

Virtual Mentor

American Medical Association Journal of Ethics
February 2009, Volume 11, Number 2: 173-177.

OP-ED

Be Aware of Bullying: A Critical Public Health Responsibility

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Health professionals have a responsibility to become informed and raise community awareness about the nature of bullying and its link to serious health risks. The term “bullying” refers to a group of aggressive behaviors to which one person is exposed repeatedly and over time by one or more others. Bullying encompasses physical aggression (hitting, pushing, punching, or kicking); verbal harassment (threatening, teasing, name calling, or making faces or dirty gestures); and indirect or relational mistreatment (ignoring someone or excluding him or her on purpose). Daring a person to perform a dangerous, illegal, or inappropriate action under the threat of losing approval among the members of a group is also considered a form of bullying. What is understood as bullying varies according to human developmental stages and cultures.

Many people may have experienced or witnessed bullying behaviors during childhood and adolescence that were then regarded as part of growing up or a rite of passage. Today, published evidence supports the view that bullying is a very toxic form of abuse prevalent across the lifespan on a global scale. It occurs not only in schools, but over the Internet and cellular phones, in the neighborhood, at summer camp, at home between siblings, as hazing among young adults in colleges or the armed forces, and in the workplace. During the last 2 decades, bullying episodes have been linked to hundreds of deaths due to suicide, accidental injuries, and homicide.

Adolescents who are bullied and those who bully others are often subject to other serious health, safety, and educational risks including emotional and physical symptoms; eating disorders; self-inflicted, accidental, and perpetrated injuries; abusing over-the-counter medication; hurting people on purpose; and frequent absenteeism. Bullying at the workplace has been linked to cardiovascular disease, fibromyalgia, depression, and posttraumatic stress disorder. The development of social phobia among adults has been shown to be associated with teasing or bullying during childhood.

Recently published longitudinal studies have established that psychiatric symptoms and conditions can be antecedents and consequences of bullying. Furthermore, young males who have been frequent bullies and bully victims are at high risk for future criminality.

The death of Megan Meier prompted attention toward a new version of bullying: cyber-bullying—acting cruelly to others by sending or posting harmful material using the Internet or a cellular phone. In October 2006, Meier, a teenager in Missouri, committed suicide after receiving messages on her MySpace web page that could be classified as bullying. Cyber-bullying differs from the more traditional forms in that it can occur at any time, its messages and images can be distributed instantaneously to a wide audience, and perpetrators can remain anonymous, often making them difficult to trace.

Bullying is a multifaceted form of maltreatment derived from complex biopsychosocial and cultural precursors. Health professionals can contribute to a community awareness of bullying and its prevention. A step in this direction is implementation of programs to improve the environmental emotional safety of schools and adult workplaces through strategies that enhance peer support, mutual respect, and a zero tolerance for bullying. Such a primary prevention approach, however, will be insufficient to avert the occurrence of bullying episodes, which may require further school or workplace intervention and referral for treatment.

Health professionals have the unique opportunity to detect occurrences of bullying in every emergency or routine medical visit by ascertaining whether a patient participates in this type of maltreatment as a perpetrator or victim. A positive detection should lead to a referral for an organizational (school or workplace) intervention to prevent the occurrence of further incidents (secondary prevention). At this time, the perpetrator should be made aware of the harm inflicted on the victim, leading to “restorative justice” through an apology. The guidance given to the bully should promote respect, empathy, tolerance, and sensitivity to diversity. At the same time, the victim should be supported and protected from retaliation and further episodes of bullying. Penalties such as suspensions, expulsions, or protective orders should not be thought of as punishments or deterrents to bullying, but as means of protecting the victims by temporarily separating the bully from his or her peers. Reporting of bullying incidents should be encouraged as a public health tool that leads to organizational intervention. This entails a change in the cultural belief that reporting is a means to get the perpetrator in trouble.

Both victims and bullies should be screened to identify health, emotional, or academic risks associated with their involvement in the bullying incident. Mental health treatment should be considered for those who are unable to stop bullying in spite of organizational intervention and for those (bullies or victims) who are suffering from health or safety problems. Treatment should address the medical or psychiatric conditions that precede or result from bullying. Ongoing monitoring should be in place to rule out suicidal or homicidal ideation or plans. Finally, it is important to document the recurrence of bullying episodes or exposure to new types of victimization.

As we become aware of the toxicity of bullying, we face the possible recognition of our own participation in these behaviors as a victim or perpetrator during childhood

or adolescence. Bullying can exist in the hospital milieu, among medical students, physicians, and nurses. In a social and cultural framework that tends to divide the world between good and malicious, we may neglect the serious health and safety risks affecting those who are perpetrators and those who are both bullies and victims. Our training as health practitioners and our anamnestic methodology in searching for etiology may prompt us to ask the victim why he or she thinks the bully picked on him or her (e.g., something about his or her physical appearance, speech characteristics, or emotional vulnerabilities). This type of inquiry may worsen the victim's self esteem and perhaps make him or her feel responsible for the victimization. The urgent need to prevent the morbidity and mortality of bullying brings psychosocial issues to the forefront of pediatric and adult medicine—at a level not reached in the last 45 years since the lethal aspects of child abuse came to public awareness.

Suggested Readings

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