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At Last, Facing Down Bullies (and Their Enablers)

By PERRI KLASS, M.D.

Back in the 1990s, I did a physical on a boy in fifth or sixth grade at a Boston public school. I asked him his favorite subject: definitely science; he had won a prize in a science fair, and was to go on and compete in a multischool fair.

The problem was, there were some kids at school who were picking on him every day about winning the science fair; he was getting teased and jostled and even, occasionally, beaten up. His mother shook her head and wondered aloud whether life would be easier if he just let the science fair thing drop.

Bullying elicits strong and highly personal reactions; I remember my own sense of outrage and identification. Here was a highly intelligent child, a lover of science, possibly a future (fill in your favorite genius), tormented by brutes. Here's what I did for my patient: I advised his mother to call the teacher and complain, and I encouraged him to pursue his love of science.

And here are three things I now know I should have done: I didn't tell the mother that bullying can be prevented, and that it's up to the school. I didn't call the principal or suggest that the mother do so. And I didn't give even a moment's thought to the bullies, and what their lifetime prognosis might be.

In recent years, pediatricians and researchers in this country have been giving bullies and their victims the attention they have long deserved — and have long received in Europe. We've gotten past the "kids will be kids" notion that bullying is a normal part of childhood or the prelude to a successful life strategy. Research has described long-term risks — not just to victims, who may be more likely than their peers to experience depression and suicidal thoughts, but to the bullies themselves, who are less likely to finish school or hold down a job.

Next month, the American Academy of Pediatrics will publish the new version of an official policy statement on the pediatrician's role in preventing youth violence. For the first time, it will have a section on bullying — including a recommendation that schools adopt a prevention model developed by Dan Olweus, a research professor of psychology at the University of Bergen, Norway, who first began studying the phenomenon of school bullying in Scandinavia in the 1970s. The programs, he said, "work at the school level and the classroom level and at the individual level; they combine preventive programs and directly addressing children who are involved or

identified as bullies or victims or both."

Dr. Robert Sege, chief of ambulatory pediatrics at Boston Medical Center and a lead author of the new policy statement, says the Olweus approach focuses attention on the largest group of children, the bystanders. "Olweus's genius," he said, "is that he manages to turn the school situation around so the other kids realize that the bully is someone who has a problem managing his or her behavior, and the victim is someone they can protect."

The other lead author, Dr. Joseph Wright, senior vice president at Children's National Medical Center in Washington and the chairman of the pediatrics academy's committee on violence prevention, notes that a quarter of all children report that they have been involved in bullying, either as bullies or as victims. Protecting children from intentional injury is a central task of pediatricians, he said, and "bullying prevention is a subset of that activity."

By definition, bullying involves repetition; a child is repeatedly the target of taunts or physical attacks — or, in the case of so-called indirect bullying (more common among girls), rumors and social exclusion. For a successful anti-bullying program, the school needs to survey the children and find out the details — where it happens, when it happens.

Structural changes can address those vulnerable places — the out-of-sight corner of the playground, the entrance hallway at dismissal time.

Then, Dr. Sege said, "activating the bystanders" means changing the culture of the school; through class discussions, parent meetings and consistent responses to every incident, the school must put out the message that bullying will not be tolerated.

So what should I ask at a checkup? How's school, who are your friends, what do you usually do at recess? It's important to open the door, especially with children in the most likely age groups, so that victims and bystanders won't be afraid to speak up. Parents of these children need to be encouraged to demand that schools take action, and pediatricians probably need to be ready to talk to the principal. And we need to follow up with the children to make sure the situation gets better, and to check in on their emotional health and get them help if they need it.

How about helping the bullies, who are, after all, also pediatric patients? Some experts worry that schools simply suspend or expel the offenders without paying attention to helping them and their families learn to function in a different way.

"Zero-tolerance policies that school districts have are basically pushing the debt forward," Dr. Sege said. "We need to be more sophisticated."

The way we understand bullying has changed, and it's probably going to change even more. (I haven't even talked about cyberbullying, for example.) But anyone working with children needs to start from the idea that bullying has long-term consequences and that it is preventable.

I would still feel that same anger on my science-fair-winning patient's behalf, but I would now see his problem as a pediatric issue — and I hope I would be able to offer a little more help, and a little more follow-up, appropriately based in scientific research.

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