Participants' introductions followed. Participants were told that they did not have to answer any questions with which they were uncomfortable. Members of the research team served as recorders who audiotaped the sessions and took field notes.

During the focus groups, questions were explained, elaborated, redirected, and introduced as necessary to encourage dialogue while addressing the concepts of interest. Open-ended questions for each of the major constructs initially were explored, moving from concrete to more abstract constructs. Follow-up probes were used to clarify or gain additional information on topic areas that emerged from the initial responses to the open-ended questions. After participants had an opportunity to offer their personal views, the moderator shifted to a more directive style of questioning by asking participants what they thought about specific topics. Congruent with focus group methodology, no push towards ensuring conformity or consensus was made since the aim was to derive as comprehensive picture of the participants' views as possible and to ensure that there was opportunity for contrary opinions to arise (Krueger & Casey, 2009). As described below, data analysis began as soon as the first focus group transcript was available and additional focus groups were held until saturation was reached and no new categories emerged from the data.

Analytic Procedures

Descriptive statistics were used to describe the characteristics of the study population. For the qualitative analysis, focus group audiotapes were transcribed verbatim at the conclusion of each session by a professional CITI-certified transcriptionist. The accuracy of the

transcription was ensured by having the moderator and recorder listen to the tape and compare it to the transcript text. The transcripts were entered into Hyper-RESEARCH 3.03, a qualitative software computer program, to facilitate the analysis. Field notes about the environment, and participant observation, context, and tone were added to facilitate interpretation.

The primary data analytic technique employed was conventional qualitative content analysis (Krippendorff, 2013). To be consistent with an inductive approach to generate codes, the initial goal was to extract those verbatim text statements that could help explain the youths' views of bullying and their healthcare providers' role in addressing it. There were no preconceived codes, but the data analysis was guided by the research purpose.

Three members of the research team, working independently, read each of the transcripts in its entirety in order to obtain a general sense of the participants' perceptions of their nurse practitioner's or physician's role in assessing bullying. They then re-read the transcripts word-by-word and line-by-line analysis was conducted. In vivo codes, consisting of significant words, phrases, and statements, were identified and similar codes were clustered together into categories.

Following first level coding, the referential adequacy of the findings was determined. This was done by having the research team members compare their preliminary codes against the raw data. In keeping with content analysis processes, the groups and topics were reviewed multiple times by the research team to identify key themes existing within and across the focus groups. Areas of disagreement were resolved through discussion, further transcript review, and through consultation with focus group participants. Lastly, coding redundancies were removed. A final set of themes was identified through the process of constant comparison.

An iterative, deductive, analytic process then was used to aid in data interpretation while fully illuminating the emergent themes (Sandelowski, 2000). First, categories were developed from codes; broader themes then were developed from the categories capturing the essence of youths' perceptions of their healthcare providers' role in addressing bullying (DeSantis & Ugarriza, 2000). Care was taken to ensure that the new categories and themes described related, but differing, phenomena at each level of abstraction (Guba & Lincoln, 1985). At each stage of the process, the team discussed discrepancies in coding and conducted further transcript review to reach consensus. Data analysis was completed when no further information emerged from the transcripts.

Maintenance of Rigor

Strategies to maintain rigor were used throughout the study. Rigor in qualitative research is evaluated by credibility, fittingness, and auditability (Morse, Barrett, Mayan, Olson, & Spiers, 2002; Sandelowski, 1986). During the focus groups, the moderator attempted to make the participants feel comfortable in order to ensure that the participants spoke freely about their experiences. The emergence of data was driven by the participants; this was achieved by allowing participants to express what was important to them rather than leading them with notions of what the study investigators assumed would be important. To ensure

credibility in this study, selected focus group participants reviewed the findings and verified that they represented their thoughts, feelings, and statements. They validated that youths who experienced bullying would immediately recognize the information that was been reported. Purposive sampling, where the participants were representative of youths at risk for bullying exposure, helped to ensure that the findings would be seen as meaningful to the audience or readers (fittingness). For example, participants were selected from the middle through high school age group, where youth bullying is known to peak. In addition, flyers were placed in settings known to include a diverse range of socioeconomic statuses, racial and ethnic backgrounds. Auditability was achieved by having the research team ensure the accuracy of the focus group transcripts, keep clear notes, and track all of the decisions regarding data analysis so that others could replicate the study and arrive at the same conclusion based on the original data and decision trail.

Results

Three focus groups of middle school students from diverse communities across New England provided the initial data. Groups ranged in size from seven to eight participants. A fourth group of two hospitalized youths with ongoing chronic health conditions was added to reach data saturation. The study period was September–November, 2015. The participants (N=24) ranged in age from 12 to 16 years with a mean of 12.3 years. Participants were 22.7% male; 63.6% white, 13.6% African-American/black, 18.2% Asian/Pacific Islander, and 4.5% of more than one race; and 22.7% were of Hispanic ethnicity. The median income of the participants' communities ranged from \$28,000 to \$131,000 with a median of \$75,640 (U.S. Census Bureau, n.d.).

Themes

Three primary themes emerged from the data that addressed healthcare providers' role in addressing bullying: 1) *not sure that's part of their job*, 2) *that's way too personal*, and 3) *they couldn't help anyway*. Exemplar codes, categories and themes are provided in Table 2.

Theme 1: Not sure that's part of their job—When asked, “(w)ho would you seek help from if you or a friend were bullied?” the participants were quick to identify friends, school counselors, older siblings, and parents as individuals that they felt would be empathetic and knowledgeable. When specifically probed to whether they would seek help from their nurse practitioner or pediatrician, the participants were visibly flummoxed. They noted that their healthcare provider often made general conversation about school but did not specifically ask about bullying, as noted in this quote: “Like my doctor goes ‘how’s school?’ and I’m like ‘good’ and she doesn’t get that personal like are you getting bullied.” They clearly had not considered the possibility that healthcare providers had a substantive role in addressing bullying. More commonly youths viewed bullying as a school and community issue rather than a healthcare concern. After giving the idea some thought, the following response captured the participants’ shared views:

I don’t even think it’s like a question that people think to bring up to their doctors because people think doctors are for more like mental illness and physical illnesses. They don’t think of it as a help for that type of thing.

The participants did endorse healthcare providers' role as helping with 'mental illness' and were quick to identify bullying's psychosocial sequelae – including fear, sadness, depression, self-harm, and school avoidance — but they did not classify these outcomes as mental health concerns. The participants only saw their healthcare provider as having a primary role if bullying sequelae rose to the level of suicide ideation as noted by this quote: "I think that if you're getting to the point in bullying that you're trying to hurt yourself or commit suicide."

Theme 2: That's way too personal—Youths were queried about what would make them more or less comfortable in talking about bullying with their nurse practitioner or physician. The lack of a patient-provider relationship was the first identified barrier as noted by this quote: "Some kids don't feel okay talking to their doctors because they don't know them personally because it (bullying) is like outside of the doctor's office you don't see them...". The second concern was that they would be made to feel uncomfortable as noted by this quote: "... like maybe if your stress was up or something. I don't think that a lot of kids feel comfortable talking to their doctor about that." Study participants clearly endorsed the notion that an indirect approach for initiating the conversation should be used. One participant stated, "If it was like casual.... you didn't go there just to talk about bullying and stuff like that." Another added, "I think maybe if it was on paper or not physically just talking to them. I think it makes it uncomfortable because you might not know what to say."

The use of technology, such as an electronic tablet, also was endorsed by the participants. They supported the idea that an electronic screening tool could be completed at a health visit and that this modality might afford more privacy than a paper version or direct questioning by a provider.

The role parents play in mediating healthcare encounters between youths and providers was viewed as both positively and negatively. While many youths stated that they were comfortable talking about sensitive topics with their parents in attendance, others expressed significant reluctance and had concerns about provider-patient confidentiality as noted by these quotes: "I don't know how many kids are actually going to answer those questions (about bullying)...because doctors can tell your parents ... if something is happening like bullying, they're probably going to tell your parents" and "I'd rather talk to the doctor first (without parents present)."

Theme 3: They couldn't help anyway—Lastly, youths were concerned that even if they discussed bullying with their healthcare provider, that the provider would not be in a position to help. "Second, they perceived healthcare providers' roles as primarily limited to assisting in the case of physical injury such as noted by this quote: "...if they are getting physically bullied they may help you." Second, youths viewed bullying as a school- or community-related issue as noted by the quote: "...but I don't know how much say they would have, if it's connected to school or where ever else you may go."

Lastly, they doubted that providers had the necessary compendium of resources to offer meaningful help, as noted in the quote below:

I think that you know that if something's going to be done, it makes you feel more comfortable that you know that what you're doing is going to be successful. Like if you just talk to someone and they're not going to do anything about it, it doesn't really matter.

Discussion

The three themes that emerged from this study: 1) *not sure that's part of their job*, 2) *that's way too personal*, and 3) *they couldn't help anyway* provide a deeper insight into the understanding of youths' perceptions of their healthcare providers' roles in addressing bullying.

The idea that youths have a limited view of their healthcare providers' role in preventive health care is concerning. The first focus groups were comprised of essentially healthy youths who likely had limited interface with their providers, however a fourth group was convened of youths with significant healthcare needs who had had extensive contact with their primary care and specialty providers. Regardless of group, the participants indicated that during primary care visits, neither they nor their nurse practitioners nor physicians routinely brought up bullying, with conversation limited to the general quality of their school life. Nor did the youths indicate that other healthcare care providers, such as school nurses, emergency department personnel, or specialty care providers, initiate conversations about bullying. None of the youths saw this as a deficit in care; they just did not view bullying as a topic that was within their providers' scope of practice but rather something that was the school's purview.

It is interesting to note that the study participants did see a role for healthcare providers if bullying reached the level of suicide ideation. One participant had experienced a bullied peer who attempted suicide. For others, suicide ideation likely arose to the level of a mental health problem that their nurse practitioners or physicians could address. Another although unconfirmed explanation is that youth views on suicide/suicide ideation have been shaped from healthcare providers implementing screening for depression and suicidal ideation secondary to the 2007 American Academy of Pediatrics recommendations (Shain, 2007) and the 2016 Joint Commission's Sentinel alert (Joint Commission, 2011).

There is little research on the quality of adolescent-healthcare provider relationships. The results of one landmark study reported by Brown and Wissow (2009), however, demonstrate that when sensitive topics are explored in primary care visits, adolescents had a more positive and robust view of the visit. These findings were independent of the characteristics of the participant population. Youths can be helped to gain a fuller appreciation of the role their nurse practitioners and other healthcare providers can play in assisting them to address situations that lead to stress, psychological, and physical problems. Prior research indicates that adolescents are more comfortable talking about sensitive topics during primary care visits when they are primed to do so in advance, when providers facilitate an active dialogue designed to elicit adolescent disclosure of personal concerns, when there is adequate time during the visit for this to occur, and when an appropriate level of confidentiality is ensured (Boekeloo, Bobbin, Lee, Worrell, Hamburger, & Russek-Cohen, 2003; Carlisle, Shickle,

Cork, & McDonagh, 2006; Jacobson, Richardson, Parry-Langdon, & Donovan, 2001). Youths who frequently seek healthcare at school or specialty clinics often benefit from a long-term trusting relationships with the staff; such visits provide an excellent opportunity for healthcare providers to initiate discussions around bullying.

Youths' willingness or reluctance to be open about sensitive topics with their healthcare providers is highly influenced by their degree of trust and knowing, *a priori*, what pieces of information, and how selected information, would be disclosed to parents. This is a realistic concern as parents unanimously wish to be informed about any health issue their adolescent may have (Carlisle et al., 2006). Youths will often forego care or avoid discussing sensitive topics if they include illegal behavior (e.g., drug and alcohol use; texting while driving); are in conflict with familial cultural norms (sexual activity; gender identity); or are associated with societal stigma (e.g., serious mental health disorders) (Akinbami, Gandhi, & Cheng, 2003; Carlisle et al., 2006; Lehrer, Pantell, Tebb, & Shafer, 2007). Bullying fits none of these categories, especially as the youths in this study did not view the consequences of bullying as rising to the level of a significant mental health problem worthy of their providers' attention. This is congruent with teens' general views on common adolescent mental health issues (Coles & Coleman, 2010). For some youths, a breach of confidentiality would require them to contend with their parents' responses to bullying. This is a legitimate concern as parents' responses are often uninformed, ineffective, and potentially can aggravate the situation (Sawyer, Mishna, Pepler, & Wiener, 2011).

Recent Pew estimates suggest that at least 93% of youths 12–17 years of age are regularly online (Lenhart, Ling, Campbell, & Purcell, 2010) and while adolescent internet use can present dangers, it also provides an opportunity for screening and health-related education activities (Kachur et al., 2013; Olson, Gaffney, Hedberg, & Gladstone, 2009; Lord & Marsch, 2011). Across demographic and socioeconomic profiles, youths participating in this study were comfortable with the notion of completing an online bullying screen and even felt that this would afford additional confidentiality over other forms of screening. This is consistent with prior research indicating that adolescents are comfortable with electronic screening, even when used for sensitive topics such as sexually transmitted infection screening (Goyal, Teach, Badolato, Trent, & Chamberlain, 2016) and assessment of risky behaviors (Chisolm, Gardner, Julian, & Kelleher, 2008). Given the widespread use of both general technology and electronic health records, future screening tools would likely be more readily adopted by both patients and providers in an electronic form.

Unfortunately, it was not surprising that youths do not immediately view bullying as a critical issue for healthcare providers to address. Despite calls in the professional literature declaring youth bullying a professional responsibility for over a decade (Lyznicki et al., 2004; Storch & Ledley, 2005; Spector & Kelly, 2006), there are currently no explicit preventive health care recommendations specific to bullying screening and intervention by pediatric healthcare organizations (Committee on Practice & Ambulatory Medicine, 2014; Committee on Injury, Violence, and Poison Prevention, 2009; NAPNAP, 2013; Vessey et al., 2013). The incorporation of explicit information pertaining to bullying into professional position statements and practice standards is needed. While adolescents are well aware that bullying is harmful, those participating in this study believed the role of their nurse

practitioners and physicians in addressing bullying to be very limited. Expanding the paradigm for nurse practitioners and other providers to include anticipatory guidance, prevention strategies, and screening specific to bullying will help insure that more comprehensive mental health care is provided. Moreover, when such developmentally appropriate strategies are routinely incorporated into primary care, youths will more readily recognize that healthcare practitioners can be valuable allies in addressing bullying.

Conclusions

It is vitally important that the perceptions of the youths for whom we care are assessed and addressed if contextually meaningful preventive healthcare is to be provided. The issues identified during these focus groups underscore that youths see little room for involvement of advanced practice nurses and other healthcare providers for health concerns not perceived as directly related to their general well-being. Evidence-based strategies to help both adolescents and providers develop more robust expectations around collaboration during preventive healthcare, including discussion of sensitive topics, is needed. In addition, the information shared provides the necessary groundwork needed to create a nexus of formalized screening and intervention strategies appropriate for routine use in primary care settings. The identification and implementation of such strategies will help improve adolescent well-being while mitigating the short- and long-term sequelae that often result from bullying.

References

- Akinbami LJ, Gandhi H, Cheng TL. Availability of adolescent health services and confidentiality in primary care practices. *Pediatrics*. 2003; 111(2):394–401. [PubMed: 12563069]
- Boekeloo BO, Bobbin MP, Lee WI, Worrell KD, Hamburger EK, Russek-Cohen E. Effect of patient priming and primary care provider prompting on adolescent-provider communication about alcohol. *Archives of Pediatrics & Adolescent Medicine*. 2003; 157(5):433–439. [PubMed: 12742878]
- Brown JD, Wissow LS. Discussion of sensitive health topics with youth during primary care visits: Relationship to youth perceptions of care. *Journal of Adolescent Health*. 2009; 44:48–54. [PubMed: 19101458]
- Cabana MD, Rand CS, Powe NR, Wu AW, Wilson MH, Abboud PAC, Rubin HR. Why don't physicians follow clinical practice guidelines?: A framework for improvement. *JAMA*. 1999; 282(15):1458–1465. [PubMed: 10535437]
- Card NA, Little TD. Proactive and reactive aggression in childhood and adolescence: A meta-analysis of differential relations with psychosocial adjustment. *International Journal of Behavioral Development*. 2006; 30:466–480.
- Carlisle J, Shickle D, Cork M, McDonagh A. Concerns over confidentiality may deter adolescents from consulting their doctors. A qualitative exploration. *Journal of Medical Ethics*. 2006; 32(3): 133–137. [PubMed: 16507655]
- Centers for Disease Control and Prevention & U.S. Department of Education. Bullying surveillance among youths: Uniform definitions for public health and recommended data elements. 2014. Retrieved from: <http://www.cdc.gov/violenceprevention/pdf/bullying-definitions-final-a.pdf>
- Chisolm DJ, Gardner W, Julian T, Kelleher KJ. Adolescent satisfaction with computer-assisted behavioral risk screening in primary care. *Child and Adolescent Mental Health*. 2008; 13(4):163–168. [PubMed: 19779573]
- Coles ME, Coleman SL. Barriers to treatment seeking for anxiety disorders: initial data on the role of mental health literacy. *Depression and Anxiety*. 2010; 27(1):63–71. [PubMed: 19960488]

- Committee on Injury, Violence, and Poison Prevention. Role of the pediatrician in youth violence prevention. *Pediatrics*. 2009; 124:398–402.
- Committee on Practice and Ambulatory Medicine and Bright Futures Periodicity Schedule Workgroup. Recommendations for preventive pediatric health care. *Pediatrics*. 2016; 137:1–3.
- Cook CR, Williams KR, Guerra NG, Kim TE, Sadek S. Predictors of bullying and victimization in childhood and adolescence: A meta-analytic investigation. *School Psychology Quarterly*. 2010; 25:65–83.
- Copeland WE, Wolke D, Angold A, Costello J. Adult psychiatric outcomes of bullying and being bullied by peers in childhood and Adolescence. *JAMA Psychiatry*. 2013; 70:419–426. [PubMed: 23426798]
- Copeland WE, Wolke D, Lereya T, Shanahan L, Worthman C, Costello EJ. Childhood bullying involvement predicts low-grade systemic inflammation into adulthood. *Proceedings of the National Academy of Sciences*. 2014 epub ahead of print.
- DeSantis L, Ugarriza D. The concept of theme as used in qualitative nursing research. *Western Journal of Nursing Research*. 2000; 22:356–372.
- Due P, Holstein BE, Lynch J, Diderichsen F, Gabhain sN, Scheidt P. The Health Behaviour in School-aged Children Bullying Working Group. Bullying and symptoms among school-aged children: international comparative cross-sectional study in 28 countries. *European Journal of Public Health*. 2005; 15:128–132. [PubMed: 15755782]
- Faith MA, Reed G, Heppner CE, Hamil LC, Tarkenton TR, Donewar CW. Bullying in medically fragile youth: a review of risks, protective factors, and recommendations for medical providers. *Journal of Developmental and Behavioral Pediatrics*. 2015; 36:285–301. [PubMed: 25923529]
- Fekkes M, Pijpers FIM, Fredriks AM, Verloove-Vanhorick SP. Do bullied children get ill, or do ill children get bullied? A prospective cohort study on the relationship between bullying and health-related symptoms. *Pediatrics*. 2006; 117:1568–1574. [PubMed: 16651310]
- Gini G, Pozzoli T. Association between bullying and psychosomatic problems: A meta-analysis. *Pediatrics*. 2009; 123:1059–1065. [PubMed: 19255040]
- Goyal MK, Teach SJ, Badolato GM, Trent M, Chamberlain JM. Universal screening for sexually transmitted infections among asymptomatic adolescents in an urban emergency department: high acceptance but low prevalence of infection. *Journal of Adolescent Health*. 2016; 58:S86–S118.
- Guba, E., Lincoln, Y. *Naturalistic inquiry*. 1st. Beverly Hills, CA: Sage Publications; 1985.
- Hawker SJ, Boulton MJ. Twenty years research on peer victimization and psychosocial maladjustment: A meta-analytic review of cross-sectional studies. *Journal of Child Psychology and Psychiatry*. 2000; 41:441–455. [PubMed: 10836674]
- Healthy People 2020. 2012 Aug 29. Violence and injury prevention. Retrieved from <http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=24>
- Hendershot C, Dake JA, Price JH, Lartey GK. Elementary school nurses' perceptions of student bullying. *The Journal of School Nursing*. 2006; 22:229–236. [PubMed: 16856778]
- Hepburn L, Azael D, Molnar B, Miller MA. Bullying and suicidal behaviors among urban high school youth. *Journal of Adolescent Health*. 2012; 51:93–95. [PubMed: 22727083]
- Horowitz JA, Vessey JA, Carlson KL, Bradley JF, Montoya C, McCullough B. Conducting school-based focus groups: Lessons learned from the CATS project. *Journal of Pediatric Nursing*. 2003; 18(5):321–331. doi: [http://dx.doi.org/10.1016/S0882-5963\(03\)00104-0](http://dx.doi.org/10.1016/S0882-5963(03)00104-0). [PubMed: 14569580]
- Horowitz JA, Vessey JA, Carlson KL, Bradley JF, Montoya C, McCullough B, David J. Teasing and bullying experiences of middle school students. *Journal of the American Psychiatric Nurses Association*. 2004; 10:165–172.
- Jacobson L, Richardson G, Parry-Langdon N, Donovan C. How do teenagers and primary healthcare providers view each other? An overview of key themes. *British Journal of General Practice*. 2001; 51:811–816. [PubMed: 11677704]
- Joint Commission. Detecting and treating suicide ideation in all settings. Sentinel Event Alert [serial on the Internet]. Oak Brook (IL): Joint Commission. 2016. Retrieved from: https://www.jointcommission.org/assets/1/18/SEA_56_Suicide.pdf

- Kachur, R., Mesnick, J., Liddon, N., Kapsimalis, C., Habel, M., David-Ferdon, C., Schindelar, J. Adolescents, technology and reducing risk for HIV, STDs and pregnancy. Atlanta, GA: Centers for Disease Control and Prevention; 2013.
- Kautz, C., Mach, D., Smith, SA. Reimbursement of mental health services in primary care settings (HHS Pub. No. SMA-08-4324). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration; 2008.
- Kim YS, Leventhal B. Bullying and suicide. A review. *International Journal of Adolescent Medicine and Health*. 2008; 20:133–154. [PubMed: 18714552]
- Krippendorff, K. Content analysis: An introduction to its methodology. 3rd. Thousand Oaks, CA: Sage; 2013.
- Krueger, RA., Casey, MA. Focus groups: A practical guide for applied research. 4th. Thousand Oaks, CA: Sage; 2009.
- Lee S, Kim CJ, Kim DH. A meta-analysis of the effect of school-based anti-bullying programs. *Journal of Child Health Care*. 2013 Epub ahead of print.
- Lehrer JA, Pantell R, Tebb K, Shafer MA. Forgone health care among US adolescents: associations between risk characteristics and confidentiality concern. *Journal of Adolescent Health*. 2007; 40:218–226. [PubMed: 17321421]
- Lenhart, A., Ling, R., Campbell, S., Purcell, K. Teens and mobile phones. Washington, DC: Pew Internet & American Life Project; 2010.
- Lord S, Marsch L. Emerging trends and innovations in the identification and management of drug use among adolescents and young adults. *Adolescent Medicine: State of the Art Reviews*. 2011; 22(3) 649–xiv.
- Lyznicki JM, McCaffree MA, Robinowitz CB. Childhood bullying: Implications for physicians. *American Family Physician*. 2004; 70:1723–1728. [PubMed: 15554490]
- Merrell KW, Gueldner BA, Ross SW, Isava DM. How effective are school bullying intervention programs? A meta-analysis of intervention research. *School Psychology Quarterly*. 2008; 23:26–42.
- Morgan M, Gibbs S, Maxwell K, Britten N. Hearing children's voices: methodological issues in conducting focus groups with children aged 7–11 years. *Qualitative Research*. 2002; 2:5–20.
- Morse JM, Barrett M, Mayan M, Olson K, Spiers J. Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods*. 2002; 1(2):13–22. Retrieved from: <https://ejournals.library.ualberta.ca/index.php/IJQM/article/viewArticle/4603>.
- Nakamoto J, Schwartz D. Is peer victimization associated with academic achievement? A meta-analytic review. *Social Development*. 2009; 19:221–242.
- NAPNAP. NAPNAP Position Statement on the Integration of Mental Health Care in Pediatric Primary Care Settings. 2013 Jul-Aug. Retrieved from: [http://www.jpeds.org/article/S0891-5245\(13\)00078-3/pdf](http://www.jpeds.org/article/S0891-5245(13)00078-3/pdf)
- Olson AL, Gaffney CA, Hedberg VA, Gladstone GR. Use of inexpensive technology to enhance adolescent health screening and counseling. *Archives of Pediatric and Adolescent Medicine*. 2009; 163(2):172–177.
- Reijntjes A, Kamphuis JH, Prinzie P, Telch MJ. Peer victimization and internalizing problems in children: A meta-analysis of longitudinal studies. *Child Abuse and Neglect*. 2010; 34:244–252. [PubMed: 20304490]
- Reijntjes A, Kamphuis JH, Prinzie P, Boelen PA, van der Schoot M, Telch MJ. Prospective linkages between peer victimization and externalizing problems in children: A meta-analysis. *Aggressive Behavior*. 2011; 37:215–222. [PubMed: 21433031]
- Sandelowski M. The problem of rigor in qualitative research. *Advances in Nursing Science*. 1986; 8(3):27–37. [PubMed: 3083765]
- Sandelowski M. Focus on research methods, whatever happened to qualitative description? *Research in Nursing & Health*. 2000; 23:334–340. [PubMed: 10940958]
- Sawyer JL, Mishna F, Pepler D, Wiener J. The missing voice: Parents' perspectives of bullying. *Children and Youth Services Review*. 2011; 33(10):1795–1803.

- Sege RD, Hatmaker-Flanigan E, De Vos E, Levin-Goodman R, Spivak H. Anticipatory guidance and violence prevention: results from family and pediatrician focus groups. *Pediatrics*. 2006; 117:455–463. [PubMed: 16452366]
- Sentenac M, Arnaud C, Gavin A, Gabhainn SN, Godeau E. Peer victimization among school-aged children with chronic conditions. *Epidemiologic Review*. 2012; 34:120–128.
- Shain BN. Suicide and suicide attempts in adolescents. *Pediatrics*. 2007; 120(3):669–676. [PubMed: 17766542]
- Shiu S. Positive interventions for children with chronic illness: Parents' and teachers' concerns and recommendations. *Journal of Education*. 2004:48. Retrieved from: <http://www.freepatentsonline.com/article/Australian-Journal-Education/124791655.html>.
- Spector ND, Kelly SF. Pediatrician's role in screening and treatment: bullying, prediabetes, oral health. *Current Opinion in Pediatrics*. 2006; 18:661–70. [PubMed: 17099367]
- Stewart, DW., Shamdasani, PN. Focus groups: Theory and practice. Newbury Park, CA: Sage; 2014.
- Storch EA, Ledley DR. Peer victimization and psychosocial adjustment in children: Current knowledge and future directions. *Clinical Pediatrics*. 2005; 44:29–38. [PubMed: 15678228]
- Takizawa R, Maughan B, Arseneault L. Adult health outcomes of childhood bullying victimization: Evidence from a five-decade longitudinal British birth cohort. *American Journal of Psychiatry*. 2014 epub ahead of print.
- Ttofi MM, Farrington DP. Effectiveness of school-based programs to reduce bullying: A systematic and meta-analytic review. *Journal of Experimental Criminology*. 2011; 7:27–56.
- Van Hook S, Harris SK, Brooks T, Carey P, Kossack R, Kulig J. New England Partnership for Substance Abuse Research. The “Six T’s”: barriers to screening teens for substance abuse in primary care. *Journal of Adolescent Health*. 2007; 40(5):456–461. [PubMed: 17448404]
- Vessey JA, DiFazio RL, Strout TD. “Names can also hurt me.” Youth bullying: A review of the science and call to action. *Nursing Outlook*. 2013; 61:347–345.
- U.S. Census Bureau. American Fact Finder. (n.d.). Retrieved from: <http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml#>
- U.S. Preventive Services Task Force. Guide to Clinical Preventive Services, 2012: Recommendations of the U.S. Preventive Services Task Force. Agency for Healthcare Research and Quality, Rockville, MD. 2011 Oct. Retrieved from: <http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/guide/index.html>

Table 1

Semi-structured Interview Questions on the Detection and Handling of Bullying

QUESTIONS ABOUT BULLYING*Can you tell me what you think bullying is?**Describe a situation you remember when another kid was bullied. What was that like? What happened?**What kinds of things do kids get bullied about?*

- Probe: Kids bullied about a lot of things. Can you think of a time recently when it happened? What kinds of things do kids get bullied about?

How do you know when bullying is taking place:

- Probe: How is it different from teasing: Or kids just 'acting stupid' with each other?

HANDLING BULLYING*If you or a friend was being bullied, how would you handle it?**Who would you seek help from?*

- Probe: Your parents? A school teacher, school nurse, guidance counselor, resource officer or coach? Someone from your church, synagogue, mosque? Another adult?

How would you feel if your doctor or nurse asked you about bullying when you went for care?

- Probes:
 - Would you bring it up by yourself?
 - Would you want your doctor or nurse practitioner to bring it up?

What would make you more—or less—comfortable in talking with your doctor or nurse practitioner about bullying?

- Probes:
 - How well you know your doctor or nurse practitioner?
 - If you knew what you said was going to be private?
 - If you knew something was going to be done?
 - If your parents were there?

SUMMARY QUESTION*We want to understand as much about bullying as we can. Are there other things that kids get bullied about that we have not talked about?*

Table 2**Youths' Perceptions of Healthcare Providers' Role in Addressing Bullying**

Code Exemplars	Categories	Themes
Bullying seen as a school issue The topic not brought up by youths or providers Not a topic appropriate for acute care or chronic care visits	Not a topic for discussion	"Not sure that is part of their job"
Seek care for physical health problems Did not see psychosocial sequelae (anxiety, depression) as mental health issues Only would seek provider help for suicide	Healthcare providers' role limited to mental & physical health concerns	
Only saw the provider annually Specialty providers only interested in treating the illness Feeling uninformed, many questions	Lack of patient-provider relationship	"That's way too personal"
Introduce topic of bullying casually Complete a form or use an app about bullying while waiting	Uncomfortable discussing topic	
Many parents viewed as 'best friends' Concerned parents would read what they are writing Did not think providers would keep conversation confidential	Lack of confidentiality	
Codes	Categories	Themes
Bullying happens at school Cyberbullying	Bullying seen as a school or community issue	"They couldn't help anyway"
Just can listen Not going to do anything about it	No compendium of useful resources	