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Perspectives on Bullying Among Children Who Present to the Emergency Department With Behavioral Misconduct:

A Qualitative Study

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Abstract

The problem of bullying is an increasing public health threat encountered by emergency physicians especially in inner city emergency departments (EDs). Bullying may result in emotional disturbances and psychological trauma in children. Many children sent to the ED because of behavioral misconduct require immediate stabilization and treatment. The emergency physician performs an initial assessment and stabilization. Emergency departments are increasingly on the frontline of the bullying problem.

Objectives—Our objective was to explore children's perspective of bullying and their views of potential solutions.

Methods—A qualitative study was conducted in a cohort of 50 children (age, 8–17 years),who were referred to the ED from school because of their behavioral misconduct. An interview survey tool about bullying was administered. It focused on what bullying meant to them and what advice they have for a child who is bullied. They were also asked what advice they would have for adults who try to help. We used grounded theory to analyze the data. Similar concepts were grouped, and the categories with similar properties and dimensions were defined. Common themes were then identified.

Results—We interviewed 50 children, of whom 27 were boys and 23 were girls. Their mean (SD) age was 12.5 (2.12) years (range, 8–17 years). Bullying was identified by children as including physical, verbal, and emotional actions. Several themes emerged. First, a power

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imbalance between a bully and victim may render an individual vulnerable to bullying. Being different and weak also increases the risk of being bullied. Second, bullying is wrong, and the bully should be punished. Third, children should learn how to handle bullying situations and develop resilience against bullying. Finally, adults need to be more proactive to prevent or stop bullying.

Conclusions—Our results provide insights into the perceptions of children regarding bullying. We have garnered a better understanding of what these children feel adults should do to prevent bullying.

Keywords

bullying; behavioral misconduct; bully; victim

Bullying is a major concern among students attending schools. Approximately 30% of children in the 6th to 10th grades are targets of bullying, and among high school students, it climbs up to 55%.[1] Bullying poses multiple health risks for its victims including physical health problems and behavioral and psychological problems such as depression, anxiety, and school avoidance and can lead to poor academic achievement.[2–4] Research has also shown that victims of bullying are more likely to be engaged in physical fighting.[5,6]

The emergency department (ED) is an important arena for the assessment of the sequelae of bullying in children, and this study provided an optimal opportunity to understand children's perspective on bullying. Students who are involved in bullying acts are often engaged in other violent acts and, therefore, may be brought to the ED.[7] In a previous study, bullying was found to increase the probability of being referred for psychiatric consultation.[8] Children who present to an ED in an urban setting in low-income communities are at higher risk for victimization.[9] Children in socioeconomically disadvantaged communities are particularly at risk of involvement in bullying.[10] This study applied qualitative techniques to evaluate the perceived etiology, underlying contributing factors, and recommendations that children who were involved in bullying interactions make.

Understanding how bullying is perceived by the children is essential in developing intervention strategies. Previous studies on bullying in school-aged children have provided a definition of bullying, its categorization, and possible solutions.[11–13] An understanding of potential solutions, however, from the perspective of the children involved has not been evaluated. The pediatric ED provides a perfect context within which to examine children's perspective on bullying because this is the setting where children with behavioral problems who are involved in bullying incidents are often brought. A 24% prevalence of bullying in children referred to the ED with behavioral symptoms has been identified.[7] This study focuses on perceptions of bullying, provided by a select group of children immediately after being involved in such an incident. The aim of this study was to explore the children's perception about bullying, their opinions and thoughts about why children are being bullied, and what possible solutions might help to stop or prevent future bullying.

METHODS

This qualitative study was conducted in the pediatric ED of a large inner city urban hospital. The study was conducted from October 2010 through December 2012. Individual interviews were conducted with each child. We also collected demographic information including age, sex, race, and grade level in the school. This study was approved by the institutional review board of Lincoln Medical and Mental Health Center, Bronx, NY.

PARTICIPANTS

The sample consisted of 50 students age 8 to 17 years, attending 40 public schools in New York City (n = 50). For this study, our inclusion criterion included an ED referral because of an involvement in violent altercations at school. We included only those children who did not have a history of development and cognitive health problems. Informed consent was obtained from the parents and assent from the child before enrollment in this study.

PROCEDURES AND MATERIALS

To understand the involvement of the children in bullying interactions, we asked the following questions:

1. Have you been bullied in the past couple of months?
2. If yes, have you told anyone that you have been bullied?
3. To whom have you told?

Then, a 5-part questionnaire was administered to understand their perceptions about bullying (Table 1). All participants were asked to answer the 5 items that were administered in a structured questionnaire format. Participation was voluntary, and parental consent was obtained for enrollment. In this study, children provided their independent responses and did not consult parents for answers. There was no compensation for participation in this study.

DATA ANALYSIS

In this pilot study, we used a formative qualitative research method. This allowed us to analyze data as the study progressed. Data from the first 50 participants were analyzed when the data saturation point was reached. To further elaborate findings, we continue to enroll children and will continue to analyze the data. We used the grounded theory to analyze the data. Data analysis occurred in the following steps: data review, creation of codes, and categorization. All responses were analyzed line-by-line. In vivo codes or raw data were assigned codes. Codes are descriptive labels or tags that represent key concepts that are being conveyed in the data. Codes can be actual responses or in vivo codes, select words from the transcripts, or words that represent key concepts. Subsequently, we grouped codes into categories. Higher-order themes were constructed from these categories.[14]

RESULTS

Baseline Demographic and Clinical Characteristics

In the sample of 50 youth age 8 to 17 years, there were 27 boys and 23 girls. Thirty-five participants (70%) were Hispanic, and 15 (30%) were African American. The mean (SD) age of participants was 12.0 (2.12) years (range, 8–7 years). Thirteen participants (26%) were in elementary school, 30 (60%) in middle school, and 7 (14%) were in high school. The children's grade in school ranged from 2nd to 11th grade (Table 2).

Forty children (80%) reported being bullied in the last few months. Of these, 85% (34/40) stated that they had informed someone about bullying. Thirty-three percent told parents, 25% informed a teacher, and 17% told another adult at school. Only 8% told a friend.

Definition of Bullying

The act of bullying was categorized by the children as having physical, verbal, and emotional dimensions. Physical bullying was exemplified by hitting, kicking, or pushing. One child stated that bullying meant “to hurt someone physically.” The verbal aspects of bullying included name calling or teasing. One child responded, “it is when someone speaks to you in a bad way.” Another child said bullying is when someone “calls you names and threatens you.” Emotional bullying was characterized as those activities that evoke negative feelings or had an impact on one's self-image. Examples of this included “bullying is when you make a person feel bad,” “make fun of someone,” or “makes someone cry.” Another child stated “when you hurt someone mentally.”

Factors That Underlie Bullying

The factors that students felt caused bullying episodes were categorized. Many said that bullies want to show that they have power, including imbalance in power such as differences in stature or grade level between the bullied student and the perpetrator. Students also described that bullies often hold an inherent disdain for the bullied student because he or she is perceived as “different.” Some students described bullying as having nothing to do with the bullied student, rather it is a desire for the perpetrator to impress other students. Examples of what students said included “the way they look”; “it is their race, color, and how they dress”; and “the way the kids look, dress, or their weight.” As one student said, “I feel like putting someone down,” and another said kids can bullied “if they look better than the bully or if they have something the bully wants.” Other students felt that bullying was an act to “show off ” or for the perpetrator to impress his or her classmates. “I have picked on people because I wanted to fit in,” said one child. Another child stated, “I want attention to be popular.” Some felt that bullying results from jealousy of the victim. One child said, “the person may envy other person or want what they have.” Another reason that emerged is that the bully was once a victim of bullying who now wants to retaliate. One child stated, “if they were bullied first and want to try it themselves.” Another child said, “because they were bullied when they were kids.”

Advice for Bullies

When asked what they would say to other children who bully others, respondents said they would advise these students to treat others as they would like to be treated themselves. Children in this study provided a clear message to the bullies that bullying is wrong and should be stopped. One child stated that he would say to a bully “why are you bullying this kid? It is not fair to hurt someone. If you don't like it done to you, don't do it to someone else.” Another child said, “don't do what you would not want done to you.” Bullying was also viewed as a cry for help. Some children felt that a bully has problems and they should seek adult intervention. Recommendations to children who are bullying included “go tell your parents or someone you are close to.” Another child's advice for a bully was “talk to someone about your problem.”

Advice for Victims

When asked about advice they would give to other children who are being bullied, responses focused on “fighting back” and “standing up for oneself.” “Stand up for yourself,” “fight back,” and “ask for help” were recurrent responses. Many children stressed the importance of communicating their experience with an adult such as a teacher or parents. The participants also indicated a need to convey their feelings to an adult after being bullied. Some children stated that they should “learn how to stay away from bullies.” Although children urged the bully victim to defend themselves, some said that they themselves would not get involved. Children felt that other children should not get involved if they observed an act of bullying and said, “let him deal with it; I would not get involved.”

Advice for Adults

Children overwhelmingly felt that parents and adults were well-positioned to make a difference by imposing stricter measures such as involving the police or suspension or expulsion from school. They felt that prevention had to do with adult intervention. One child stated that adults should “do something to make it stop.” Some recommended strict enforcement of disciplinary actions. One child said, “kick them out from the school.” Another stated, “suspend them.” Some students asked for police involvement to control bullying. One child said, “get more cops in the school.” Another student said to give “jail time.” Some students suggested to “put the bullies in other kid shoes.” Some students seemed to experience a state of despair and helplessness. One child said, “you can't do anything to prevent bullying.” Another child stated, “you cannot help a bully.” There were many who said that they didn't know what to do; one student said, “adults should know better.” Having serious conversation with the bullies was another suggestion offered by the participants.

Several themes emerged from the discussion with the participants. Given the importance of their responses, each theme should be considered individually as follows:

Theme 1: Power Imbalance or Being Different and Weak Puts Someone at a Higher Risk—Power imbalance between the bully and the victim was described as a common cause of bullying. One child stated that “bullies think that they have power.” Another child said, “they think they are tougher than others.” Another common response by

the group as to why children are bullied was that either they are “different” or “weaker” compared with bullies. One child said, “bullies are bigger and stronger.” Another stated that “bullies pick on kids who are in lower grades.”

Theme 2: Bullying Is a Wrong and Punishable Act—All participants in our study expressed antibullying attitude. Many children felt that bullying was absolutely wrong and that it should be punished. All children reported negative opinion about bullying. A common response was that “bullying is wrong.” One child stated, “punish them in school.” Another child said, “you should punish them if they do not listen.” Another response was that “you should suspend them from school.”

Theme 3: Children Should Develop Resilience Against Bullying—Children also suggested the importance of learning how to handle a bullying situation. One child said, “learn how to deal with it.”Many children stated, “stand up for yourself.” Some suggested that “the victim should speak up and tell someone.” Several children stated that the victim should retaliate and fight back. They believed children should develop resilience against bullying.

Theme 4: Children Want Adults to be More Proactive and Accountable for Stopping Bullying—Children suggested that adults should assume an active role to prevent or stop bullying. The children wanted the adults to talk with the bullies. Many children said adults should communicate and educate bullies, such as “teach kids not to bully.” Another child stated, “tell the kids to stop bullying.” One child stated that “I want to see bullies being counseled.” Some suggested that adults should be more vigilant in recognizing bullying. One child stated adults should “paymore attention and keep an eye out.” Another child said, “adults should watch those kids who are being bullied.” Some children suggested adults should stop bullying by using their power. The participants in this study demanded enforcement of strict actions against bullying. Some asked for legal actions by involving police and law enforcement agencies. Other asked for strict control by having more police officers available in the school.

DISCUSSION

This qualitative study provided an opportunity to evaluate bullying from the perspective of children who presented to the ED of an inner city academic medical center. Several categories emerged from these data, which revealed that even at a young age, children had tremendous insight about bullying. Children conveyed that bullying reflected a power differential. Most children expressed that bullying is wrong and that it should be punished. In our study participants, bullying was related to achieving or maintaining power, and victimization was associated with weakness and being different. Developing resilience against bullying was an important suggestion offered by the participants. They wanted the bullying to be recognized by adults and wanted more help from them to stop the bullying. Children want adults to be more proactive and develop strategies to assure their safety. Participants saw the role of adults as exceedingly important in combating bullying.

Many studies have been performed defining bullying and delineating its underlying causes. However, data are limited regarding children's perspective of what should be done to stop bullying.[13,15] Clearly, this area of investigation should receive more attention as interventions to stop bullying and its negative consequences need to be instituted.

There is also limited research that focuses specifically on the issue of bullying in the context of the ED visits. To our knowledge, this is the first qualitative study exploring bullying in children visiting the ED because of behavioral misconduct. Previous qualitative studies of bullying were conducted mainly in the school setting.[16,17] Although these studies highlighted an urgent need to stop bullying, solutions remain inadequate.

This study has provided an opportunity to explore potential solutions to bullying offered by children who have experienced or witnessed it just before their ED visit. This research methodology may reveal important information, when the bullying experience is fresh in the participants' memory. Therefore, suggestions offered by the participants are based on their memory of recent events, not on recalling previous events when memory may be faulty. This is in contrast to other qualitative studies, which selected a random school population regardless of their involvement in bullying incidents.[16,18,19] We included participants in this study who directly experienced and were affected by bullying. In addition, this study has provided an opportunity to examine bullying outside the school setting. Children may not feel comfortable discussing bullying in the environment in which it occurred. They may be reluctant to disclose information under those circumstances. With this study, we hope to gain new insight into bullying.

Bullying has been commonly described in relation to power. One obvious source of power is physical strength. Being different and weak was another common response in this study. Children who are seen as different whether physically or with respect to temperament can easily become a target for a bully. Our findings are supported by studies describing a commonly cited reason for being bullied as being perceived as different or having a different appearance.[13,20] It is likely that children will be rejected when their behavior is dissimilar to that in their peer group context.[21] In our study, many children indicated that it was because they were smaller or weaker than the bully that bullying occurred. In a previous study, victimization was also associated with weakness and being different.[16]

Supporting children who are involved in bullying interactions is important to avert potential future psychological events.[22] As one cannot eliminate bullying and teasing completely, children must learn to cope in these situations. Resilience is a way to achieve a positive outcome despite psychological, physical, and environmental vulnerabilities.[23] We should teach children how to respond to bullying. One approach to enhancing coping skills with bullying incidents is to strengthen and improve the resiliency skills of children. Our participants also felt that children should learn how to speak up and/or stand up for themselves. Previous research has shown that many children do not inform their teacher that they were being bullied.[24] Although majority of participants in our study have told someone, only one fourth have disclosed their bullying experience to their teacher. Reporting the situation to authorities (or adults) was a common solution recommended in this study. In addition, children may benefit and learn how to cope or handle situation by themselves.

Reporting the situation to authorities (or adults) was also commonly recommended by children in this study. Family support can promote resilience against bullying.[22]

Interestingly, children in this study were very explicit and provided concrete and definite actions for adults. This is in contrast to a previous study where participants were implicit in their responses and stated that something needed to be done.[20] In a previous study, having serious talks with the bullies was a common suggestion.[25] The participants in our study differed and suggested that antibullying measures should extend beyond talking and counseling. They believed adults can use their power and resources to put an end to bullying. Children suggested strong measures and actions. Bullying has been reported to be more prevalent when bystanders display a behavior that reinforces bullying, instead of defending and supporting the victims.[26–28] Many children believed that strong disciplinary actions should be undertaken at the adult level. To them, adults have a responsibility; if they see bullying, they have to do something to stop it. The participants of our study did not believe that adults are taking enough steps to stop bullying. In a previous study, parents of victimized children reported inadequate actions and sometimes resistance from school officials. They stated that bullying often continued despite reports to school officials.[29] In our study, children felt frustrated and angry when they didn't see enough action against bullying. It is essential that children perceive adults and especially the school administration to be serious and proactive in bullying prevention. Passive strategies by adults may result in repeated victimization and negative psychological consequences.[30,31] It is also important that victims should not feel that they are ignored. This may result in serious psychological consequences.[32]

The ED setting provides a perfect context for identifying children who are at risk for bullying. The ED may be the first point of entry and provide an opportunity for intervention. However, given the time constraints in the ED, this may be challenging, and a multidisciplinary approach should be used to address this issue. Emergency department physicians can educate parents and provide available resources for bullying prevention. In addition, they can communicate with the schools and provide important recommendations.

Limitations

This was an exploratory study; therefore, subsequent research is needed to develop a fuller understanding of bullying in this as well as other high-risk populations. This study involved a select group of children already identified as involved in acts of aggression in school warranting transport to the ED and, therefore, may not be representative of all children in this inner city community. Another limitation is our inability to compare these findings with children in rural neighborhoods. In addition, the study participants were predominantly Hispanic; it is therefore difficult to generalize results to children with other demographic characteristics. It was also difficult to determine which of the children were bullies or victims of bullying or both. We have also missed some bullies, as we excluded children who were violent in the ED. We chose to collect the data through qualitative research as it is an ideal method to study a phenomenon that has had limited scientific inquiry. Thus, we wanted to focus on the overall phenomenon of bullying without categorization. In fact, research shows that 6% of children who are bullies have also been victimized.[33] We

therefore did not categorize the children as bully or victim. In addition, we do not know whether or how much the stress of being in the ED might have influenced their responses. The study did not use probes, and requests for further elaboration or more explanations with follow-up questions may have provided additional information.

Implications

The results of this study have implications for designing antibullying intervention strategies and programs. The interventions should be targeted to stakeholders involved including bullies, victims, parents, school administrators, teachers, and emergency physicians. It is more likely that interventions will be more successful if built around the understanding and attitudes of affected children. Antibullying measures should be realistic and obtainable, directed both toward bullies and victims.

Primary prevention programs geared toward building resilience may be helpful. These techniques will equip children to appraise, interpret, and respond to bullying situations. This study also raised significant questions regarding our antibullying interventions. It is important to examine existing antibullying policies in our school systems and reevaluate for possible lapses. We also need to determine why children did not perceive current policies to be effective in stopping and preventing bullying. Antibullying policies and measures should be clearly defined and visible to the children. Schools should explicitly remind students that bullying is not accepted and such behaviors will have consequences. Future actions include development of interventions based on the responses of participants. We also seek to develop culturally tailored interventions specifically designed to address the needs of both bullies and victims. The results from this study can also be used to develop policies on the management of children who present to the ED after a bullying encounter at school.

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TABLE 1

Study Questionnaire

What does it mean to bully someone?
What are the kinds of things that make kids decide to bully or “pick on” someone?
Would you have advice for a kid who is bullying another child?
What advice would you have for a kid who is being bullied? What would you tell them?
What advice would you have for adults who are trying to help bullies? How could adults help?

TABLE 2

Demographic Characteristic of Children in the ED With Behavioral Misconducts

Age		
Age, mean (SD), y	12.5 (2.12)	Range, 8–17
Sex		
Male	27 (54%)	
Female	23 (46%)	
Race		
Hispanic	35 (70%)	
African American	15 (30%)	
School grade		
Elementary school	13 (26%)	
Middle school	30 (60%)	
High school	7 (14%)	