

Evaluating Healthcare Providers' Practices of Screening for Bullying in Pediatric Patients

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Abstract

Bullying is a common occurrence in the United States that is experienced by the adolescent population. Bullying and suicidal behaviors are closely linked, and healthcare providers have a responsibility to be involved in the screening and management of bullying and suicidal behavior (Center for Disease Control and Prevention, 2014). Screening for bullying starting at six years of age is a recommendation by the American Academy of Pediatrics. The purpose of this research paper was to improve healthcare providers' screening of bullying and to improve the healthcare provider's ability to identify adolescents who are being bullied. The outcome of this project was to evaluate healthcare providers practices and perceptions on screening for bullying. In addition, the project was designed to determine if frequent screenings for bullying compared to annual screenings for bullying would assist providers in identifying adolescents who are being bullied or identifying bullies. The most significant finding of the study was that 100% of participants in the study agreed that bullying was an issue the adolescent populations faced. While the study had limitation with the sample size, the results indicate a need for further research on screening for bullying in the adolescent population. The findings of the study should be used to determine further research on how best practice guidelines for healthcare providers can lead to frequent screening for bullying in the adolescent population and to provide educational materials to assist providers in screening at-risk adolescents.

Keywords: bullying, the adolescent population, screening recommendations

In the United States, bullying is a common occurrence experienced by the adolescent population. Forty-eight percent of adolescents reported that bullying remains a common occurrence in the United States (Leff and Feudtner, 2017). Bullying can have a significant impact on the adolescent's social and psychosocial functioning, as well as their academic achievements. Adolescents who experience bullying have an increased risk for suicide, suicidal ideations, depression, and anxiety (Leff and Feudtner, 2017). Bullying during adolescence can have long-term effects that can affect adulthood. Long-term effects include depression, an increase in suicidal attempts, social impairment, post-traumatic stress disorder, and further psychiatric illnesses (Stephens et al., 2018). Often, bullying is not reported by the adolescent population, thus, leading to the potential for harmful consequences that bullying yields.

Screening the adolescent population for bullying at routine and annual appointments may allow for early recognition of depression, anxiety, and suicidal ideations. According to Faith et al. (2015), the American Academy of Pediatrics and the Society for Adolescent Medicine recommend that providers caring for the pediatric population recognize and screen adolescents who are being victimized by bullying. The American Academy of Pediatrics has implemented numerous programs and interventions that can assist the healthcare provider with the management of depression and anxiety that have been associated with being a victim to bullying.

The purpose of this research paper is to improve healthcare provider screening of bullying and to improve the healthcare provider's ability to identify adolescents who are being bullied. Furthermore, this paper will improve healthcare providers ability to identify adolescents who are participating in acts of bullying. In the Family Medicine setting, does frequent screenings for bullying compared to annual screenings for bullying assist providers in identifying adolescents who are being bullied or identifying bullies?

Review of Literature

Bullying was once viewed as a phase all children and adolescents experienced during their life. Today, we know that many adolescents experience bullying at some time in their adolescent years. According to Roberts et al. (2016), 55% of adolescents report experiencing bullying at some point in their adolescent years. Bullying can have a significant impact on the overall health of the adolescent population. Bullied adolescents often experience depression, anxiety, suicide ideation, suicide attempts, academic decline, and have an increase in substance abuse and violent behavior (McClownry et al. 2018; Hornor et al. 2018; Roberts et al. 2016; Stephens et al. 2018; and Vessey et al. 2016). Adolescents who have experienced bullying often have long-term effects that lead into adulthood. Long-term effects that occur in adulthood include depression, anxiety, suicide and suicidal ideations, relationship problems, poor work performance, and an increased risk of substance abuse and criminal acts (Stephens et al. 2018). It appears that the effects of bullying need early recognition and intervention.

There are adolescents that are at a higher risk for experiencing bullying, thus, early recognition is possible for the provider. Adolescents that are overweight, have a physical or mental disability, are of a low socioeconomic class, are of a certain race or ethnicity, or belong to the LGBTQ community are at an increased risk for experiencing bullying during adolescence (McClownry et al. 2018; Honor et al. 2018; and Leff et al. 2017). Furthermore, the research points out that African Americans and Hispanics experience bullying more than any other race. In addition, females tend to be at a higher risk of experiencing bullying, specifically females in junior high school. The importance on early recognition can possibly provide a better outcome for adolescents and their future. Early recognition and intervention of mental health disorders can

lead to improved outcomes mentally, socially, and developmentally in the adolescent population (Attygalle, Perera, & Jayamanne, 2017).

Screening adolescents and those that are at an increased risk for experiencing bullying is a role of healthcare professionals. The American Academy of Pediatrics recommends that screening for bullying occur during their well child examination starting at age six years of age (Mason et al. 2018; Faith et al. 2018; Stephens et al. 2018). Furthermore, the American Academy of Pediatrics expresses the importance and responsibility of healthcare providers in recognizing adolescents who are being victimized by bullying (Faith et al., 2015). The role of the healthcare professional is to ensure that screening for bullying is done on an annual basis. One barrier to not meeting the best practice guidelines and recommendations by the American Academy of Pediatrics is that providers did not have an appropriate screening tool (Vessey et al. 2017). Although there is not a specific screening tool for screening for bullying, having an open-relationship with the adolescents and asking specific questions can determine those that are experiencing bullying. Stephens et al. (2018) suggest asking questions related to safety and peer-to-peer relationships at school. Questions including “Do you feel safe at school?” “How do you get along with teachers and other students?”, and “Many young people experience bullying, have you ever experienced bullying yourself?” open the conversation for adolescents to speak with the healthcare provider about whether they are currently a victim of bullying.

Even though screening is recommended on an annual basis at the adolescent’s well-child exam, there is limited information on if annual screening for bullying is appropriate or if more frequent screening is needed. In addition, there continues to be a barrier and a need for further assessment and evaluation of healthcare provider practices of screening for bullying. Johnson and McRee (2015) reported that in a survey of Minnesota healthcare providers, only 50.9% of

pediatricians, 32.8% of family medicine physicians, and 45% of nurse practitioners screening for bullying at annual exams. Ninety percent of adolescents are seen by a healthcare professional during their adolescent years, however, not all are seen for a well-child examination (Difazio et al. 2018). Well-child examinations differ from acute visits as they are more comprehensive and are only performed annually. Well-child examinations consist of a comprehensive physical examination, screening for risky behaviors, and ensuring health maintenance, such as immunization status and lipid screening. Having more frequent screening in addition to well-child examinations could provide an early recognition of individuals being bullying or those participating in the bullying.

Theoretical Framework

The Theory of Interpersonal Relations was developed by the theorist Hildegard. E. Peplau. One of the major concepts within Peplau's Theory of Interpersonal Relations explains the purpose of helping others discuss their difficulties (Alligood, 2014). Healthcare providers have the responsibility of assisting patients with their difficulties. Utilizing Peplau's Theory of Interpersonal Relations major concepts as a guidance of patient care can be performed by utilizing office visits to screen adolescent patients for bullying. Screening for bullying in the adolescent population may allow adolescents who experience the effects of bullying to be provided resources that are readily available. The healthcare provider could build a trusting relationship with the patient.

Peplau's Theory of Interpersonal Relations has four phases which include orientation, identification, exploitation, and resolution. The orientation phase begins with identifying the problem and building a trusting relationship with the patient (Senn, 2013). Building a trusting relationship will allow for better communication between the provider and the patient. The

provider during this phase can assist the patient with the resources needed after determining the effects the patient had from bullying. Referring or offering resources to the patient leads to the next phase in Peplau's theory.

The identification phase consists of selecting the appropriate resources for the patient (Senn, 2013). During this phase, the patient is assured that healthcare professionals are addressing their needs and are determining what options fit the interest of the patient. Following the identification phase is the exploitation phase. This phase serves to enable the patient to establish coping skills taught by a healthcare professional to manage their anxiety and depression symptoms. During this phase, patients' feeling of helplessness or hopelessness decrease (Senn, 2013). The importance of this phase is to develop the coping skills and the support system to be able to manage their anxiety and depression.

The final phase is the resolution phase. In the resolution phase, the patient has developed their coping strategies and may not need further assistance from the healthcare professionals on a frequent basis (Senn, 2013). However, it is important that healthcare professionals routinely provide follow up care to the patient. This would ensure positive progression of their anxiety and depression and ensure there is not a relapse in symptoms.

Nursing theories can provide a foundation on the process of screening for bullying, connecting patients to resources, ensuring patients have developed coping strategies to become independent in their treatment of anxiety and depression, and building a trusting provider-patient relationship. Peplau's Theory of Interpersonal Relations has been used in many psychiatric nursing research studies. The theory itself may assist nurses and providers in the development of practice on screening adolescents for bullying.

Methodology

The study design was a quantitative correlation research study to evaluate healthcare providers' practices of screening for bullying in pediatric patients. Convenience sampling of healthcare providers in the hospital's family medicine department and outreach clinics were obtained. The healthcare providers consisted of physicians, physician assistants, and advanced registered nurse practitioners, ranging in age from 19 years to 70 years of age and gender of male or female. Healthcare providers were eligible to participate if they met the following inclusion criteria: (1) routinely cared for the adolescent patient; (2) was a physician, physician assistant, or advanced practice nurse practitioner, and (3) were employed by the hospital's family medicine department or outreach clinics.

The healthcare providers that met the inclusion criteria were provided a survey that was distributed out via email by the medical director of family medicine. SurveyMonkey was the source of data collection completed by the healthcare providers. The email to the providers explained the purpose of the research study, provided informed consent, and noted anonymity for the healthcare providers who participated in the study. The instrument used in the study was a self-developed survey that consisted of a Likert scale ranging from strongly agree to strongly disagree. The survey consisted of nine items evaluating the healthcare providers practices of screening for bullying on the adolescent population. Descriptive statistics of frequency were used to describe the percentage of healthcare providers response to the survey questions. None of the data was linked to individual participants or the institution, therefore data collection was completely anonymous.

Summary and Findings

The survey evaluating healthcare providers practices of screening for bullying at a University Hospital and Clinics resulted 15 participants (n=15). The 15 participants in the study consented to participation in the study and responded to the questions that were asked in the survey. The 15 participants were physicians, physician assistants, or nurse practitioners in the family medicine department at the University Hospital and cared for adolescent patients.

The results of the study evaluated the healthcare providers practices and opinions on screening for bullying in the adolescent population. The study results indicated that 85.71% of the participants cared for the adolescent population once per week, several times per week, or several times per day (50%+28.57%+7.14%). There were two (14.29%) participants who cared for adolescent patients but was less than once per week. All of the participants reported that they screened their adolescent population for bullying, however, there were variations in the frequency. Five (35.71%) participants that reported they screen their adolescent population for bullying only when there is a concern. The other participants screened their adolescent population for bullying either frequently throughout the year (n=2 or 14.29%) or annually (n=7 or 50%). Of those participants that screened their adolescent population for bullying, 11 (78.57%) reported that 25% of their adolescent population reported bullying and one (7.14%) reported that 50% of their adolescent population reported bullying. The remaining two (14.29%) participants reported that none of their adolescent population reported an issue with bullying.

The remaining of the questions of the survey were Likert scale questions ranging from strongly agree to strongly disagree. The participants were asked questions based on their perception of bullying amongst the adolescent population. Of the 15 participants in the study,

fourteen answered the question about adolescent's experience of bullying. Seven (50%) of the participants reported that they strongly agreed while the remaining seven (50%) agreed that bullying is a common experience the adolescent population encounter. A majority of the participants strongly agreed (n=6 or 42.86%) or agreed (n=6 or 42.86%) that they felt comfortable discussing bullying with the adolescent and their parents. There were 2 (14.29%) participants that were either neutral or disagreed that they felt comfortable speaking with the adolescent and parents about bullying.

The participants were asked if they believed screening was a priority at the physical exams. Approximately seventy-one percent (28.57%+42.86%) of the participants either strongly agreed or agreed that screening for bullying was a priority at the adolescent's physical exam. The remaining 4 (28.57%) of the participants were neutral. Of the 15 participants, 6 (42.86%) strongly agreed that screening adolescents yearly at their physical exams was adequate while 4 (28.57%) were neutral. The remaining 4 (28.57%) participants disagreed that one annual screening was adequate. Approximately 78% (50%+28.57%) of the participants were either neutral or disagreed that screening for bullying should be performed at every visit type. The remaining 21% (7.14%+14.29%) either strongly agreed or agreed that screening for bullying should be performed at every visit type. At the end of the survey, the participants were asked if they believed that doing frequent screenings for bullying would assist providers' ability to identify adolescents who are being bullying or identify adolescents who are participating in acts of bullying and a majority of the participants either strong agreed (n=5 or 35.71%) or agreed (n=8 or 57.14%).

Although there was a small sample size of only 15 participants of the survey, the results supported prior literature regarding the comfortability of the provider discussing bullying with

the adolescents and the parents. While a majority of the participants were comfortable speaking about bullying to their adolescents and their parents, there is still a barrier that can potentially lead to serious complications of adolescents are not screened for bullying. In addition, many of the participants believed that screening for bullying at least once per year was adequate. These findings supported the recommendations of the American Academy of Pediatrics that healthcare providers should be screening for bullying annually starting at six years of age.

Conclusion and Recommendation

To conclude, the survey indicated that all of the study participants agreed that bullying in the adolescent population, however, thirty-five percent of the participants screen the adolescent population only when there are concerns of bullying. The study indicated that there was a knowledge gap amongst providers regarding the recommendations by the American Academy of Pediatrics regarding screening for bullying. The study findings indicated that there is a need for best practice guidelines to ensure annual screening for bullying in the adolescent population. Best practice guidelines can be implemented by the electronic health records reminding providers to screen their adolescent populations for bullying. There is limited information regarding if the implementation would be beneficial and further research studies would be needed to determine its effects.

The survey also concluded that 14.29% of the participants did not feel comfortable speaking about bullying amongst the adolescent population and their parents. There seems to be a need of further education not only locally but nationally on ways providers could discuss bullying amongst adolescents and their parents comfortably. Further research regarding educational programs on how to screen and address bullying of the adolescent patient and their parents are needed. If healthcare providers screened there adolescent population more frequently

bullying, it may allow for better recognition of those who were experiencing bullying or those that were participating in the act of bullying. Further research would be necessary to determine the effectiveness of early recognition on the at-risk population with bullying.

The study did have limitations due to the sample size of 15 healthcare providers that cared of the adolescent population. It would be beneficial to have a larger population of healthcare providers to determine statistical significance of the study questions. Further research that would be beneficial could include evaluating the knowledge of best practice guidelines when it comes to screening the adolescent population in relation to recommendations by the American Academy of Pediatrics.

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