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Pediatric Bullying and Victimization: Quality Improvement Project in a Primary Care Setting

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Quality Improvement Project in a Primary Care Setting

by

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DISSERTATION

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Abstract

Bullying is a form of aggression characterized by repeated psychological or physical oppression, which negatively impacts children. More recently, the phenomenon of cyberbullying, or electronic bullying, has become prevalent. Despite efforts by schools to address forms of bullying, young people continue to be victimized. Primary care settings are well placed to address these issues with patients and their families to improve care and outcomes. Screenings and mental health referrals by physicians have been shown to reduce future involvement in bullying and increase access to treatment. When thinking about healthcare improvements in primary care settings, screening has been shown to be useful for addressing concerns that might not have otherwise come up. Prior to the current study, young adolescent patients were going to be screened for bullying during well-child visits and invited for follow-up. Due to the changes in primary care practice caused by the response to the global COVID-19 pandemic, well-child visits were canceled, requiring that the focus of the study be to explore physicians' perspectives. The current study aimed to explore physicians' attitudes and beliefs regarding bullying through a qualitative approach with the use of semi-structured individual interviews with primary care providers from one practice. Thematic analysis was conducted. The results yielded providers' impressions and beliefs about screening for bullying, indicating the utility of screening as a successful tool to gather more information on adolescent victimization to help patients and families address these concerns. Implications, limitations, and future research ideas are also explored.

Keywords: bullying, cyberbullying, victimization, primary care provider

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Key Terms and Concepts

Bullying

Bullying has been defined as a category of personal aggression that consists of intentionality, repetition, and "an imbalance of power," with the abuse of power as a major distinction between bullying and other types of aggression (Hymel & Swearer, 2015).

Direct Bullying

Most research on bullying focuses on direct, overt bullying patterns, such as physical aggression, verbal threats, swearing, or mocking (Scheithauer et al., 2006).

Indirect or Relational Bullying

Indirect or relational bullying is a form of behavior that intends to harm another by damaging the victim's relationships with other students (Liu & Graves, 2011). Indirect or relational bullying is less typical than direct bullying but is nonetheless considered harmful. This might take the form of group exclusion or spreading rumors about other students. Indirect or relational bullying was linked to externalizing symptoms among girls, and contributed to the prediction of internalizing problems in both males and females (Prinstein et al., 2001).

School Climate

School climate refers to the character of a school, the emphasis on respectful behavior, and the importance of collaboration between students and educators (Measuring School Climate, 2018). A positive school culture and climate are important for feelings of safety within students and are associated with less bullying behaviors (Evans & Smokowski, 2015).

School Culture

Although the term culture is usually applied to ethnic or religious groups, the concept of culture can also apply to organizations, which shape their success and well-being (Evans & Smokowski, 2015). School culture, a broader concept than school climate, is defined as, "unwritten rules and traditions, norms, and expectations…that seems to permeate everything..." (Deal & Peterson, 2009, p. 2).

Victimization

Similar to bullying, *victimization* has been defined as "repeated exposure to maltreatment" (Rosen et al., 2013, p. 2).

Literature Review

Bullying is a problem for children and adolescents that can negatively impact their functioning (Juvonen et al., 2011). While there are several factors and interventions that seem to moderate the impact of bullying, these do not reach enough children. Schools are one such place where bullying is addressed (Nansel et al., 2001). Other than schools, children are seen and cared for in primary care. This study assessed the feasibility of using primary care as a site for population approach to identifying and intervening for children and adolescents involved in bullying.

Bullying is Widespread and Has Been Shown to Result in Deleterious Effects

Bullying is an Ongoing Problem in Schools

Bullying is a pervasive problem that has received worldwide attention (Zins et al., 2003). Documented rates for bullying vary across studies, with 5% to 13% of students admitting to bullying others, and 10% to 33% of students reporting victimization by peers (Cassidy, 2009; Dulmus et al., 2006; Nansel et al., 2001). Nansel and colleagues found that 16% of 15,000

students in grades 6–10 surveyed reported being victims of bullying. Since the late 1980s, the World Health Organization (WHO) has conducted cross-national studies on health behavior, where bullying is considered an important aspect of research that has received worldwide attention (Boulton & Underwood, 1992). Additionally, a survey commissioned by the National Crime Prevention Council found that 43% of youth ages 13–17 years experienced some form of bullying during the school year (Facts about Bullying, 2019).

Despite Policy Changes, Bullying is Still a Problem

In 1999, two events became critical turning points in the United States' recognition of school bullying as an important societal problem. The shooting at Columbine High School was viewed as actions by victims of bullying seeking vengeance (Dinkes et al., 2009). Although less reported in the national news, the U.S. Supreme Court (*Davis v. Monroe County Board of Education*) voted that schools would be accountable and liable for failure to stop student-to-student sexual harassment. This decision has supported nationwide lawsuits against bullying as well as directives from the U.S. Department of Education's Office for Civil Rights concerning addressing forms of bullying as civil rights violations (U.S. Department of Education, Office for Civil Rights, 2010). Over the past decade, over $10 billion has been spent to improve school safety (U.S. Department of Justice, Office of Community Oriented Policing Services, 2003). Despite over a decade of legislative activity, as well as scientific research, bullying is still a nationwide concern.

Bullying Exists Regardless of Culture, Socioeconomic Status, and Gender

In one 2004 study, 73% of children in Cambodia reported that they had seen other children teased or mistreated by other children (Miles, 2004). Poverty was identified as the main reason for being bullied (by 40%), followed by disability (25%), gender-related reasons (8%),

ethnicity (6%), and religious belief (5%). When asked how children who had been bullied can be helped, children stated that the best way was to educate the bullies and provide emotional support to the bullied child. In a 2012 survey report summary for Malaysia, students reported being bullied on one or more days in the past 30 days (Sittichai & Smith, 2015). This was 20.9% for ages 13–15 and 12.5% for ages 16–17. In Singapore, Kwan and Skoric (2013) worked to examine cyberbullying occurring on Facebook, using an adapted offline bullying scale from North American studies. Researchers found that 59.4% of Facebook users reported experiencing at least one form of bullying in the last year (receiving nasty messages or blocking someone); they found that boys were more involved in bullying as bullies or victims and there was a significant association between Facebook bullying and school bullying. Gender differences are mostly in line with Western findings, suggesting that boys are more often perpetrators of bullying and there is less of a gender difference in being the victim of bullying (Sittichai & Smith, 2015). In another study in New South Wales, Australia, more boys than girls reported bullying, or both being bullied and bullying others (Forero et al., 1999).

Bullying Has a Substantial Impact on Students

Bullying has been shown to be associated with school aversion, somatic complaints, and feelings of low self-worth for victimized students. The topic of bullying is undoubtedly important for society, as it is one of the most pervasive issues affecting youth in schools and results in strong, negative emotions (Evans & Smokowski, 2015).

School aversion. Research shows that witnessing peer harassment at school is linked to an increase in school aversion and can negatively impede the learning process (Sanders & Phye, 2004). In the middle-school years, victimization has been shown to relate to poor academic performance (e.g., grade point average, national tests, teacher evaluations; Juvonen et al., 2011),

negative reports about the school climate (Nansel et al., 2001), and a heightened sense of risk and fear in school (Youth Violence Prevention, 2016). Students who witness or experience peer victimization are at risk for low motivation to attend school (Juvonen et al., 2011).

Negative consequences of psychological stress. Victims of bullying are more likely to have poor mental health and report somatic complaints as a consequence of psychological stress and pain inflicted in schools (Forero et al., 1999). Individuals who are victimized reported poorer overall general health and struggled managing and maintaining relationships (Sigurdson et al., 2014).

In a cross-sectional self-report survey of 3,918 school children in grades six, eight, and ten from 115 schools in New South Wales, Australia, the prevalence of bullying behaviors was found to be associated with poor psychological and somatic health (Forero et al., 1999). Students were randomly selected and completed a self-administered survey in the classroom; they read a definition of bullying and answered two questions asking if the student had been bullied or taken part in bullying other students. Students were then presented with several psychosomatic health symptoms (i.e., headache, stomachache, backache, irritability, feeling nervous, difficulties falling asleep, feeling dizzy) and reported the frequency with which they experienced each symptom. Participants then responded to questions about smoking to determine their risk behavior, which was associated with bullying. Researchers performed a multinomial logistic regression and found that students who bullied others and were bullied experienced frequent psychosomatic symptoms and reported smoking (Forero et al., 1999), although it is unclear if smoking served as a coping skill for victimized children or if children who smoke are more likely to bully their peers. Overall, 1,650 students (42.4%) reported neither being bullied nor bullying others. Of the remaining 2,268 students (57.8%), 928 (23.7%) of those students reported bullying other

students, 843 (21.5%) reported bullying others and were bullied, and 497 (12.7%) reported being bullied (Forero et al., 1999). This study demonstrated a significant association between bullying behaviors, psychosomatic symptoms, and smoking in students who bully and are victims of bullying. Evidently, individuals who bully peers and are bullied by others suffer.

More recently, researchers have started to examine the association between cyberbullying and mental health. Cyberbullying victimization has been shown to be related to poorer mental health outcomes including negative psychosocial variables such as depression and loneliness (Olenik-Shemesh et al., 2012). Adolescents who were cyberbullying victims in one Israeli study measuring depression and loneliness expressed a poorer mood and higher sense of loneliness than those who were not cybervictims (Olenik-Shemesh et al., 2012).

Verbal bullying about weight related to psychosocial problems. Peer harassment and weight-based teasing is an important risk factor for clinical eating disorders and unhealthy behaviors regarding weight (Kendler et al., 1991; Klump et al., 2001). Eisenberg and colleagues (2003) examined verbal bullying through teasing about body weight. In this study, 4,746 adolescents from 31 United States secondary and high schools participated. It was found that 30% of adolescent girls and 24.7% of adolescent boys reported that they had been bullied about their body weight. Of this sample, 28.7% of the adolescent girls and 16.1% of the adolescent boys reported that they had been bullied about their weight by a family member. Bullying about body weight was highly related with low satisfaction about their bodies, high depression, suicidal ideation, and suicide attempts. Overall, these adolescents who had been verbally bullied about their weight had 1.39–2.35 more chances to present with these psychosocial and emotional difficulties mentioned above.

Peer victimization negatively impacts victims' self-esteem. Victimization has been linked to lower and decreasing self-esteem and poor self-efficacy socially (Youth Violence Prevention, 2016). Self-worth is one construct of self-esteem, negatively impacted by peer victimization (Bellmore & Cillessen, 2003). Repeated victimization in elementary and junior high school predicts lower self-reported social competence, in addition to social self-worth over a six-month to two-year period (Bellmore & Cillessen, 2003; Boulton et al., 2010). To better understand self-concept development, researchers Bellmore and Cillessen examined the association between adolescents' social self-perceptions and their peers' perception of them in a study of 491 middle school students over three years. Adolescents reported their peer-perceived victimization, peers' social preference for them (i.e., "Who likes me the most/least?"), and self-reported social self-concept. The results supported a model where adolescents' reputations as victims of peer harassment affected their self-concept and peers' perception of social preference.

Self-blaming attributions have also been shown to place students at significant risk for lower feelings of self-worth (Graham & Juvonen, 1998). When victims are self-blaming, they may come to believe that they somehow deserve the abuse. Given the many risks associated with bullying, including school aversion, mental health concerns, and self-esteem, interventions targeting these deleterious effects are needed. One victimized youth stated,

> There is no conclusion to what children who are bullied live with. They take it home with them at night. It lives inside them and eats away at them. It never ends. So neither should our struggle to end it. (Hymel & Swearer, 2015, p. 296)

Parenting Behaviors Directly Linked to Bullying

Parental traits are linked to peer victimization and family characteristics including poor parental supervision, parental conflict, negative family environment, inappropriate discipline, and a lack of parental support (Barboza et al., 2009; Espelage & Swearer, 2010). For instance, Doh (2002) found that overprotectiveness and yelling or using profanity as parenting behaviors increase the child's vulnerability to bullying. Consistent with Doh's research, parents implementing harsh parenting practices produce children who internalize the core belief that they are unworthy of affection (Patterson et al., 1991). If children believe that they are unworthy, they are more likely to accept abuse and mistreatment from others, including peers. Additionally, children with overprotective parents are provided with limited opportunities to learn and exhibit appropriate social skills when responding to peer aggression (Hong & Eamon, 2011). Wolke and colleagues (2000) found that school children who are victimized had the highest rates of behavioral problems, measured by interviews and questionnaires relating to bullying behavior. Family influences on victimization have also been linked to neglect, abuse, and overprotective parenting (Duncan, 2011). Not surprisingly, parents of bullies lack appropriate parenting skills and are described as hostile (Smokowski & Kopasz, 2005). These negative events in a child's life influence negative beliefs about self, world, and future; students who experience a variety of negative events are at an increased risk for externalizing and internalizing problems.

Family Support

Research indicates that schools with higher average rates of students reporting dysfunctional family environments were associated with higher average rates of bullying perpetration (Merrin et al., 2018). These findings support the essential role families have on bullying behaviors. Hostile discipline practices, sibling bullying, poor parental supervision, and

inadequate modeling of problem-solving skills must be addressed, as they are related to bullying behavior (Baldry, 2003; Duncan, 1999). If the school and the youth's parents communicate that bullying is unacceptable, the likelihood that bullying behaviors will change is considerably increased (Olweus et al., 2007). Given that aggressive children and adolescents struggle conforming to rules, it is critical that parents work together with their child to discuss family rules. Parents of victimized children can also help the youth build social skills and acquire an advanced understanding of informal social rules of peer groups. The family, therefore, is an essential presence for helping youth who contribute to bullying behaviors and those who are victimized.

Protective Factors Against Bullying

Positive Adult Role Models

Positive adult role models can help support children and serve as a buffer from effects of known risk factors (Fallu & Janosz, 2001; Meehan et al., 2003). In a two-year prospective investigation exploring the association between the quality of student–teacher relationships and children's levels of aggression in sample of 140 aggressive children in the second and third grade, researchers found a that a positive student–teacher relationship was beneficial for aggressive African American and Hispanic children (Meehan et al., 2003). In the study, teachers identified two to three children who fit the description of an aggressive child, based on physical or relational qualities. Children participated in a structured interview (Network of Relationships Inventory; Furman & Buhrmester, 1985) to rate persons in their social network, and parents completed the Weinberger Parenting Inventory (WPI; Feldman & Weinberger, 1994), a measure of parenting practices to assess aggressive measures. Researchers found, through regression analyses, that students who viewed their teachers as supportive and involved are less likely to

show behavioral problems such as bullying and tend to do well in school compared to students who do not view teachers as supportive (Meehan et al., 2003). Although Meehan and colleagues did not specifically examine the impact of bullying, other researchers have examined the association between aggression and bullying (Rodkin et al., 2013). Positive adult role models are associated with reducing student aggression (Meehan et al., 2003), which might reduce bullying in schools as a protective factor.

Positive Peer Relationships

Social support from friends, in addition to teachers and professionals, were related to high levels of student resilience, self-esteem, and overall life satisfaction (Beltrán-Catalán et al., 2015). Having quality friendship is associated with protecting students from being involved in bullying and victimization. Social support from friends, teachers, and professionals might be related to qualities of self-esteem and life satisfaction that promote bonding, or the emotional attachment and commitment that encourages social relationships in the peer group, family, school, or culture (Beltrán-Catalán et al., 2015). The reciprocal relationships between quality relationships, self-esteem, and life satisfaction seem to serve as protective factors from bullying.

Interventions to Reduce Bullying Rates

Improving Social Skills and Relaxation Interventions

Several interventions have been shown to be effective for reducing bullying rates. In school and therapy settings, researchers have demonstrated the effectiveness of skills training for children (Ttofi & Farrington, 2011). Social skills training (SST) teaches children adaptive social skills so that children can play an active part in the process, rather than children simply being told what to do. For example, in an SST session (Spence, 1995), a trainer might ask children to think about how they knew someone was listening to them. The trainer would steer the children

in the direction of identifying eye contact as an important social skill and encouraged them to break social skills down into various *steps*. Through role-plays, providers can give positive and constructive feedback to help children work on social skills and learn to model positive behavior.

Researchers have also demonstrated the benefits of introducing relaxation techniques to create positive change (Simon & Olson, 2014). As a component of the SST Program (Fox & Boulton, 2003), children are taught *Progressive Muscular Relaxation* combined with relaxing images and deep breathing. Previous research findings indicate that many children who are bullied display behavioral vulnerabilities (e.g., looks scared, stands in a way that looks like he/she is weak; Fox & Boulton, 2003). Learning SST techniques has been shown to improve postural changes or facial expressions, which could help to reduce bullying.

Assertiveness Training and Boosting Self-esteem

Techniques to boost a child's self-esteem have been incorporated into an Assertiveness Training Program (Sharp et al., 1994). Children are taught when it is appropriate for them to leave a social situation (e.g., physical abuse, being hit or kicked) and are encouraged to tell someone (e.g., teacher, parent, or friend). This component is important for the program given that approximately one third of bullied children have been found not to tell anyone about being victimized (Whitney & Smith, 1993). Sharp and colleagues have proposed that teaching children how to be assertive such as keeping an upright posture, smiling when appropriate, and keeping hands and arms relaxed by their sides as well as teaching non-verbal behaviors encourages children to be flexible and provides them with important tools.

Improved self-esteem is a protective factor for children against bullying but has not been widely explored at the individual level in primary care settings (Fox & Boulton, 2003). As fear and helplessness are often experienced by children who are victimized (Jeffrey et al, 2001), fears

relating to bullying should be identified so that children can process these feelings. The more victimized children are, the more they dislike themselves and have the potential to be rejected in the future (Jeffrey et al., 2001).

Engaging Parents

Educating parents how to best manage bullying symptoms for their child is an important consideration. Carr-Gregg and Manocha (2011) recommend that healthcare practitioners implement a parental action plan that represents clear actions for parents to follow. The parental action plan should include: (a) seeking an in-person meeting with the student's teacher and principal to discuss the incident(s), (b) use of written communication should the situation escalate, (c) find and engage appropriate resources from education websites by state, (d) move up the leadership chain if they feel their concerns are being ignored, and (e) ask follow-up questions at school meetings to discuss the investigation and future plans. Additionally, parents can implement problem-solving and literature-based lessons that help increase the child's awareness and knowledge of bullying (Hall, 2006).

Primary Care is an Untapped Resource for Addressing this Problem

Primary care is an important setting for detecting social and emotional problems children and adolescents experience. Approximately one-half of all medical visits are to primary care physicians (Stafford et al., 1999). By the time children are 16 years old, 37% to 39% will have been diagnosed with a behavioral or emotional disorder (Weitzman & Wegner, 2015). Since childhood victimization is associated with worse mental health outcomes and somatic complaints, targeting problems can be essential for promoting optimal development (Weitzman & Wegner, 2015).

PCP as First Point of Contact for Patients

The primary care setting is unique because children and adolescents have the opportunity to address concerns with their Primary Care Provider (PCP), sometimes with or without a parent present. Given that many psychological symptoms can be addressed in primary care settings, children have the opportunity to speak about important topics with primary care physicians. In many cases, the PCP is the first point of contact for children involved with bullying. Despite this, many youths fail to report that they are being bullied (Fleming & Towey, 2002). Feelings of shame, blame, or fear might play a role in self-report, which is why it is critical for primary care settings to incorporate bullying screening into office visits (Carr-Gregg & Manocha, 2011). As many adolescents are reluctant to discuss bullying because of possible embarrassment or having negative experiences sharing about bullying before, screening for bullying can be a helpful tool in primary care clinics.

Many adolescents are willing to discuss concerns with their PCP if engaged in an 'adolescent-friendly' manner. The HEADSS (Home, Education and Employment, Activities, Drugs, Sexuality, Suicide/depression) psychological assessment tool (Carr-Gregg & Manocha, 2011) is a common screener for establishing a meaningful rapport between adolescent patients and providers. This can usually be completed within the scope of most consultations and provides a framework to discuss academics and social-emotional factors related to school. Concerns about confidentiality are often a concern for young people, so it is especially important that providers reassure adolescents that their responses will be confidential except in instances of danger or mandated reporting (Carr-Gregg & Manocha, 2011). Providers can detect bullying early on, assess the severity and impact, encourage the adolescent to disclose the bullying to parents, and help develop an action plan with the adolescent and/or family. Primary care

providers can also advocate on behalf of the patient, encourage parents to engage in school activities, or help adults recognize physical or psychological symptoms associated with pediatric bullying.

Identifying Bullying Behaviors

Boulton and Flemington (1996) examined the beliefs regarding bullying pre- and post-viewing of an anti-bullying video and found that children who had watched the video expanded their definitions of bullying, which might be helpful for them to recognize that bullying can occur in various modalities. Virtual or web-based delivery might be particularly relevant to young people, and feasible to offer in a primary care setting (Pacer's National Bullying Prevention Center).

Parents Can Express Concerns in Primary Care and Learn from Physicians

In primary care settings, parents are often unaware that they can discuss mental health concerns with primary care doctors. Evidence suggests that parents are more likely to seek services for children when they display behavioral issues, such as aggression and hyperactivity, rather than internalizing symptoms (Arcia & Fernandez, 2003). If screening practices are implemented in clinics, this would provide opportunities to screen for bullying in pediatric patients and provide evidence-based interventions.

Behavioral Health Support in Some Primary Care Settings

Behavioral health care includes the treatment of mental illness as well as behavior change and other psychosocial needs, provided by masters or doctorate-level providers in social work or psychology fields (Hunter et al., 2017). Recent health care legislation and financing strategies in health care are shifting medical and mental health care in the United States (Asarnow et al., 2015). The term integrated care refers to behavioral health care in a primary care setting, defined

by the Patient Protection and Affordable Care Act as an “essential health benefit” that promotes care coordination among providers and the use of a multidisciplinary team to address whole-person care (Croft & Parish, 2013). Integrated medical-behavioral care has been shown to improve behavioral health outcomes in adolescents in primary care settings (Asarnow et al., 2015). Physicians can address social and emotional concerns during well-child visits in primary care or refer patients to behavioral health providers. Behavioral health specialists in primary care can facilitate various interventions in brief therapy sessions targeting emotional management (emotion awareness, expression) and managing anger and stress (reactions, complaints; Kiriakidis & Kavoura, 2010). Interventions targeting emotion management appears feasible in a primary care setting, and has been shown to be an effective, brief intervention in other settings.

Use of Screening. Recent guidelines have recommended standardized instruments in primary care settings to recognize, identify and manage problems of children and adolescents. Screening is defined by the Commission on Chronic Illness Conference on Preventive Aspects of Chronic Disease (Goldstine, 1952) as “the presumptive identification of unrecognizable disease or defect by the application of tests, examinations, or other procedures which can be applied rapidly” (Wilson & Jungner, 1968, p. 11). The objective for medical screening is to identify people at risk for certain problems or diagnoses to increase the probability for helping the patient’s condition through early intervention.

Researchers mention a number of factors that contribute to the lack of routine screening: (a) many screening instruments and psychometric properties mentioned in psychology-based journals are not regularly reviewed by providers (Simonian, 2006), (b) there is a poor fit for existing screening tools in primary care settings (Simonian, 2006), and (c) arguments that it might be unethical to identify children from screening measures unless there are adequate mental

health services and supports readily available for referred children and adolescents (Perrin, 1998).

Identifying and developing treatment plans early, before emotional and behavior problems can be diagnosed, can minimize detrimental mental health disorders in addition to reducing costs (Aos et al., 2004; Campaign for Mental Health Reform, 2005). Hester and colleagues (2004) found that early identification and intervention for children who are at risk for behavior and emotional disorders seems to be "the most powerful course of action for ameliorating life-long problems associated with children at risk" (p. 5).

Although primary care providers have begun to identify several emotional and behavioral problems (15–30%), the rates of recognition and referrals to mental health specialists do not always happen (United States Department of Health and Human Services, 1999). Evidence is lacking regarding the extent to which primary care settings are identifying and responding to the needs of children who are bullying others or being bullied (Dale et al., 2014). Research supports that internalizing problems are best identified through self-report (Pagano et al., 2000). A common issue is the reduced willingness of children and adolescents to speak to a Primary Care physician (PCP) with a parent present. Youth self-reports have been shown to become more valuable as the youth ages with reporting both externalizing and internalizing symptomatology, as younger children are often unable to accurately report and reflect upon behaviors (Grills & Ollendick, 2003). Due to cost-efficiency factors, self-reports have been the first choice in a multi-gated approach with preadolescents and adolescents (Levitt et al., 2007).

Measurement-based care (MBC) is recommended when treating children with mental health concerns. MBC has been defined as, "enhanced precision and consistency in disease assessment, tracking, and treatment to achieve optimal outcomes" (Harding et al., 2011).

Symptom scales, or patient-reported outcome measures, and screening tools are used to report experiences and perceptions about the severity of symptoms. The *Journal of the American Academy of Child and Adolescent Psychiatry* lists nearly 100 instruments (Winters et al., 2005), and *American Academy of Pediatrics* provides a link of over 50 available tools (Disabilities CoCW, 2006).

Several screeners have been adapted to identify pediatric concerns. Screening tools such as the *Mood and Feelings Questionnaire-Short Form* (MFQ-SF), child version, the *Patient Health Questionnaire-Adolescent* (PHQ-A), and the *Pediatric Symptom Checklist* are all validated tools designed to facilitate the recognition of emotional, cognitive, and behavioral concerns so that appropriate interventions can be targeted for children and adolescents (Vinson & Vinson, 2018).

Screenings and mental health referrals by primary care clinicians have been shown to reduce future involvement in bullying when parents are involved (Borowsky et al., 2004). Recommendations for best care practices include incorporating preventive education, risk screening, and helping patients navigate necessary intervention and follow-up services (Borowsky & Ireland, 1999). In one primary-care based intervention study, the Pediatric Symptoms Checklist (PSC) was used to screen for psychological problems at acute-care or well-child visits for high-risk children and adolescents ages 7 to 15 years of age (Borowsky et al., 2004). Overall, 44% of youths who participated were involved in moderate or frequent bullying as the bully, target of bullying, or both, as reported by parents. In the intervention group, primary care clinicians referred families to participate in a phone-based educational program called *Positive Parenting* for 13 lessons (Borowsky et al., 2004). This program included two videotapes and a manual for the parenting course, in addition to 15 to 30-minute weekly telephone sessions

with an educator. Video segments included role-playing and group discussions with parenting topics. The content of these sessions included topics such as respect, responsibility, communication, conflict, and parenting styles provided by three parent educators with a parent education license. In follow-up assessments, compared with control subjects after 9 months of study enrollment, children in the intervention group had lower rates of parent-reported bullying and child-reported victimization by bullying.

The Youth Risk Behavior Survey (YRBS). The YRBS assesses youth for substance use, behaviors contributing to violence, inadequate physical activity, bullying, and other domains (Gladden et al., 2014). The YRBS includes questions to determine if patients report being bullied in school or electronically. The YRBS defines being bullied as "repeated aggression (teasing, threatening, spreading rumors, hitting, shoving, or hurting) among youth where the targeted youth has less strength or power than the perpetrator" (Gladden et al., 2014, p. 15). These types of bullying relate to being bullied or bullying others on school property and electronically and is available at the CDC website (http://www.cdc.gov/healthyyouth/yrbs). These national surveys have been administered biannually and have measured several risk behaviors since 1991. On this public survey, two questions about bullying exist (Appendix A).

Pediatric Symptom Checklist. One of the most commonly used screening tools for this population is the Pediatric Symptom Checklist (PSC; Jellinek & Murphy, 1988). The PSC is a psychological screener used to detect cognitive, emotional and behavioral problems so that primary care physicians and behavioral health coordinators can initiate appropriate interventions as early as possible.

The validity and reliability of the PSC has been demonstrated in several pediatric settings (Jellinek & Murphy, 1988; Walker et al., 1989). In one study, Jellinek and colleagues (1988)

validated the screening accuracy of the PSC against assessments made by clinicians in two pediatric settings: (a) a private practice serving mostly Caucasian patients, and (b) another in an urban setting serving a more diverse group of patients. In the study, the overall agreement between the PSC and presence of psychiatric diagnosis was 87%.

Routine mental health screening is encouraged by the American Academy of Pediatrics (AAP) as the best strategy to identify concerns and facilitate appropriate early intervention during annual well visits (American Academy of Pediatrics, Appendix S4, 2010). Given the prevalence of childhood bullying and the opportunities for primary care interventions, this setting seems well placed to screen and address bullying concerns.

Screening Barriers

The sequence in which duties are performed in the clinic is called *workflow* (Holman et al., 2016). This refers to the actual way in which work is supposed to be carried out, rather than how it is believed to be carried out (Holman et al., 2016). This includes the role of support staff, clinic policies, and technology (Crabtree et al., 2005). Additionally, the structure of relationships between members of the clinical team impacts workflow (Holman et al., 2016). Although screening is recommended during well-child visits, there are several factors that impact workflow and must be taken into consideration. As healthcare becomes more complex, the demands on primary care physicians (PCPs) are increasing (Holman et al., 2016). Researchers have found that introducing new information always has the potential to restart a workflow cycle and address new issues (Holman et al., 2016). Holman and colleagues describe this unpredictable workflow as a “dance” between physician and patient (p. 33). Currently, evidence is lacking regarding the implementation of a procedure for identifying bullying, much less develop a clinical pathway (Dale et al., 2014). Despite workflow challenges in various settings, the

literature suggests that screening for bullying in primary care settings is feasible and beneficial for children and adolescents.

Statement of Purpose

The purpose of this practice improvement project is to explore physicians' attitudes and beliefs regarding bullying. The questions addressed in the study include (a) Do providers hear about bullying from adolescent patients? (b) Is screening for bullying viable in a primary care setting? and (c) What is the most logical clinical care pathway for adolescents whose screening data is positive for bullying?

To examine if screening for bullying in primary care is an appropriate setting for collecting data and intervention, I designed a study to explore the utility in assessing for bullying. Other researchers might wish to use some of this information and study design in the future to implement in their clinic.

Intended Study (1)

The goals of the original study included implementing routine screening and treatment planning made available to the reader. If the findings of this dissertation are compelling, in that physicians believe that bulling is an important health issue, then primary care should be the place that bullying is addressed. If physicians understand bullying to be a concern, there will need to be a simple yet reliable screening program to keep them from missing cases of bullying. The groundwork to design the screening program and treatment options will potentially be useful for healthcare workers in primary care settings.

Method

Study Design: Intended Study (1)

This pilot study project intended to (a) assess the possibility of administering survey questions to children and adolescents who are at risk for bullying victimization and/or at risk for bullying peers, and (b) suggest care pathways to assist the PC practice in delivering effective services according to the screening results. Two questions about bullying were drawn from a literature review of existing screening questions related to pediatric bullying. This included utilizing various search phrases and terms in addition to reviewing clinical care pathways that are well-established.

Data Sources

Adapting an existing screening tool that will help identify bullying could be an intervention that would greatly improve the lives and health of children who are treated at their primary care clinic. Adding two bullying screening questions following a formal screening tool would attempt to answer if the target population was endorsing bullying. This study intended to propose incorporating questions from the bullying section of the Youth Risk Behavior Survey (YRBS), a validated tool in the public domain to the administration of the Pediatric Symptom Checklist (PSC; (https://www.cdc.gov/healthyyouth/data/yrbs/pdf/2019/2019_YRBS-Standard-HS-Questionnaire.pdf).

Setting. Hahnemann Family Health Center (HFHC) is a community health center located in Worcester, Massachusetts, which provides care for the Worcester population and the surrounding area. This site serves a relatively urban, ethnically diverse population, predominantly from and lower socioeconomic bracket. HFHC is a part of the University of Massachusetts Memorial Hospital system and serves as a residency training site for the UMass

Medical School Family Medicine Residency program. The HFHC staff consists of 8–10 attending physicians, 12 medical residents, 3–4 third-year rotating medical students, and 5 behavioral health clinicians (one LICSW, one licensed PhD, two unlicensed PhD/PsyD, one post-master's psychology doctorate student). The most recent available data concludes that HFHC serves approximately 35,000 patients from a variety of socio-economic statuses from diverse backgrounds (African American, Latino/a, Asian, Caucasian, etc.). HFHC allows providers to utilize live interpreters for patients where English is not their first language.

Participants

Target Population

Patients at HFHC who visited their primary care physician (PCP) would have included children and adolescents ages 12 to 16 years. To be included in the intended study, participants would be required to have parental approval to participate (under age 18). A large sample offers greater test sensitivity and the promise to fulfill its population-level purposes compared to a small sample, so a large sample size is ideal (Warner, 2012).

Measures

The rationale for asking about mental and physical health history to determine if children with other symptoms (physical or emotional/psychological) may have been more likely to be victimized or bully other children. Demographic questionnaires would have operationalized age, race/ethnicity, gender, grade, mental health history, physical health, etc. Bullying would have been assessed using two screening questions from the bullying portion of the Youth Risk Behavior Survey (YRBS).

Screening

Screening for bullying in primary care. To assess for bullying, two questions from the YRBS would have been added to an existing survey, The Youth Pediatric Symptoms Checklist (Y-PSC), which is administered to children ages 12–16 years-old during their Well-Child Visit at HFHC. The questions that would have been added to the Y-PSC would ask the child if they have been bullied in school or electronically bullied (cyberbullying), adapted from the YRBS.

Addressing barriers to implementing screening. The HFHC workflow and procedural difficulties would have continued to be examined and tracked for a better understanding of when youth between ages 12–16 years were completing the Y-PSC. An assessment of the workflow was conducting during meetings with the Office Manager, Medical Director, and Medical Assistants (MAs). Currently, the PSC, Y-PSC, and MCHAT are the only screening tools provided in the current setting for this population, and several MAs were unclear regarding the procedure (e.g., When to screen? Who is given the information: parent vs. child?). Education was provided to MAs regarding the patient population and appropriate times to screen.

While orienting the MAs to this project and emphasizing the issue of bullying, we determined that this screening tool should be provided to the patient during every well-child visit. In the current workflow, the questionnaire was provided to parents at check-in and the intent was to simply update the packets. It was also determined that the Y-PSC should be provided in Spanish as appropriate; UMass interpreter services provided translation of the YRBS questions and informed consent. Questionnaire packets were color coded for quick and easy identification of English and Spanish versions.

Clinic concerns that came up during this process were the following: (a) Where should screening tools be built into the Electronic Health Record (EHR), (b) What is the best way to

drive this new behavior for check-in staff and MAs? and (c) What path is the least disruptive for this workflow change? Although important issues to consider, navigating changes in the Electronic Health Record (EHR) and driving new behaviors were outside the scope of this study.

Physicians were also informed of the dual purpose of this project: (a) identifying patients in primary care that have experienced bullying and (b) investigating what services and resources are feasible. During a meeting with both residents and faculty at HFHC, several slides were presented to orient physicians to this topic (See Appendix C and D). Primarily, physicians were concerned about possible shifts in workflow and how they would respond if parents or children had questions for their PCP. Several PCPs during the meeting endorsed possible discomfort relating to sensitive issues that could come up, such as reported child abuse and the importance of discussing appropriate procedure for addressing such concerns.

Data analysis. Participants' responses from the bullying section from the YRBS would have assisted in determining eligibility for a bullying intervention. Assessment was thought to help determine the appropriate care pathway for each patient, which would have included a brief interview asking the patient why they endorsed bullying item(s). If a child or parent endorsed one or more bullying questions, they would have been invited to follow-up with a behavioral health provider on the phone or in person. Case material would have informed the clinical care pathway recommendations. Based on face-to-face or phone interviews on the group of children with positive screens, the study would have attempted to offer ideas that could be used by practices to build a clinical pathway pending further research. The research questions for the study design would have asked (a) the degree to which pediatric patients are reporting being bullied or bullying others? and (b) how can screening in a primary care setting enhance systematic and reliable treatment planning?

Intervention

Suggested Clinical Pathways

If screening identified patients for whom intervention in a primary care setting could be helpful, the next step would have specified what care should be offered, and to which patients. Clinical care pathways (CPWs) are increasingly being used as computer-based documents, tailored to structures and time frames (Kinsman et al., 2010; McGlynn et al., 2003; Tomaszewski, 2012). Educational or brief psychological interventions have been shown to be feasible interventions in a primary care context, as well as complex interventions or referrals to specialty care recommended by a primary care physician or BHC.

Patient/Interventions Matrix

The CPW would have included which service provider and treatment modality would have been best suited for each pediatric patient who endorsed being bullied or bullying others. Listed below is a matrix with possible clinical pathways and the provider responsible for the intervention, including a BH (behavioral health) specialist or primary care provider (PCP).

Target pop	Intervention Description	Mode of Tx	Provider
Children lacking in social skills who are bullied (in person or electronically)	Improving social skills	Strategies from Social Skills Training (SST) Program- interventions such as relaxation skills/verbal strategies (e.g., mirroring) (Fox & Boulton, 2003)	BH specialist in PC
Children presenting with low self-esteem who are bullied (in person or electronically)	Increasing self-esteem	Boosting assertive skills (Assertive Training Package for victims of bullying) (Arora, 1991)	BH specialist in PC
Adolescents who report "not fitting in" who are bullied (in person or electronically)	Identifying bullying and advocacy skills	-"What Youth Can Do if They're Experiencing Bullying" handout (Pacer's National Bullying Prevention Center) -PACER video, "Advocacy and Self-Advocacy" episode Psychoeducation -Cyberbullying Handout: "Tips for Teens" **or BH referrals if needed*	PCP and/or BH specialist to process

Current Study (2)

COVID-19 Clinical Disruptions

Due to the global COVID-19 pandemic that hit Massachusetts in March 2020, the State government and medical systems such as UMass Memorial Hospital acted to reduce patients coming into the clinic. All patients scheduled for well-child checks at HFHC were postponed consistent with CDC and Massachusetts DPH guidelines. Although this dissertation initially aimed to screen for adolescent bullying within well-child checks, the research goals were shifted to measure the providers' perspective about bullying and beliefs regarding screening feasibility in primary care. Therefore, the intended methodology outlined above was not completed. Instead, I examined providers' opinions and attitudes via telephone or Zoom interviews to discover more about childhood bullying in a primary care clinic.

It is useful to understand providers' perspectives to explore what is possible for future programming or planning visits with families if children in primary care endorse bullying. The new study design focused on PCP interviews to investigate: (a) providers perspectives on bullying as a factor for adolescent patients, (b) the way in which providers are aware of the health risks associated with bullying, and (c) provider perspectives on the utility in screening for bullying within the adolescent population (see Appendix E). However, few residents and physicians in pediatrics and family medicine routinely offer screening and guidance for patients and parents with youth who are struggling. To understand what is feasible in primary care settings, it is necessary to understand physicians' perspectives and attitudes regarding screening in primary care clinics.

Research Paradigm and Qualitative Method Strategy

The current study used a qualitative design, under a pragmatic paradigm, to capture the essence of providers' experiences and better understand their attitudes and beliefs about pediatric bullying in an integrated primary care setting. The pragmatic paradigm highlights the importance of understanding various subjective realities experienced by individuals within an objective context, and the research process relies on interacting directly with people who understand and experience a certain phenomenon (Mertens, 2015). Evidence is lacking regarding PCPs' opinions regarding bullying. The link between bullying and adverse impacts on adolescent health is well established, yet there is a void between knowledge of the consequences of bullying and the assessment and intervention by healthcare providers (Dale et al., 2014). While several studies have focused on assessing and intervening in school systems, extraordinarily little research exists regarding the role of healthcare providers in addressing bullying.

Qualitative Design

The current study used a phenomenological qualitative design to capture and understand the essence of providers' experiences and attitudes. Phenomenological research aims to explore the subjective experience or understanding of individuals of the phenomenon under investigation (Mertens, 2015). Qualitative data were gathered to explore how providers view bullying in an adolescent patient population and to examine their beliefs about screening this patient population. This information was then used to design a clinical care pathway including various interventions for adolescents and parents for whom bullying is a concern.

Participants

Target Population

Participants included primary care providers (PCPs) at HFHC. The desired number of participants for the interviews was between five and seven participants. In the end, seven participants in total participated in the study.

Measures

Demographic information operationalized gender, years practicing medicine including residency, and years working within the UMass Memorial healthcare system. The rationale for including the number of years practicing was to examine a possible association with beliefs about screening or attitudes towards bullying among the adolescent patient population, although the sample size would not be strong enough for statistical significance.

Study recruitment focused on PCPs with exposure to the primary care behavioral health model in the clinic at HFHC. The recruitment strategy included presenting the topic of adolescent bullying at a resident/faculty meeting in the clinic to introduce the importance of understanding bullying for this population. About one month later, an email was sent to invite

PCPs to participate in the study. The email requested participation in a 10 to 15-minute interview with willing providers due to COVID-19 canceled well-child checks, explaining the adjustment in this dissertation.

Participants in the resident/faculty meeting were made aware of potential benefits from this research. Primary care-based interventions have the potential to help future programming in the practice as well as for planning more generally in the field of primary care. The results from the current study could support screening and developing appropriate interventions for adolescents who are victimized.

A brief summary of results from the interviews is presented to help understand providers' attitudes and beliefs about bullying. It is important to hear this perspective to understand what is feasible in a primary care setting. Results from this study will also add to the larger body of research related to adolescent screening on the topic of bullying in an integrated primary care setting. At both levels, the current study could help adolescent patients in primary care who are victimized and subsequently lead to improved patient and family outcomes.

Interview Protocol

One phase of interviews took place over a two-week time period. I conducted these interviews personally by video platform (Zoom) and by phone. One exception was made for a provider who was experiencing COVID symptoms and therefore responded to the interview questions by email. The other six interviews were scheduled by email. The interviews followed a semi-structured protocol that allowed for follow-up or clarification based on the nature of participants' responses.

Participants were asked six questions pertaining to their experience with adolescent bullying. This aimed to allow the emergence of the unique provider perspective in an integrated

primary care setting. The development of interview questions was guided by the literature review on bullying, addressing issues relevant to understanding provider knowledge regarding adolescent bullying, and screening feasibility. Additional questions asked providers if they were aware of any health risks associated with adolescent bullying and their beliefs regarding how they can be helpful as providers. Providers also had the opportunity to discuss barriers to care if and when adolescents or parents report bullying. The interviews were audio and/or video recorded for future analysis.

Data Analysis

This study used thematic analysis for data gathered in the interviews. Thematic analysis is a widely utilized qualitative approach for analyzing data that allows researchers to identify patterns and themes across data, yielding rich descriptions of the data as it relates to the research question or area of focus (Braun & Clarke, 2006). Participants' responses to the interview questions determined if providers believe adolescent bullying is a problem for patients at HFHC and what they think can be changed. Case material informed the clinical care pathway recommendations. Based on phone and video interviews, the study attempted to offer ideas that could be used by practices to build a clinical pathway pending further research.

This process of analysis used five phases. In the first phase, I familiarized myself with the data that was transcribed from audio or video recordings into written format which included 6 transcriptions, given that one participant typed her responses to the interview questions. I read through the data many times and made note of initial ideas about what should be included in the data and if anything was of interest or importance.

In the second phase, I generated sets of codes across the data set. These codes are considered basic elements of the raw data that identified what I considered to be important

features of the data set, or of interest based on my research questions (Braun & Clarke, 2006). Individual data extracts, derived from the transcripts, were organized so that raw data were grouped according to the relevant codes (Braun & Clarke, 2006).

The next phase consisted of examining the data for broader themes. This included looking at the developed codes and combining codes (and relevant data extracts) that appeared to fit together into a larger, overarching theme (Braun & Clarke, 2006). During the coding process, data were organized into meaningful groups, and the interpretative analysis portion occurred at the level of broader themes. It is also possible for codes that do not appear to fit in a larger theme category to be grouped on their own as miscellaneous (Braun & Clarke, 2006).

In the fourth phase, I reviewed and edited the identified themes, some of which were omitted, combined with other themes, or separated into distinct themes. According to Braun and Clarke (2006), important considerations in this phase are (a) if generated themes are supported by enough data, (b) if certain themes are similar and can be combined into a theme that is descriptive of the data, or (c) if one particular theme contains more data than necessary or if the data are too diverse. The themes are then assessed based on further review of the fit of coded extracts within each of the themes, examining if all coded extracts within a theme form a pattern, and allows for the revision of themes (Braun & Clarke, 2006). Themes are examined to ensure they relate to the overall data set in order to confirm that they accurately represent what the data presents (Braun & Clarke, 2006). This process included re-reading data so that the thematic map I developed appeared to accurately reflect the meanings from the data set as much as possible. Refining themes and codes are ongoing processes used in thematic analysis (Braun & Clarke, 2006), which occurred several times throughout this process.

Then, the final refinement of themes occurred which involved defining individual themes and writing possible sub-themes within larger themes. This process is known as identifying the essence of each theme, focusing on what each particular data extract captures overall (Braun & Clarke, 2006). The final analysis component and report should tell a succinct and understandable narrative based on what is revealed in the data. This report is not one of simply descriptions but serves to reflect an informative message pertaining to the research questions(s) under investigation (Braun & Clarke, 2006).

To maintain the essence of each provider's experience, I consistently referred back to the initial data and relied on several quotes from providers when creating themes. Throughout the analysis component, I made note of my own biases that arose. Additionally, I consulted with an auditor on this dissertation committee to confirm that the themes effectively represented my data. In the validation and evaluation process, issues of trustworthiness were considered such as credibility (Lincoln & Guba, 1985). Credibility refers to the extent to which the research is appropriate and believable, with appropriate reference to the level of agreement between participants and the researcher (Lincoln & Guba, 1985). The auditor reviewed the data analysis process, which included themes, subthemes, and data extracts, and they provided feedback in this process to ensure that themes remained consistent with the raw data as much as possible.

The research questions for the current study included: (a) Have PCPs encountered adolescent patients who report bullying? (b) Do PCPs understand/believe that there are negative health consequences for these patients? and (c) Is screening viable in this setting? The current study will also include intervention recommendations for adolescents who are being bullied and parents of the adolescents that are feasible in this setting.

Results

Using the methods described above, the study provides a synthesis in conclusions offering limitations and stating future research. Helping adolescents with the current problems of bullying will benefit families, schools, and could even impact the larger community.

Demographic Information

Seven primary care physicians (PCPs), two men and five women, participated. The mean number of years PCPs had been practicing as medical doctors was 16.29 years including residency, and the practice range was between 4 and 36 years. The mean number of years PCPs had been practicing in the UMass system was 12.29, and the range included between 1.5 and 36 years.

Overview

A total of five main themes emerged from the interviews. Reference tables listing all main themes, subthemes, and associated data extracts are provided in Appendix F. Throughout the results section, primary care provider will be abbreviated as "PCP."

Questions

Question 1: Have you encountered early adolescent patients for whom bullying is a factor? All PCPs endorsed having encountered early adolescent patients that reported bullying. A common theme in how this issue came up appeared to be through parent reports regarding the child, or PCP's suspicions of "stereotyping" patients who are more likely to be victimized. Specifically, some PCPs stated raising the issue of bullying if they noticed the adolescent is struggling with being overweight, underweight, or observe gender identity issues. One PCP mentioned hearing stories about cyberbullying that the adolescent does not directly name or identify as bullying. For instance, one PCP mentioned that a female adolescent patient explained

a story involving peers sending images of that patient to an unintended audience. While she did not directly label this situation as bullying, the PCP named this incident as cyberbullying.

Question 2: How did you discover that this was the case? Generally, PCPs answered that they discovered bullying by (a) adolescent self-report, (b) parent report, or (c) the PCP suspecting bullying and raising this issue. One PCP reported that physical bullying is observed by noticing overt symptoms upon further examination. The same PCP also stated that, "sometimes, it's more subtle."

Providers blaming themselves for not doing enough to discover bullying emerged as a general theme. Several providers made statements such as, "I'm really terrible about asking" and "I suspect I'm missing a lot" when they reflected on their roles in addressing bullying. Another PCP stated that well-child checks are another opportunity for bullying to come up. For instance, PCPs reported that they will often ask about how school is going for adolescents. Another PCP reported that she uses her own screening methods by asking about internet safety. In this way, the topic of cyberbullying comes up and she can address if the child has been experiencing online bullying.

Providers did not unanimously report how bullying comes up in practice. Results were mixed whether parents or adolescent patients spontaneously share this information, or whether PCPs raise the issue of bullying. Some physicians reported only asking about bullying if they suspect the patient is high-risk, while other providers reported asking about bullying in almost every well-child visit.

Question 3: Are there patients who report cyberbullying as opposed to in person bullying and do you handle that differently? Two PCPs reported that they have witnessed adolescent patients report cyberbullying and two other providers mentioned what they might do

if cyberbullying came up for patients. One provider mentioned “specific challenges” in thinking about cyberbullying, reporting that it is “much more buried and difficult.” Specifically, this provider stated, “the ways how adolescents can be cool with each and the way they hide that cruelty with one another and texts that can be read two ways, it’s much more difficult than more overt forms that we see.”

Question 4: Do you think there are negative health risks associated with adolescents who are bullied? All seven PCPs acknowledged negative health risks associated with bullying. PCPs commonly cited self-esteem as a concern, as well as substance use, eating disorders, depression, and anxiety. Of note, several PCPs believe that bullying is associated with downstream effects for adolescents who have underlying mental health diagnoses, such as anxiety, depression, or eating disorders. Issues relating to food such as restrictive eating or overeating were mentioned. In some cases, PCPs reported feeling that cyberbullying is especially negatively impacting adolescents and that this experience might be isolating. Several PCPs noted the importance of schools being aware of any type of bullying going on.

Bullying within the family system and with peers also came up as a concern in response to this question. One PCP shared an anecdote about an adolescent patient who experienced bullying from a family member related to his eating disorder. PCPs also cited social media as a place where cyberbullying has been reported. Anecdotes about photos spreading to unintended audience and the use of Facebook and Instagram as social media platforms for bullying were mentioned.

Question 5: What would you do in your role as a physician when your patient reports to you they’re being bullied and what do you wish you could do? Several PCPs reported assessing for bullying when they suspect bullying might be a factor and validating the

patient's experience. Creating a "safe space" for patients came up as well as exploring safe people (such as teachers and/or parents).

Limitations such as "skill set" and time emerged from the interviews. Some providers mentioned feeling uncomfortable and unsure of the protocol for bullying. PCPs noted relying on behavioral health supports or making referrals when patients acknowledge bullying. Several PCPs reported that they wished they could have more involvement with schools, and that time is often a barrier.

Question 6: By adding two questions to a validated screening tool, we can find out this information. Do you think it makes sense to screen adolescent patients? Most PCPs stated that they believed screening would be helpful for this population so that they could help connect patients and families to resources. One provider specifically mentioned that he would feel more inclined to bring up the issue of bullying when it's reported on a screening measure.

One PCP reported the importance of behavioral health providers and a team-based approach for addressing the issue of bullying. She reported that the impacts of screening for bullying would not be as effective without the integration of behavioral health to help adolescents and families access services and supports.

Another PCP acknowledged the issue of screening as a general procedure. He noted that if screening were implemented in the clinic, a pathway for identifying services and supports should be considered. This provider suggested that if the clinic participated in screening, direct follow-up with patients and/or families should be considered in the workflow so that these patients can ultimately benefit from screening.

Interview Themes

Main Theme 1: Providers May Raise the Topic of Bullying Under Certain Circumstances.

All seven physicians elaborated on adolescent bullying when they see patients. Analysis of providers' responses resulted in the emerge of two subthemes: (a) Providers inconsistently ask if adolescents are being bullied and (b) PCPs raise the issue of bullying if they suspect concerns based on the patient's emotional and physical presentation.

Providers inconsistently ask if adolescents are being bullied. Out of the seven providers who participated in the study, only one PCP reported confidently that she always addresses the topic of bullying at every well-child visit. While most providers reported that bullying usually comes up when they discuss school, PCPs generally believed that they inconsistently bring up the topic of bullying. For example, one PCP described wanting to address bullying more than what happens in practice. This participant reported, "I wish I could say that I always ask about bullying in my adolescent interviews, but I can't say that that's always true" (Participant 1). Another PCP stated, "When I ask about it, which I have to confess I don't ask about it religiously at every visit, but when I do, I'd say that there are times when it comes up" (Participant 7). PCPs seemed to feel guilty and emphasized that they wished they could ask more about bullying during the visits. This was also evidenced by another PCP who stated, "Honestly, I'm really terrible about asking about cyberbullying so, no. That's the one thing I wish I could remember to ask about and I never remember to" (Participant 5).

PCPs raise the issue of bullying if they suspect concerns based on the patient's emotional and physical presentation. Overall, several providers reported asking about bullying if they believe the adolescent is at risk based on physical appearance and affect. One PCP reported, "This is where stereotyping comes in, where if the patient seems like someone who

might be at risk, I get reminded to ask more. Obviously, this isn't an ideal way to practice, but I'm going to be perfectly honest about this. Like really overweight kids, I'm more apt to ask kids. Or kids who are dealing with gender identity issues, I'm more apt to ask" (Participant 7). Similarly, another PCP stated, "Sometimes if I haven't asked the question [bullying], it might come up. If the kid is sad or something, and then I'll ask why they have the symptoms" (Participant 6). Another PCP believed that bullying comes up in sessions if concerns are suspected. He stated, "A patient I have that's probably on the autism/Asperger's type of functioning, and especially kids at risk, I ask what their experience is like at school and social isolation that might come up" (Participant 1).

Main Theme 2: Barriers to Screening for Bullying Exist.

Five participants elaborated on various time constraints during well-child visits and after visits for appropriate follow-up with schools. The two subthemes that emerged were: (a) Providers do not have enough time to ask about bullying if there are other concerns, and (b) Providers acknowledge barriers involved in following up with schools.

Providers do not have enough time to ask about bullying if there are other concerns. Despite many PCPs reporting that they address bullying, several providers encounter time barriers that prevent them from asking about bullying. For instance, one PCP reported, "Practicing in a 15-minute environment, even 30 minutes [with children] who have issues, especially teenage girls with issues, it's impossible to talk about everything in 30 minutes" (Participant 1). Similarly, another PCP stated, "With that age group, if they're otherwise healthy, we're only seeing them once a year. That's the one time we have to check in with them. A lot of times other concerns or other things get in the way of us really talking about it [bullying] during

the visit" (Participant 5). Another provider discussed feeling that there is a limited amount of time during each visit and having to prioritize the content. For instance, Participant 7 stated:

> There's a limited number of things you can address in a well visit, and I don't ask every parent of every child if there are guns in the house. If I practiced in Texas maybe I would, but here that tends to be limited. I would focus on diet, obesity, screen time, substance use, and there's not always enough time to address everything you could possibly bring up.

Overall, several providers agreed that the idea of addressing a variety of topics is not always feasible, and that bullying is unfortunately not always addressed.

Providers acknowledge barriers involved in following up with schools. In addition to time constraints during visits, two providers mentioned that time constraints interfere with them reaching out to patients' schools when bullying is reported. One PCP stated, "I think from a time standpoint that having dialogue with school is hard. That would be the wish, I think behavioral health can get involved with schools" (Participant 4). Similarly, another PCP discussed the realities of following up with schools, describing that not having enough time is a barrier for providing follow-up care. Participant 6 stated, "I guess with any issues that come up, barriers might be between teachers at the school and physicians. They're busy, we're busy and that kind of thing."

Main Theme 3: Providers Inconsistently Hear about Cyberbullying Despite it Being an Issue for Many Adolescent Patients.

In response to the question, "Are there any patients who report cyberbullying as opposed to in person bullying and do you handle that differently?" providers reported conflicting ideas. Three providers stated that cyberbullying has never come up during visits, while other providers

shared that cyberbullying is a concern for several of their adolescent patients. The two subthemes that emerged were: (a) Cyberbullying is an issue for many adolescent patients, and (b) Cyberbullying is typically not reported or asked about.

Cyberbullying is an issue for many adolescent patients. Four PCPs acknowledged that cyberbullying is a concern for adolescent patients. In some cases, adolescents do not explicitly name cyberbullying, but instead describe situations that PCPs have labeled as such. One provider stated, "It's [cyberbullying is] more buried and difficult. The ways how adolescents can be cool with each and the way they hide that cruelty with one another and texts that can be read two ways, it's much more difficult than more overt forms that we see" (Participant 1). Another PCP stated, "Cyberbullying has come up more. My approach would be similar in terms of checking in about the impact. It's important for adolescents, and for any patients, to identify a trusting adult is one of my interventions for visits" (Participant 4). Similarly, another provider reported, "I have had instances where adolescents have shared with me that they are having experiences on social media that are making them feel persecuted or badly" (Participant 7). Evidently, cyberbullying is a topic that comes up for several PCPs when they meet with adolescent patients.

Cyberbullying is typically not reported or asked about. Two PCPs did not elaborate on cyberbullying, while one provider explained that she would like to ask more about bullying than she currently does. Participants stated, "No" (Participant 2) without elaborating and "No one has ever reported cyberbullying to me" (Participant 3). One PCP elaborated and stated, "Honestly, I'm really terrible about asking about cyberbullying so no. That's the one thing I wish I could remember to ask about and I never remember to" (Participant 5).

Main Theme 4: Bullying is Associated with Health Risks.

All seven participants acknowledged negative health risks associated with bullying in response to the question, "Do you think there are negative health risks associated with adolescents who are bullied?" The two subthemes that emerged were: (a) Bullying has negative effects on adolescent self-esteem and other mental health symptoms, and (b) Victims of bullying may also engage in risky coping behaviors.

Bullying has negative effects on adolescent self-esteem and other mental health symptoms. Several participants reported feeling that bullying negatively impacts adolescents' self-esteem and self-worth. When responding to this question, one PCP stated, "Yes. Mental health issues, depression, anxiety. For females, eating disorders. Self-esteem comes up" (Participant 3). Another provider reported, "Self-worth, anxiety… [there is a] downstream interpersonal impact for kids. Anecdotally, the women I've mentioned before have struggled with depression and anxiety" (Participant 4). Similarly, another PCP reported, "I think that being bullied totally affects someone's self-esteem and I think one's self-esteem is incredibly crucial to being well-adjusted and successful. I think anything that undermines self-esteem is going to have very significant down-stream consequences" (Participant 7). Participant 5 also mentioned that underlying symptoms might also worsen as a result.

Victims of bullying may also engage in risky coping behaviors. Providers elaborated on other mental health concerns that might worsen as a result of being bullied. One PCP stated, "Oh definitely. Obviously mental health, depression, anxiety, and with a lot of things can come food issues, whether that's restrictive or overeating. Downstream effects of more risk-taking behavior, exposure to substances, things like that" (Participant 6). Another provider commented on the negative risks that might be associated. Participant 1 stated:

> Oh yes. I think there are terrible health risks! I think adolescents by nature are risk-takers. They are more apt to have more extreme emotions, wider swings, a bad day being bullied on Facebook could have very significant health consequences [such as] substances, sexual behavior, or self-harming behavior.

Participants generally felt that adolescents engage is risk-taking behaviors, and if they are bullied, this could certainly lead to worse outcomes and mental health concerns.

Main theme 5: Screening for Bullying Can be Useful.

In response to the last interview question, "By adding two questions to a validated screening tool, we can find out this information. Do you think it makes sense to screen adolescent patients?" all seven providers commented that screening can be useful to some degree. Two providers mentioned implications that might be barriers to screening. Two subthemes emerged within this main theme: (a) A screening tool would be useful and allow for more reporting of bullying, and (b) The usefulness of screening can be facilitated by addressing considerations such as integration of behavioral health and follow-up planning for identified children.

A screening tool would be useful and allow for more reporting of bullying. Three participants expressed that bullying is likely underreported, and that screening would help find out which patients are being bullied. Another provider mentioned that a screening tool she used with patients to address bullying was lengthy, "but was very helpful and thorough" (Participant 2). Several PCPs stated that they do not always have the opportunity to ask about bullying when other issues come up during visits. For example, Participant 7 stated:

> I really only ask now when I suspect they're at risk, so I can certainly see myself missing a lot of patients. It absolutely would be helpful, and I would probably do a better job

> when there are cases where it's not obvious. Adolescents are particularly good at not sharing stuff like that. It would help out our clinic too.

Providers also mentioned that they try to screen for bullying but do not always remember to screen unless they suspect bullying is going on.

The usefulness of screening can be facilitated by addressing considerations such as integration of behavioral health and follow-up planning for identified children. In response to the last question item, three PCPs indicated various implications involved in screening that would require planning. These areas of concern involved utilizing behavioral health integration and identifying a clinical care pathway or referral system to manage patients who report bullying. For instance, Participant 1 expressed:

> I've got to believe that we have direct evidence, I don't know the literature strongly, that identifying kids who are bullied, if that's beneficial, what do we do with kids who are identified? What do we do with follow-up, do we have the resources to manage it? Once you let genie out of bottle, it ain't going back in.

Other providers referenced needing behavioral health supports for helping children and adolescents who identify being bullied. For instance, one provider stated, "The ongoing efficacy for integrated behavioral health is needed. Screening is worthwhile but it's not possible without a team" (Participant 4). Participant 6 similarly expressed:

> I think it makes sense to screen everyone school age, adolescent or otherwise...I think we're set up here because we're set up here for behavioral health access, but not everyone has this. Insurance issues, and sometimes parents aren't always the best advocate. I can imagine other places this can be more challenges.

Potential Solutions for Assessing Bullying

Psychological Support Services

Several PCPs reported the need for behavioral health involvement in the form of referrals and consultation for adolescents who report bullying. Providers additionally mentioned that increasing communication with schools can be helpful to connect patients who are bullied with school guidance counselors and/or teachers.

Parent/guardian Involvement

Providers reported that it can be helpful for parents to be aware of any ongoing bullying their child is experiencing. PCPs acknowledged that building a safe space with parents and/or teens is necessary to assess for their safety and address other symptoms that might come up, such as anxiety and depression. Providing parent education around bullying came up as a general recommendation by several PCPs.

Standardized Protocols

Many providers reported not knowing best standardized screening options or best practices for intervention. One provider mentioned the possibility of examining screening options or protocols to have a more informed approach regarding the topic of bullying. Another physician mentioned using the HEADSS (Home, Education and Employment, Activities, Drugs, Sexuality, Suicide/Depression) tool as a general approach to assess risk in adolescent patients (Participant 7; Carr-Gregg & Manocha, 2011).

Discussion

This study examined the provider perspective of integrated care PCPs in an effort to understand if screening for bullying is viable in a primary care setting. Through qualitative analysis of semi-structured interviews with providers, the study aimed to capture the essence of

the provider experience within a phenomenological research paradigm. The interviews elicited information about the providers' attitudes and beliefs regarding early adolescent bullying within an integrated care setting.

Implications

Providers are Aware of the Negative Risks Associated with Adolescent Bullying

One of the most important findings from the current study was the fact that providers acknowledge different aspects of negative health risks for their patients who identify bullying, which might likely influence their motivation to screen. Providers addressed the issue of bullying as potentially worsening existing mental health conditions for patients and acknowledging the importance of addressing these concerns with patients during well-child visits.

Beliefs that Screening Could be Helpful for Adolescent Patients in the Future

Most providers stated that screening for bullying would be helpful to include in the clinic's practice. PCPs who had previous experience in screening mentioned that it was helpful and provided a way to discuss important issues. Providers also mentioned that screening helps children and adolescents access supports when they see needs. Given the many benefits in routine screening in primary care, the importance of identifying screening instruments would be helpful to identify and address bullying early on.

Providers believe in screening even if it is difficult to set up. While PCPs acknowledged several benefits to screening adolescents in the interview phase, providers also stated lacking knowledge about feasibility and best practices. Consistent with the literature, some PCPs acknowledged that they are unsure which screening tools are recommended by reputable journals and the ethical considerations involved in screening adolescents.

Screening Should be Accompanied with Clear Pathways

Several providers touched upon issues of having an appropriate care pathway in place and referenced the possible workflow demands this might create if screening for bullying became a standard protocol. PCPs also mentioned the ethical concerns of screening without treatment options and appeared informed of the limitations that might exist without a specified pathway for referrals.

Possible interventions could be useful. Several PCPs mentioned the importance of parental involvement and education. Physicians treat children who struggle with a variety of concerns that parents should be aware of. Parental involvement not only prevents adolescents from bullying others but prevents them from being bullied. Bleistein (2010) estimates that a physician can review with parents how to develop a safety plan in about two minutes to discuss bullying. Although PCPs reported the importance of parental involvement, many acknowledged time constraints in addition to working with parents who are informed of the detrimental impact of bullying on their child (e.g., one parent stating, “kids will be kids”).

Behavioral health referrals. Several physicians mentioned involving behavioral health practitioners when adolescents report bullying to help clarify interventions and provide support. Providers asserted that screening would be feasible with a team-based approach that integrated primary care provides with the assistance of behavioral health clinicians. Some PCPs even stated that treating bullying concerns would not be possible without an integrated, team-based approach. Indeed, PCPs believed that an integrated care setting is feasible to screen for adolescent bullying and understood the importance of how findings could help patients in the clinic as well as the larger community and family systems.

Limitations

Transferability

Transferability is the extent to which results from one qualitative study can be compared to other studies and settings (Mertens, 2015). It is possible that the data might not be transferable to other integrated primary care clinics within different health care systems, diverse geographic locations, or other levels of behavioral health integration. I was unable to gather data on the current level of integration at this primary care clinic where this research was conducted for the present study. Detailed, richer descriptions of this context in terms of level of integration might have provided more insight into transferability considerations.

The relatively homogenous demographic information of participants in this study was another limiting factor to transferability. Within the seven PCPs who volunteered to participate, there was a wide range of demographic factors that included the number of years the PCP had been practicing as a physician and directly within the UMass Healthcare system, however, there was a lack of racial and ethnic diversity in this study. It is possible that results would have differed had there been a greater range of racial and ethnic backgrounds represented in the current sample. The study also had a limited sample size overall, and a larger number of participants would have likely led to greater transferability by offering a wider variety of participant characteristics.

The recruitment process might limit transferability considerations of the results. Although attempts were made to encourage PCP participation by interest, it is possible that PCPs were driven to participate in the study to either avoid any negative communications with behavioral health providers or by feeling a sense of obligation. Positive responses to questions might have

been influenced by providers wanting to look good or appearing knowledgeable in regard to how they provide care for their patients.

Participants might also have been worried about making negative impressions, leading to the possibility of potentially skewed themes emerging in the results section. Additionally, several participants mentioned that bullying has been addressed with their own children and that they were aware this is problematic from at home, anecdotal evidence. It is possible that providers with or without adolescent-age children might have responded in a biased format based on personal experiences. It will be essential for consumers of this research to consider the results within the context of their site and within their own patient populations to consider potential transferability and conclusions that they may draw based on this data.

Future Research

Screening Young Adolescent Patient Population

While this study successfully analyzed providers' perspectives, the initial intended screening questions about bullying were not distributed before or during well-child visits. While the results from the current study is a step in the right direction for determining screening feasibility, more research in this area is needed. Future research should include piloting bullying screening questions in an integrated care clinic to assess if this a current problem for patients. Additional research in this area would allow for screening questions to be more reliably used within primary care.

Psychoeducational Interventions Mentioned by Providers

Several providers mentioned that when bullying is assessed during well-child visits, PCPs believe that providing parent support is helpful, emphasizing that children should not be blamed for the bullying that is happening. Future research might examine the parent perspective of

adolescent bullying. This additional research could yield information to adapt interventions that might provide parents with greater confidence on how to address the issue of bullying with their children and/or provider.

Exploration with Clinics with Varying Levels of Integration

Considering the lack of transferability of the results of this study due to studying only one clinic in the health system, future research could explore the views of PCPs within a variety of primary care clinics with different levels of integration. Conducting interviews and obtaining data from established PCPs in other clinics within different healthcare systems across the country would yield results that could benefit other integrated primary care clinics overall.

Conclusion

Primary care is a common place for adolescents to address behavioral health needs and concerns. Although some high schools assess for bullying in a validated screening questionnaire once per year, individual results from this screener are not communicated with administrative personnel or parents. The solution to addressing adolescent bullying could happen in primary care. It is important for PCPs to understand the negative health implications of childhood bullying and to understand providers' experiences and attitudes with regard to bullying and the possibility for screening within clinics.

Ultimately, seven participants from one primary care clinic participated in the study. Semi-structured interviews were conducted to learn more about individual providers' perspectives and approach to addressing adolescent bullying. Thematic analysis was used to analyze the collected data from seven interviews. The analysis resulted in several main themes and subthemes that highlighted the unique perspective of PCPs in integrated primary care in regard to addressing and supporting adolescents who have experienced bullying.

Results from the study indicated that overall, providers are aware that adolescent bullying can result in serious negative implications for patients. Results also suggested that providers believe screening is viable and acknowledge several barriers that exist to providing the best care for these patients. This information can likely help clinics understand and discuss the benefits to screening for adolescent bullying in primary care. The results of these interviews show that it is reasonable to conclude that further work on designing screening and preparing interventions will be supported by PCPs, if they are part of the development of the program, and if certain workflow problems can be addressed.

Results from this study indicated that providers are aware of the utility in screening for bullying and understand several negative health risks associated that have been identified in the literature. These results may be useful for anyone working collaboratively in healthcare settings who treat adolescent patients and/or families. While future research is needed to examine the validity and reality of bullying interventions in an integrated care setting, responses from PCPs suggested that the current study is likely a useful foundation for developing a clinical care pathway to address the issue of adolescent bullying. A multidisciplinary collaboration among the physician, behavioral health provider, adolescent patient, family, or school personnel can assist in developing a safe network of empathy for the patient that might lead to meaningful change. Family physicians can make a difference by understanding the harm associated with bullying and helping to create meaningful change. If the issues in identification and treatment can be addressed, this will likely benefit children and adolescents across the nation.

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Appendix A: Bullying Questions

Bullying is when 1 or more students tease, threaten, spread rumors about, hit, shove, or hurt another student over and over again. It is not bullying when 2 students of about the same strength or power argue or fight or tease each other in a friendly way.

I. Have you ever been bullied [on school property]?

A. Yes
B. No

II. Have you ever been electronically bullied? (Count being bullied through texting, Instagram, Facebook, or other social media.)

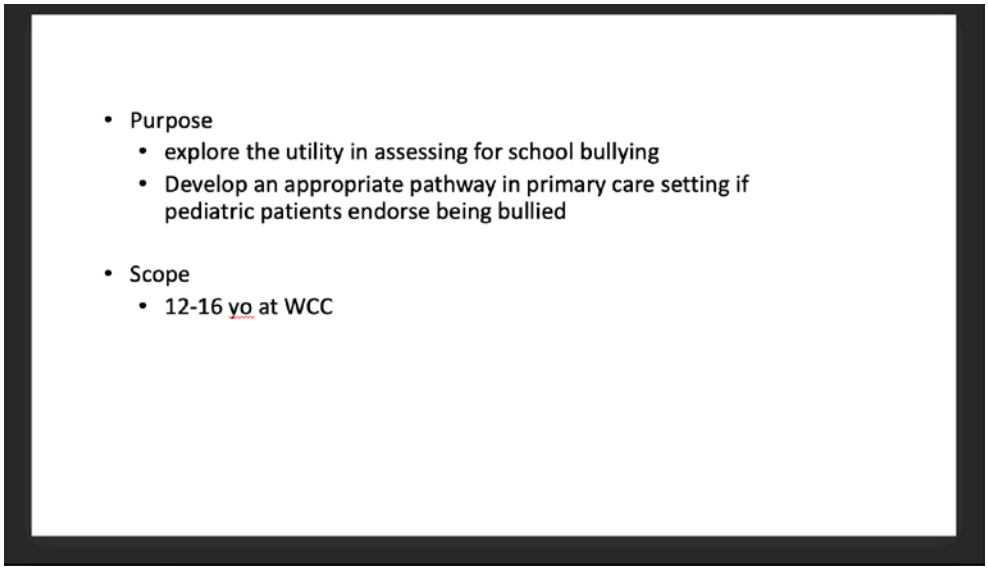
A. Yes
B. No

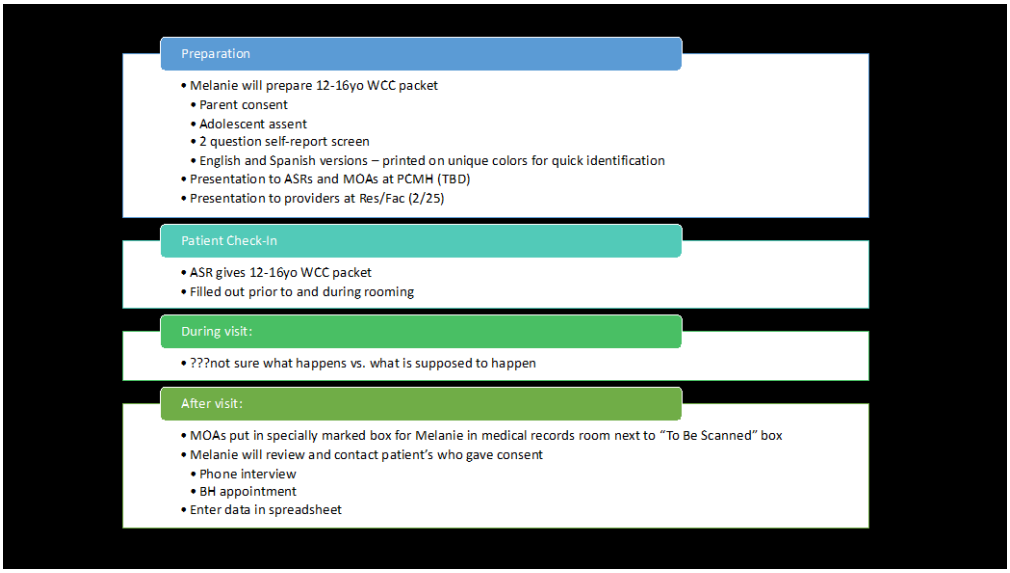
Appendix B: YRBSS Permission

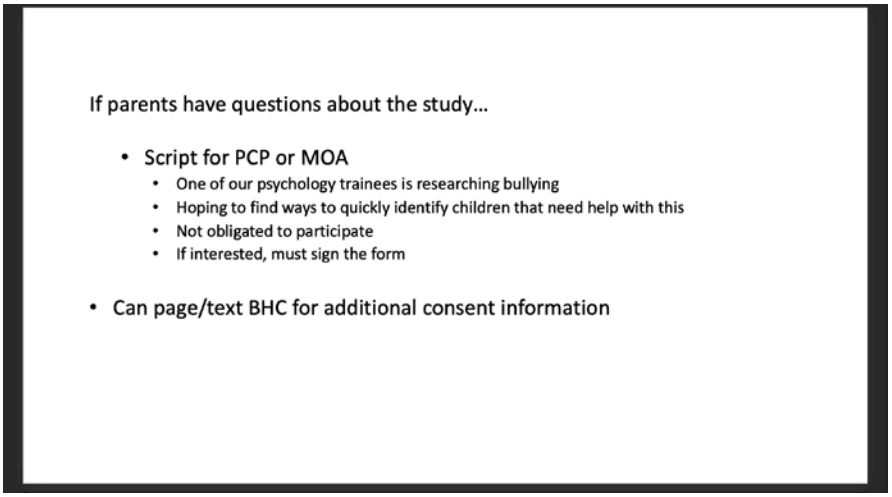
Do I need permission to use YRBSS Questionnaires for my study/area/large urban school district/school? Is there a cost?

The YRBSS questionnaires are in the public domain and no permission is required to use them. You may download and use the questionnaires as is or with changes at no charge. See YRBSS Questionnaires for the most recent YRBSS questionnaires.

Appendix C: Faculty Presentation Slides






If parents have questions about the study…
Script for PCP or MOA
One of our psychology trainees is researching bullying
Hoping to find ways to quickly identify children that need help with this
Not obligated to participate
If interested, must sign the form
Can page/text BHC for additional consent information

Appendix D: Faculty Presentation Slides Permission

Jeanna Lee 1:02 PM (9 minutes ago)

to me

To whom it may concern:

Melanie Sklar and I created a slide presentation together to present to clinical staff at the clinic where she was collecting data for her dissertation. She has my permission to use these slides in her manuscript.

Jeanna R Lee, PhD

Appendix E: Interview Questions

Name of PCP _____
Gender _____
Number of years practicing, including residency _____
Number of years practicing within UMass healthcare _____

Questions:

1) Have you encountered early adolescent patients for whom bullying is a factor?

2) How did you discover that this was the case?

3) Are there any patients who report cyberbullying as opposed to in person bullying and do you handle that differently?

4) Do you think there are negative health risks associated with adolescents who are bullied?

5) What would you do in our role as a physician when your patient reports to you that they're being bullied and what do you wish you could do?

6) By adding two questions to a validated screening tool, we can find out this information. Do you think it makes sense to screen adolescent patients?

Appendix F: Interview Results

Main Theme	Subtheme	Data Extract(s)
Providers may raise the topic of bullying under certain circumstances.	Providers inconsistently ask if adolescents are being bullied.	When I ask about it, which I have to confess I don't ask about it religiously at every visit, but when I do, I'd say that there are times when it comes up. (Participant 7)
		I wish I could say that I always ask about bullying in my adolescent interviews, but I can't say that that's always true. (Participant 1)
		Honestly, I'm really terrible about asking about cyberbullying so no. That's the one thing I wish I could remember to ask about and I never remember to. (Participant 5)
	PCPs raise the issue of bullying if they suspect concerns based on the patient's emotional and physical presentation.	This is where stereotyping comes in, where if the patient seems like someone who might be at risk, I get reminded to ask more. Obviously, this isn't an ideal way to practice, but I'm going to be perfectly honest about this. Like really overweight kids, I'm more apt to ask kids. Or kids who are dealing with gender identity issues, I'm more apt to ask. (Participant 7)
		Sometimes if I haven't asked the question, it might come up- the kid is sad or something, and then I'll ask why they have the symptoms. (Participant 6)
Barriers to screening for bullying exist.	Providers do not have enough time to ask about bullying if there are other concerns.	Practicing in a 15-minute environment, even 30 minutes [with children] who have issues, especially teenage girls with issues, it's impossible to talk about everything in 30 minutes. (Participant 1)

		With that age group, if they're otherwise healthy, we're only seeing them once a year. That's the one time we have to check in with them. A lot of times other concerns or other things get in the way of us really talking about it [bullying] during the visit. (Participant 5)
		There's a limited number of things you can address in a well visit, and I don't ask every parent of every child if there are guns in the house. If I practiced in Texas maybe I would, but here that tends to be limited. I would focus on diet, obesity, screen time, substance use, and there's not always enough time to address everything you could possibly bring up. (Participant 7)
	Providers acknowledge barriers involved in following up with schools.	I think from a time standpoint that having dialogue with school is hard. That would be the wish, I think behavioral health can get involve with schools. (Participant 4)
		I guess with any issues that come up, barriers might be between teachers at the school and physicians. They're busy, we're busy and that kind of thing. (Participant 6)
Providers inconsistently hear about cyberbullying, despite it being an issue for many adolescent patients.	Cyberbullying is an issue for many adolescent patients.	It's [cyberbullying is] more buried and difficult. The ways how adolescents can be cool with each and the way they hide that cruelty with one another and texts that can be read two ways, it's much more difficult than more overt forms that we see. (Participant 1)
		Cyberbullying has come up more. My approach would be similar in terms of checking in about the impact. It's important for adolescents, and for any patients, to identify a trusting adult is one of my interventions for visits (Participant 4).

		I have had instances where adolescents have shared with me that they are having experiences on social media that are making them feel persecuted or badly. (Participant 7)
	Cyberbullying is typically not reported or asked about.	No. (Participant 2)
		No one has ever reported cyberbullying to me. (Participant 3)
		Honestly, I'm really terrible about asking about cyberbullying so no. That's the one thing I wish I could remember to ask about and I never remember to. (Participant 5)
Bullying is associated with health risks.	Bullying has negative effects on adolescent self-esteem and other mental health symptoms.	Yes. Mental health issues, depression, anxiety. For females, eating disorders. Self-esteem comes up. (Participant 3)
		Self-worth, anxiety… [there is a] downstream interpersonal impact for kids. Anecdotally, the women I've mentioned before have struggled with depression and anxiety. (Participant 4)
		I think that being bullied totally affects someone's self-esteem and I think one's self-esteem is incredibly crucial to being well-adjusted and successful. I think anything that undermines self-esteem is going to have very significant down-stream consequences. (Participant 7)
		I think they [adolescents] feel less sure of themselves, and if they already have underlying depression or anxiety, [it's] certainly going to make that worse. (Participant 5)

	Victims of bullying may also engage in risky coping behaviors.	Oh definitely. Obviously mental health, depression, anxiety, and with a lot of things can come food issues, whether that's restrictive or overeating. Downstream effects of more risk-taking behavior, exposure to substances, things like that. (Participant 6)
		Oh yes. I think there are terrible health risks! I think adolescents by nature are risk-takers. They are more apt to have more extreme emotions, wider swings, a bad day being bullied on Facebook could have very significant health consequences [such as] substances, sexual behavior, or self-harming behavior. (Participant 1)
Screening for bullying can be useful.	A screening tool would be useful and allow for more accurate reporting of bullying.	I really only ask now when I suspect they're at risk, so I can certainly see myself missing a lot of patients. It absolutely would be helpful, and I would probably do a better job when there are cases where it's not obvious. Adolescents are particularly good at not sharing stuff like that. It would help out our clinic too. (Participant 7)
		I think it [screening] does make sense. I think it's probably underreported so capturing it could be really helpful. (Participant 3)
		Yes. At Family Health Center, there is a very long adolescent screener that took a long time for kids to complete (it was 4 pages long!) but was very helpful and thorough. (Participant 2)

		I definitely do. I think it's one of the things that we try to remember to screen for anyway that sometimes, depending on how the visit goes, if they have other concerns, you just don't get to everything you want to get to. (Participant 5)
	The usefulness of screening can be facilitated by addressing considerations such as integration of behavioral health and follow-up planning for identified children.	I've got to believe that we have direct evidence, I don't know the literature strongly, that identifying kids who are bullied, if that's beneficial, what do we do with kids who are identified? What do we do with follow-up, do we have the resources to manage it? Once you let genie out of bottle, it ain't going back in. (Participant 1)
		The ongoing efficacy for integrated behavioral health is needed. Screening is worthwhile but it's not possible without a team (Participant 4).
		I think it makes sense to screen everyone school age, adolescent or otherwise...I think we're set up here because we're set up here for behavioral health access, but not everyone has this. Insurance issues, and sometimes parents aren't always the best advocate. I can imagine other places this can be more challenges. (Participant 6)