

Bullying: Children Hurting Children

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OBJECTIVES

After completing this article, readers should be able to:

1. Define bullying and recognize it as a major public health issue.
2. Identify children who are bullies and children who are victims of bullying.
3. Know how to educate parents and children about bullying and to advise those involved on how to prevent future episodes.
4. Understand the possible consequences of bullying and how to prevent them.

Introduction

Mark's parents were worried. Their 14-year-old son, who recently had entered a new school, was a small, clumsy child who was poor at games and had odd mannerisms. He was unable to enunciate his words clearly or quickly and became flustered when provoked. He had problems making friends.

After a few months in his new school, he became known as Mark the Martian because of his mannerisms. He was unable to ignore the taunting, which included being kicked, punched, and tripped by classmates. The problem was especially pronounced on the playground. He became so tense that he reacted volatily and dramatically, earning him the reputation among staff of being aggressive. His reactions encouraged the bullies to continue. No single incident was severe, but the cumulative effect was devastating. Mark did not approach school staff, and they never saw any of the bullies' attacks. They did see Mark's aggressive reactions and did not have a sympathetic attitude toward him.

The bullying finally came to light when it was discovered that Mark was walking around town all day in winter weather rather than facing school. At the same time, the mother of one of his classmates phoned his parents and the school to say that her son was becoming distressed at the extent of the bullying Mark was having to endure. Many of the chil-

dren were disturbed by the events, but no teacher had been aware of what had been taking place.¹

If he were your patient, what would you say to the child? What would you say to the parents? What would you do if no action was taken by school personnel to remedy this problem despite parental efforts? Bullying, largely a covert entity, is a problem that physicians should understand because it affects far more children than most people realize and can be devastating for those involved.

Definition

Bullying is a form of aggression in which one or more children repeat-

edly and intentionally intimidate, harass, or physically harm a victim who is perceived as unable to defend himself or herself.²⁻⁵ The key aspects of this definition are: 1) repetition over time and 2) an asymmetric, coercive power relationship. Victims perceive themselves as being weaker than bullies and feel that they cannot retaliate. Examples of bullying include being called names, being physically hurt, being threatened, being the subject of rumors, being isolated socially, and having one's belongings taken repeatedly.

Epidemiology

Bullying is a common problem around the world, and the United States is certainly no exception (Table 1). Estimates vary according to the definition used and method of data collection, but approximately 10% of children in the United States are bullied. Furthermore, recent research suggests that between 80% and 90% of preadolescents and adolescents will face ongoing psychological and physical harassment at

TABLE 1. Prevalence of Bullying in Various Countries

COUNTRY	PREVALENCE
Norway	• 14% of children were involved in bullying either as bullies or victims ⁶
England	• 19% of students reported being bullied ⁷ • 10% of primary and 4% of secondary school pupils reported being bullied at least once a week ^{8,9}
Japan	• 15% of primary and 10% of secondary school pupils reported being bullied ⁸
Spain	• 17% of students reported being bullied during the term in which the study was conducted ⁸
Ireland	• 8% of students were seriously bullied at least once a week ⁸
Australia	• 17% of boys and 11% of girls were bullied "pretty often" or more ⁸
United States	• 10% of children experienced "extreme victimization" by bullying ¹⁰

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some point in their school life that could be characterized as bullying.¹¹

Because it frequently goes unreported, bullying is more common than most people realize. Although many children say that they find talking about their experiences of bullying to be helpful, only about 50% report that they confided in anyone about it. Reporting of bullying is less likely by boys, by older children, and by those who experience bullying infrequently. Children are more likely to report bullying to someone at home than to school personnel.

Boys generally are more involved in bullying than girls; 14% of boys and 9% of girls in the United States are likely to be involved as either bullies or victims.¹² Girls more often are the targets and perpetrators of passive, indirect bullying, such as gossip and social isolation. Boys more frequently are the targets and perpetrators of aggressive, physical bullying. In Norway, boys bully more often than girls, but in the United States this difference has not been found to be as large.^{6,8,10}

Surveys of children in second through ninth grades show that the percentage of students who are bullied is highest at 7 years of age (second grade) and declines steadily through the years to age 15 (ninth

grade) (Fig. 1). In Norway and Sweden, for example, bullying was reported in 17% of students in grade two and 4.7% in grade nine. Data from around the world support these findings. This decline with age is evident among both boys and girls.

Unfortunately, virtually no data currently exist for the prevalence of bullying in preschool, kindergarten, and first grade. This lack of data reflects a methodologic difficulty in that almost all data on bullying have been based on anonymous surveys. Younger children generally cannot read well and, thus, cannot answer surveys.

Characteristics of Bullies and Victims

Studies in Norway have examined the personalities of bullies and victims. This information is useful in helping to identify children who are at greatest risk of being bullies or victims.

BULLIES

Bullies are often aggressive toward teachers, parents, siblings, and peers. They generally have a more positive attitude toward violence and the use of violent means to dominate others. They have little empathy for victims

of bullying. If male, bullies are more likely to be physically stronger than other boys in general and victims in particular. Contrary to a common stereotype, bullies have either average or lower-than-average anxiety and insecurity. In other words, these children do not suffer from poor self-esteem. Bullies do have a strong desire for power and domination. They seem to enjoy being “in control” and subduing others. They crave social influence. Prestige as well as material goods coerced from victims reward bullying.

VICTIMS

Victims react more passively and anxiously to situations and are more insecure than most children. They tend to be physically smaller and weaker and are often cautious, sensitive, and quiet. Lonely and abandoned at school, they are more likely to be alone on the playground.^{6,13,14} When attacked by other students, they commonly react passively by crying (at least in the lower grades) and withdrawing. They have a negative view of themselves and their situation and often view themselves as failures, feeling stupid, ashamed, and unattractive.

A different group of victims termed *provocative victims* is characterized by a combination of both anxious and aggressive behavior.¹⁴ These children are victims of bullying, but they seem to seek out the attention of bullies by teasing them, thus encouraging even more bullying. Olweus reported that only a small minority of Scandinavian victims—fewer than one in five—qualified as provocative victims.¹⁴ In a small study done in the United States, however, the chances of a victim being provocative or the classic passive type of victim were roughly equal.¹⁰

Although certain types of children are more prone to being involved in bullying, it is important not to stereotype. Some of the most charming and helpful pupils can be vicious to their peers, and some of the most able and socially competent pupils can experience regular bullying.⁷

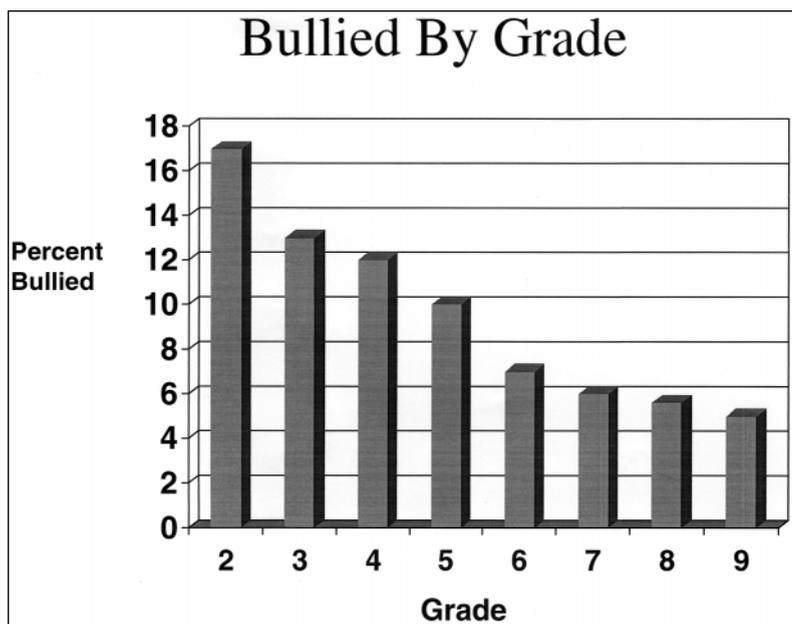


FIGURE 1. Incidence of bullying by grade. Each bar corresponds to the percentage of Norwegian students in each grade who reported being bullied in the previous year. Data from Olweus.⁶

Site of Bullying

Although bullying occurs everywhere, it is most frequent at school at the times and places that have minimal supervision. For most children, bullying occurs in and around school, most commonly on the playground.^{7,8} In primary schools, 75% of pupils who are bullied are victimized during breaks or lunch times. In secondary schools, bullying is less well localized. Hallways, playgrounds, and classrooms are the three most common places, and recess and lunch periods are the most common times.⁶⁻⁸ It has been reported that the incidence of schoolyard aggression is inversely related to the number of supervisors on duty.¹⁰ One British study reported that 14% of elementary and 5% of secondary school children who were bullied at school also were bullied outside of it, such as en route to and from school.⁷

Characteristics of the School

Whether class size makes a difference in the prevalence of bullying is controversial. Comprehensive studies indicate that the size of the class or school is of negligible importance in the relative frequency and level of bully/victim problems in the United States and abroad.⁸ Large Norwegian studies showed that the percentage of bullied students in small, one-room schools was almost the same and, in a few cases, even higher than in larger primary schools.⁶ However, in 1996, a smaller study based in the United States reported that students at larger schools are more likely than students at smaller schools to be exposed to bullying, physical attack, or robbery.¹²

Whatever the size, certain schools clearly have more trouble with bullying than others. Schools that have the worst problems seem to be those in which bullying is tolerated by adults (weaker supervision) and there are more children who experience social chaos at home.⁶

Consequences of Bullying

Consequences of bullying are many, and they vary in severity. At one end of the spectrum is fear. Some victims go through the school years in a state of more or less permanent anxiety and insecurity coupled with poor self-esteem.¹⁵ School can be an unfriendly and dangerous place for bullied children. Sending these children to school is analogous to sending an adult into an unsafe and unfamiliar neighborhood, day after day.¹⁶ This fear leads to depression, low self-esteem, and chronic absenteeism. In one survey, 90% of those bullied said that they suffered side effects, including a drop in grades, an increase in anxiety, and a loss of friends or social life, as a result of being bullied.³ Furthermore, physicians should remember that bullying can be especially difficult for chronically ill children, who may suffer worsened body image with frequent teasing.¹⁷

“... bullies have either average or lower-than-average anxiety and insecurity . . . these children do not suffer from poor self-esteem.”

Children who observe bullying as innocent bystanders, but are not directly involved with it, may suffer consequences as well. Bullying detracts from learning by all students because it interrupts teaching sessions, distracts and scares other students, and takes up teachers' time. According to one study, 7% of America's eighth graders stay home at least one day a month because they are afraid of other children.¹⁸ A study by Hazler et al in 1992 suggested that 20% or more of all children attending school are frightened through much of their school day.³ More than one in five secondary school students said that they avoid rest rooms at school out of fear. Bullying causes many children to believe that school is an unsafe, hostile environment where they are not protected.¹⁶

The most extreme consequence of bullying for victims and society is violence, including suicide and murder. The sense of powerlessness experienced by children who are victimized can be so profound that some react with self-destructive acts

or lethal retaliation. Recently, there have been numerous case reports of children who committed suicide or murder largely because they were chronically bullied. Violent retaliation is more frequent in the United States than in European countries.¹⁹ Recent killing sprees—including those in Kentucky, Arkansas, Oregon, and Mississippi—were committed by children who felt inferior or picked on.²⁰⁻²² Their killings are viewed by some criminologists and other experts as a way to end a tortured life.²¹ Sixteen-year-old Luke Woodham, for example, a boy who was repeatedly told he was fat and a nerd, killed two students and his mother and wounded seven people at his school in Pearl, Mississippi, in October 1997. He was quoted as saying, “I am not insane. I am angry. I killed because people like me are mistreated every day. I did this to show society: Push us and we will push back.”^{23,24}

Another societal consequence of

bullying is that it leads to similar acts of unacceptable and even criminal behavior by bullies in adulthood. A 1991 study found that 60% of boys labeled as bullies in grades six to nine had at least one criminal conviction by age 24 years; 35% to 40% had three or more convictions by age 24 years compared with 10% of control boys who were neither bullies nor victims as children.¹⁵ Thus, the aggressive, antisocial behavior of child bullies, if left unchecked, is likely to lead to more serious criminal behavior later.¹⁵ This may be the most compelling reason for focusing on bullying. By allowing this problem to continue, adults are giving bullying children the message that such behavior is permitted, is acceptable, and is rewarded by power. By not attacking this problem, society is passively sending positive reinforcement for criminal activity in adulthood.

The Role of the Pediatrician

The pediatrician has four primary roles: 1) identifying the problem;

2) counseling parents, children, and perhaps school personnel regarding intervention and prevention;
 3) screening for, treating, or referring to psychiatrists or psychologists when mental comorbidities are present; and 4) advocating for violence prevention and for the right of children to attend school and live free from the threat of violence by other children.

IDENTIFICATION

The pediatrician's first obligation is to find out whether bullying is a problem. If you ask a child how things are going at school and his or her response suggests that something is wrong, ask more specific questions to find out what is occurring. Table 2 lists a number of sample questions to ask the child and the parents to investigate whether a child is being bullied. One or more of these questions might be asked of school-age children as part of anticipatory guidance during health supervision visits, especially if something about the child suggests this as an issue.

Some children are more at risk and warrant special screening. Chronically ill children, those who have learning or behavior problems,

those who seem depressed or have recurrent abdominal pain, and those who prefer to stay inside for recess are more likely to be bullied. One Australian group estimated the prevalence of bullying in the form of teasing among patients attending a craniofacial clinic to be approximately 40%.¹³ Other at-risk groups are children who have recently moved and those who have known social problems.¹⁷ Children who go to special education classes may be more at risk for being victimized for their lack of social skills or clumsiness.¹⁹

Screening for bullying at sick visits is especially important when specific symptoms are being reported. Insomnia, sadness, stomachaches, headaches, and enuresis have been associated with being bullied. In a 1996 British study, 2,962 children ages 8 to 9 years in mainstream schools who visited the school nurse were interviewed to find out if certain physical complaints brought to the attention of health-care personnel at schools correlated with the presence of bullying in the lives of the patients.²⁵ The hypothesis was that children who go to the school nurse with vague complaints may be trying to escape a

classroom in which other students are terrorizing them. Table 3 shows that these somatic complaints were strongly associated with being a victim of bullying.

Once bullying has been identified, it is imperative that parents and teachers be made aware of the problem. The pediatrician should be able to counsel parents regarding what steps to take.

COUNSELING

The worksheet in Fig. 2 outlines the complex mixture of circumstances and settings in which children frequently are bullied. It is designed to help families understand the problem and to motivate them to act by showing them what can happen if bullying is allowed to continue. The worksheet also functions as a blueprint for action. It can be given to parents and children to help them identify which school personnel to contact when advocating for the child. It also might be used to give bullied children insight into how they can help stop negative behaviors aimed at them in school and in life outside of it.

Using the model as a guide, pediatricians can explain to families what is known about bullying. At each step in the cycle, the pediatrician can give suggestions to prevent bullying.

1. Children Who Are Bullied.

Victims often project an air of

TABLE 2. Sample Questions to Investigate Whether a Child is Being Bullied

Questions for Children

1. Have you ever been teased at school?
2. Do you know of other children who have been teased?
3. How long has this been going on?
4. Have you ever told the teacher about the teasing?
5. What kinds of things do children tease you about?
6. Have you ever been teased because of your illness/handicap/disability? for not being able to keep up with other children? . . . about looking different from them?
7. At recess do you usually play with other children or by yourself?
8. Have you ever changed schools because you had problems with the other students?

Questions for Parents

1. Do you have any concern that your child is having problems with other children at school?
2. Does your child go to the school nurse frequently?
3. Has your child's teacher ever mentioned that your child is often by himself or herself at school?
4. Do you suspect that your child is being harassed or bullied at school for any reason? If so, why?
5. Has your child ever said that other children were bothering him or her?

TABLE 3. Association Between Reported Bullying and Other Health Symptoms

SYMPTOM REPORTED	ODDS RATIO*
Having trouble sleeping	3.6
Feeling unhappy or sad	3.6
Having stomachaches	2.4
Having headaches	2.4
Wetting the bed	1.7

**The number under the odds ratio column equals the number of times more likely that the child was to have the symptom if he or she was being bullied compared with if he or she was not being bullied.^{25,26}*

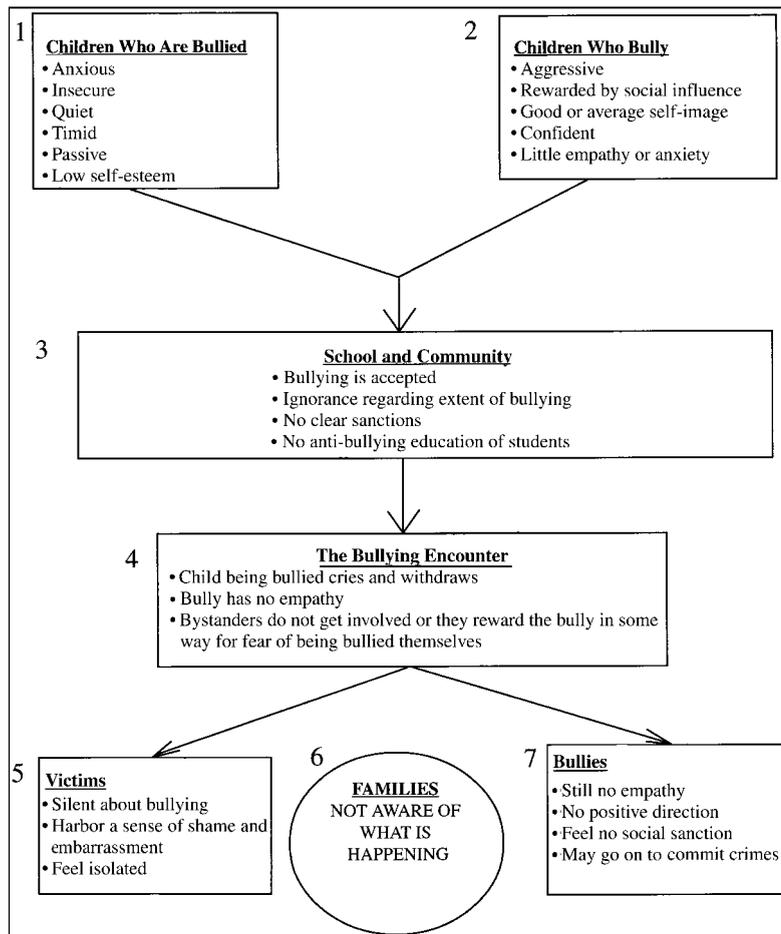


FIGURE 2. Diagram for pediatricians to use as they explain current knowledge about bullying to parents. This bullying blueprint shows how multiple factors contribute to this problem and where interventions can occur.

weakness and low self-esteem and tend to be more passive and insecure. The child and parents should be informed that data show that appearing insecure invites more bullying.¹⁰ Parents can role-play with the child to demonstrate how to project a sense of confidence. Standing up straight, making eye contact, holding arms and hands relaxed, and speaking in a strong voice can dissuade bullies.¹⁷

There are many ways to raise self-esteem. Involving the child in extracurricular activities that build confidence and expose him or her to children who have similar interests and are not involved in bullying is one such way. Drama clubs, for example, teach children how to project an air that may not represent how they actually feel, a skill they can use when being bullied. At the same time, this activity might introduce them to a different group of

people. If they excel at the task, self-esteem is enhanced. Drama also gives children a chance to practice standing up in front of others and speaking publicly. Sports is another excellent outlet for children that offers many of the same advantages in addition to promoting good health, greater physical strength, and a socially acceptable outlet for anger and frustration. Pediatricians can work with parents to find some extracurricular activity at which the child excels or expresses an interest and work to allow him or her to pursue it as much as possible.

2. Children Who Bully. Conferences between the parents of victims and bullies can help resolve conflicts, but individual personalities and circumstances will determine the feasibility of this approach. The teacher can serve as an unbiased observer at these meetings and should be present if possible to pro-

vide balance and be a part of the solution.

Parents of victims should request the child's teacher to adopt a no-tolerance policy in the classroom. Bullies seek power and social influence and will continue to bully unless adults stop it. Schools where teachers are more tolerant of this behavior have higher rates of bullying.⁶

3. School and Community.

Probably the most important action that the pediatrician can take is to encourage parents to organize a meeting at the school between parents, the child's teacher(s), and, if possible, the school psychologist. Teachers are less likely than parents to know the extent of the problem, yet they are the adults closest to the actual bullying and have more power to do something about it. Particularly motivated parents would be wise to read the concise book *Bullying At School: What We Know and What We Can Do*⁶ before the meeting to educate and prepare themselves for talking with the teacher. Teachers may change the seating arrangement in the class to minimize contact between the victim and bully. They should increase supervision over the child being bullied. If they witness or hear about another event, sanctions against the bully should be enacted. Bullies should be confronted and told that their behavior will not be tolerated. Action from the teacher is likely to enhance reporting by other children if they see that telling a trusted adult results in less bullying without repercussions for themselves.

4. The Bullying Encounter. To help bullied children understand how to respond when it happens again, teach them the phrase, "Walk, talk, squawk" (Personal communication, Mrs. Linda Hess, public school teacher). It is a simple, easy-to-remember phrase to remind children of three key concepts. 1. **Walk** away from the scene rather than hang around for more abuse. Do not run as if terrified even though you might feel that way. 2. Project an air of being strong and in-control by speaking and behaving calmly. **Talk** to bullies. Look them straight in the eyes and say something with confidence, such as, "You don't scare

me.” The talk should be brief and not provocative. 3. **Squawk** to a teacher or parent. Don’t keep what happened bottled up inside. An adult needs to know about it. Parents can watch their child’s posture and tone of voice with people outside the family and then encourage him or her to be more assertive. Role-playing may be helpful.

5. **Victims.** Children should be encouraged to identify an adult to tell if they are being bullied at school. Parents should be encouraged to speak with their children frequently to find out how things are going at school and whether the bullying is still happening. The parent should keep a record of events.

“Bullies should be confronted and told that their behavior will not be tolerated.”

6. **Families.** Teachers and parents should communicate regularly to ensure good follow-up. Teachers should report to parents whether they have witnessed any change in the children’s behavior and whether they have witnessed any bullying. This reminds the teacher to watch for it and keeps parents informed. Parents might want to set up a regular calling time in advance with the teacher to ensure the continuation of good communication.

The most important advice to give a victim of bullying is to tell an adult about all events when they happen. Because children usually fear retaliation if the bully finds out that the victim has disclosed the bullying, it is important to reassure the child that the only way to stop the bullying is to involve someone more powerful than the bully. The adult cannot promise that the bully will not seek revenge, but he or she can vow to monitor the situation closely and ask parents and teachers to do the same to prevent repercussions from reporting. The clinician who gives this advice is asking the child to imagine that life will be better eventually if he or she agrees to a plan of action that could make life more uncomfortable in the short-term. The child may prefer to continue the present situation for fear that the future will become worse. Remind children that when

adults are threatened by someone, they go to the police to “tell on” other people who are bothering them. One of the roles of teachers (like police officers) is to ensure safety.

7. **Bullies.** Involving a school psychologist to help both the bully and victim individually could be key to making long-term behavioral changes. The school psychologist can work with the bully to establish a more positive direction in his or her life. School psychologists should be able to link bullies with community programs that foster positive attitudes and expose them to strong role models. The school psychologist also can help the bully see the

effects of his or her actions and get to the root of why he or she behaves this way.

PSYCHIATRIC SCREENING, TREATMENT, AND REFERRAL

When pediatricians discover a pattern of victimization, the child should be screened briefly for American Psychiatric Association *Diagnostic and Statistical Manual (DSM-IV)* separation and generalized anxiety disorder as well as panic disorder. A history of early childhood inhibition and parental history of anxiety is particularly supportive. If the victim meets the criteria of anxiety disorder, there are many well-known and effective behavioral (fear reduction) treatments. Medications are less effective, especially for younger children.

Screening for dysthymia and depression should be undertaken as well, including questions about suicidality, self-deprecation, sleep patterns, appetite, and anhedonia. If the child has a mood disorder and is postpubescent, effective medications, particularly selective serotonin reuptake inhibitors, and behavior therapies can be instituted. It is important to remember, however, that medication should not be the sole treatment for depression caused by bullying. Instead it should be seen as one component of a plan used to make the situation bearable

while a more permanent solution is being implemented.

Only three symptoms are required to meet the criteria for conduct disorder. “Bullies, threatens, or intimidates others” and “is physically cruel to people” are two of these. If a child’s bullying is one part of a larger oppositional or antisocial pattern, there is a wide range of treatments, including parent training and medication if the form of aggression is impulsive or reactive. Special education may be useful for some bullies because aggressive children often have poor verbal and phonological processing skills. Referral to a psychiatrist or psychologist is warranted whenever a psychiatric comorbidity is strongly suspected (Personal communication, Matthew Speltz, Professor of Psychiatry and Behavioral Science, University of Washington, October 1999).

CHILD ADVOCACY AND THE GOOD NEWS

In Norway, although bullying was an issue of general concern for a number of years, school personnel and government did not become involved officially until 1982 when three 10- to 14-year-old boys committed suicide, in all probability as a consequence of severe bullying by peers. This event and the accompanying media coverage ignited considerable unease among the general public. As a result, the Ministry of Education launched a nationwide campaign against bullying problems in Norwegian schools (grades 1 to 9).

A Norwegian psychologist, Daniel Olweus, the pioneer of bullying research, created an intervention program based on extensive research. The schoolwide program was implemented in 1983 and involved parents, school personnel, and students. Data from approximately 2,500 students in Bergen, Norway, were obtained before and after the intervention was initiated. There was a 50% reduction in the levels of bullying problems 2 years after the start of the intervention. Before the intervention, the annual incidence of new cases was estimated at 2.6% for boys and 1.7% for girls. After the intervention pro-

gram, the incidence of victimization decreased to 0.6% for boys and 0.5% for girls. Results indicated that the intervention program not only affected already existing victimization problems, but it reduced considerably the incidence of new cases and associated school violence.^{11,14}

Clearly, this area is ripe for further work by child advocates. The large amount of data that already has been collected indicates that this is a widespread problem that has potentially devastating consequences. An intervention program has been tried in Norway that actually works. Why are we not doing more here in the United States to stop bullying?

Concluding Thoughts

Adults are protected by law against crimes such as extortion, harassment, and assault. Children who experience these same crimes at school are not being protected from their classmates. Students have a right to obtain an education free of violence and intimidation.⁵ Parents can and have sued schools when their children were severely threatened by bullies while at school. Attorneys James Rapp, Frank Carington, and George Nicholson, authors of *School Crime and Violence: Victims' Rights*, state that legal cases across the nation generally have affirmed the following specific rights for school victims:

1. To be protected against foreseeable criminal activity.
2. To be protected against student crime or violence that can be prevented by adequate supervision.
3. To be protected from dangerous individuals negligently placed in schools.
4. To be protected against identifiable dangerous students.

The United States Supreme Court issued pronouncements recognizing the problem of creating safe schools. Justices Sandra Day O'Connor and Lewis Powell declared, "Without first establishing discipline and maintaining order, teachers cannot begin to educate their students. The school has an obligation to protect pupils from mistreatment by other children."¹⁶ Pediatricians have information to share with teacher/principal colleagues and research to support their advice. We can serve as valuable consultants and child advocates to help remedy this problem.

Every individual should have the right to be spared oppression and repeated intentional humiliation in school as in society at large. No child should have to be afraid of going to school for fear of being harassed or degraded, and no parent should have to worry about such things happening to his or her child.⁶

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PIR QUIZ

Quiz also available online at www.pedsinreview.org.

1. Which of the following is a *true* statement about bullying?
 - A. Approximately 10% of children in the United States are bullied.
 - B. Approximately 30% of preadolescents and adolescents will, at some point in their school career, experience some type of bullying.
 - C. Approximately 75% of the victims represent the provocative type.
 - D. Approximately 80% of school children experience fear during most of the school day.
 - E. Approximately 90% of bullied victims confide in their teachers or parents.
2. Behavioral warning signs that suggest a child is at risk for being bullied include all of the following *except*:
 - A. Craves social influence and control.
 - B. Frequently visits the nurse's office for vague somatic complaints.
 - C. Is cautious, sensitive, and insecure.
 - D. Often stays inside for recess.
 - E. Reacts to confrontation passively by crying and withdrawing.
3. Which of the following school characteristics *best* correlates with a high incidence of bullying?
 - A. A higher proportion of students receiving special education.
 - B. Extremely small class sizes.
 - C. Increased percentage of male students.
 - D. Larger class sizes.
 - E. Minimal supervision at breaks and lunch time.
4. Although many factors may have a positive effect on the incidence of bullying, for which of the following is there *evidence* to prove a significant positive impact?
 - A. Adoption of school policy for zero tolerance of bullying.
 - B. Counseling and role-playing to provide the victim with self-confidence.
 - C. Counseling for the bully to help him or her resolve issues more positively.
 - D. Extracurricular activities to enhance self-esteem and introduce the child to a new circle of friends.
 - E. Medical treatment of the victim for depression and anxiety.

Bullying: Children Hurting Children
Gwen Glew, Fred Rivara and Chris Feudtner
Pediatrics in Review 2000;21;183
DOI: 10.1542/pir.21-6-183

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