

The school bullying problem

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Research into school bullying has, to date, predominantly focused on prevalence and intervention programmes. This article reviews some of this previous work and goes on to explore and discuss the holistic management of bullying, and outlines the importance of the role of the school nurse.

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ALTHOUGH BULLYING has been at the forefront of the agenda for schools during the past decade, the focus has been very much on prevalence and intervention programmes in contrast to related health issues and long-term consequences for bullies and victims. The responsibility for the management of bullying has for the most part rested with education professionals and has failed to include the multidisciplinary team. This article sets out to redress this balance, to consider bullying in its broadest sense, to look at the effect school bullying can have on individuals and schools, and to suggest how health professionals might take a higher profile in the total management of this problem.

The role of the school nurse as part of the multidisciplinary health and education team is central to this new approach. The current role of the school nurse is appraised and how this may be extended is discussed. The political dimension, with reference to recent cuts in the school nursing service, is addressed and caution advised. If this problem is to be successfully managed it is the belief of the authors that bullying must be kept at the forefront of the school agenda and attitudes toward school nursing must be modified, with practitioners embracing this challenge by changing their behaviour and showing a willingness to act in a leadership role.

What is bullying?

The concept of bullying is multifaceted. It is dependent on culture and is not easily translated from different languages (Arora 1996). Different processes are seen to contribute toward the concept and it is very difficult to ascribe a single model to all actions that constitute bullying. Although most children have an understanding of the term, this would often appear to be differentiated by their age. Smith and Levan (1995) discuss the experiences of smaller children (age six to seven), who may quantify a single aggressive episode as bullying; while an adolescent would look for a more consistent pattern.

Olweus (1994) defines bullying or victimisation as a student who is exposed repeatedly, and

over time, to negative actions on the part of one or more other students. He recognises that the bully and victim must have an asymmetrical power relationship and that the harm inflicted must be intentional. Whitney and Smith (1993) illuminate this by giving specific examples. The spectrum is wide, ranging from overt physical behaviours such as hitting or kicking, to indirect or relational bullying, such as name-calling or social exclusion.

Other researchers (O'Moore and Hillery 1989, Rigby and Slee 1991, Smith 1991) suggest that more than one in seven children experience bullying on a weekly basis. The type of bullying experienced differs according to a child's age and gender. Boys in both primary and secondary school are more likely to be physical in their approach, while indirect forms of bullying are more likely to be experienced between girls. Interestingly, name-calling is more evenly distributed between boys and girls (Rivers and Smith 1994). Direct physical bullying would appear to decrease with age.

Extrapolated from this data, it would appear that approximately four children in every class are subjected to bullying on a very regular basis. As Whitney and Smith (1993) assert, this is clearly a significant and pervasive problem. Untackled, this could lead to serious or deleterious consequences for the present generation of young children.

Whose business?

Currently, the responsibility for bullying problems would appear to lie with education. Although health professionals may become involved, they are peripheral to the main policy discussions. Health professionals' interface with bullying issues may be observed at a number of different levels. From both a personal and professional stance, nurses may view bullying from a slightly different perspective to members of the general public. This is particularly notable with regard to the possible physical and mental health consequences for all involved.

The health visitor may be concerned about the behavioural problems exhibited at home by a

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small child who is being bullied at school, whereas the community children's nurse may be worried about the return to school of a child after receiving chemotherapy for leukaemia. In contrast, a nurse from the local children's ward or A&E department might be involved regularly with teenage suicide attempts, and a community psychiatric nurse involved with ongoing counselling for clients with adolescent depression. Finally, GPs, community physicians and school nurses will all see children presenting with a number of different conditions that could be attributed to bullying.

Health problems

The focus to date has been on the psychological problems associated with victimisation. Such research has revealed a correlation between psychological damage and the bullying experience. Often, children do not admit to being bullied, although those that do frequently suffer a lower self-concept and depressive symptomology (Callaghan and Joseph 1995). Victimisation is increasingly recognised as psychologically harmful, physically damaging and socially isolating (Slee 1995). In 1995, Sharp surveyed a significant sample of secondary age school children, with 34 per cent reporting that being bullied was stressful and 11 per cent viewing it as extremely stressful. Interestingly, indirect bullying – which is frequently unnoticed by educational colleagues – was associated with the higher levels of stress.

Contrary to the widespread conception that bullies are confident individuals with a high self-esteem, they might also be depressed and dislike school (Slee 1995). This is further substantiated by Salmon *et al* (1998) who found bullies to have an inclination to lie in addition to depressive tendencies. Conversely, they were noted to have a low anxiety score in relation to their peers. The recently identified bully-victim group was noted by Kumpulainen *et al* (1998) to have the highest referral rate for psychiatric consultation.

Williams *et al* (1996) were the first to suggest that physical problems may also be attributed to bullying. An association between being bullied and minor health problems in primary school children was reported after carrying out health interviews with year-four primary school children. Examples proffered include insomnia, enuresis, abdominal pain and headache, an increase in bullying seemingly being responsible for an increase in symptomology. This prevalence might have been under-reported as parents were present throughout the interview process, which could be viewed as a methodological flaw.

Rigby (1999) looked at reported peer victimisation in one of the first attempts to address the causality of the relationship between victimisation and physical and mental health problems.

He questioned whether victimisation leads to poor health or alternatively, whether poor health makes one more open and vulnerable to victimisation by peers. He found those reporting victimisation in the early part of the study were more likely to report mental and physical health problems three years later; thus tentatively suggesting that health problems are a result of victimisation, rather than vice versa.

Contemporary management of bullying

Tattum (1997) states that countering bullying is a wide-ranging and multidimensional exercise. The recommended approach would appear to be a whole school and community-based strategy. Olweus (1994) suggests a core programme, which he acknowledges as being the English equivalent to a whole school policy approach. Specific measures relating to the school, class and individual are recommended. Although the Norwegian experience would suggest that such a policy is successful, it must be recognised that the empirical base is far from robust in terms of methodological issues. Olweus (1994) recognises this limitation and is confident that future research will address current methodological deficits.

Alternatively, Roland (1993) carried out a similar whole school investigation with only mediocre results, with a reduction in bullying being reported for schools with a strong commitment to implementing the programme, but an increase in bullying being found in others where minimal effort was displayed. This further highlights some of the above mentioned limitations regarding the implementation and evaluation of school bullying intervention programmes, illustrating how hard it is to assess whether a bullying policy is, and remains, at the forefront of a school's agenda.

This could be equated to the fact that a teacher's prime responsibility is education, and contemporary schools are reactive rather than proactive with regard to the bullying problem (Tattum 1997). Teachers might also feel overwhelmed at the choice of anti-bullying strategies, particularly as many are untested and all are time consuming with a time lapse before results are evident (Boulton and Flemington 1996).

The professional and research communities are aware of the pervasive nature and negative consequences of bullying, and all recognise that urgent collaboration is required to stem this problem. However, it would appear that recommendations have remained the same over a protracted length of time. It is our belief that in order to move forward, this problem needs to be viewed afresh, and new and innovative strategies, which emphasise the truly multidisciplinary team, need to be incorporated.

The multidisciplinary team, to date, has been viewed differentially. Tattum (1997) sees it as

including pupils, teachers, parents, mid-day supervisors, police, solicitors, social and welfare officers, and others. In contrast, Olweus (1994) explicitly includes professionals associated with the health of children, although school nurses are not recognised for a unique contribution. Community nurses in general and the children whom they serve would appear to be coming to the conclusion that it is the school nurse who has the key role in solving this problem. Some education colleagues support this view, with one head teacher being quoted as saying: '...school nurses are unique within the school community as friend and confidant to bullies and victims alike' (Ross 1993).

Roles of the school nurse

Historically, school nursing has been a reactive service with the emphasis being on reducing mortality and morbidity with reference to infection and chronic illness (Lightfoot and Bines 1998). Over recent years, priorities have changed and the role of the school nurse has evolved, while heavy emphasis is still placed on routine surveillance and screening: school nurses are also expected to respond to other more contemporary needs like an increase in emotional and behavioural difficulties. While this seems very positive, the reality in many areas is a service that has lost its way and allowed itself to become a soft option for cuts (Snell 1998).

The role of the school nurse is not well recognised by many of the community that is served. Parents, school staff and other nurses often do not appreciate the scope of the role of the school nurse (Lightfoot and Bines 1998). Other barriers regarding the provision of school health services are funding and 'turf issues' (Heneghan and Malakoff 1997). The latter referring to the ownership of responsibility and co-ordination with reference to health promotion and education.

Lightfoot and Bines (1998) clearly state four dimensions to the role of the school nurse. They state the predominant concern of the school nurse as that of safeguarding the health and welfare of the school population. To achieve this, a practitioner must be viewed by children as a confidant, while viewing the child in the context of family and, where appropriate, offering family support. Finally, health promotion is seen to enable the school nurse, as part of the wider multidisciplinary team, to see the school population holistically, taking into account pupils, teachers and the wider community.

The description offered by Lightfoot and Bines (1998) allows the management of the bullying problem to be integrated as a key responsibility of the school nurse. By so doing, the deterioration of the health and welfare of the school population could be avoided. This could be achieved by the school nurse offering a confidential service enabling individual children to raise the

alarm when bullying is taking place. Health promotion initiatives, although the responsibility of the wider multidisciplinary team, could be spearheaded by the school nurse, who would take a holistic stance and involve and support families as appropriate.

However, as a result of the contemporary situation where the school nursing service is contracting due to cuts, and therefore reducing the services available, bullying cannot be added to the agenda in a predominant position. The service therefore remains reactive and visions for a proactive service are, in most places, unachievable in the present climate.

Toward the future

To achieve this desired proactive service a number of issues need to be addressed. At the forefront of such policy change must be recognition that the school nursing service should be needed and resourced accordingly. This is in line with suggestions purported by Lightfoot and Bines (1998) and the HVA (1991) who both support an integrative role, bridging the gap between health and education. Bullying provides a good basis for planning integrative school policy, as the problems must be viewed holistically if a satisfactory solution is to be found.

To facilitate such a policy, communication links must be strengthened between all nurses who deal with children, and therefore may have experiences and information regarding health issues related to bullying. School nurses cannot act in isolation and need to be kept informed of problems identified by other nursing colleagues if they are to perform in the central key gatekeeping role with regard to bullying. Communication within the school multidisciplinary team also needs to be strengthened.

To enable the school nurse to undertake this leadership function, adequate information with regard to bullying and its effect on health must be ensured. This would necessitate the employment of nurses who had undertaken preparation to nurse children, or those who had followed a specialist nurse practitioner course in school nursing. This would support appropriate innovation and foster creative interventions and strategies with regard to the bullying problem.

Specific contributions

The specific contributions that a school nurse can make address the needs of a number of different groups. Initially, pupils should be the focus of school nursing activity although, with time, this could be broadened out to include teachers and, finally, families and other members of the wider multidisciplinary team.

Initially, school nurses must ensure time and resources to allow them to establish contact and initiate a relationship, or potential for a relation-

ship, with each individual pupil. Although this practice is well established in some areas, cuts in other areas have meant that introductions are via a questionnaire and the possibility for a relationship confined to those who are identified as at risk. Once this procedure is accepted and established other strategies, specifically designed to combat bullying problems, could be implemented and maintained. Possible propositions must take account of the age group of pupils. In primary schools, where children are less autonomous, opportunities need to be engineered for children to share their concerns. School nurses must be allocated time within the timetable where they can talk confidentially with small groups of pupils. It is important that this is viewed by all as separate from any teaching activity, with the nurse perceived as neutral rather than an extension of teacher. Conversely, older children could be offered the opportunity to use a drop-in centre.

Both strategies are based on the same principles, with the problems of bullies and victims as well as the different modes of bullying, being considered. Where there is an identified problem, further intervention might be necessary and this may target either bullies or victims. The bully-victim group (Stephenson and Smith 1989) could benefit from the involvement of the school nurse. Different approaches will prove beneficial in the different groups, with audio-visual and other resources and techniques being employed as appropriate. The method of 'shared concern' (Pikas 1989) is a good starting point for a mixed group, with bullies and victims present and able to appreciate each other's feelings and concerns. In contrast, groups of victims would welcome assertiveness training (Cowie and Sharp 1996) away from the eyes of their aggressors.

One well-accepted contemporary strategy is that of circle time (Smith 1997), where the central aim is to build self-esteem. Such time provides an ideal opportunity for students to share together their ideas about issues that are concerning them and to express their feelings as well as actively listening to others. Equality of opinion is ensured by using an object, the possession of which signal the individual child's opportunity to give a unique contribution. This, however, cannot be done in isolation. Whether carried out by the school nurse or school teacher, such an activity must be congruous with the school's general ethos.

To be accepted as a full partner in such activities, the school nurse must not only contribute, but also enable others to do so. The unique outlook of school nurses allows them to undertake this pivotal position, ensuring a holistic approach to this particular issue. Contemporary cuts in the numbers of school nurses may militate against this suggested extension in role, although authorities cut such services at their peril. The future could be bright, with the management of bullying setting the context for a new role for the school nurse in the multidisciplinary school team. The evaluation of such role extension must, however, remain on the agenda; such evaluation being the responsibility of school nursing with the opinions of all concerned being canvassed and heeded ■

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