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1 **Abstract**

2

3 **Background** Bullying among children and young people (CYP) is a major public health concern which can
4 lead to physical and mental health consequences. CYP may disclose bullying, and seek help from, their
5 general practitioner (GP). However, there is currently little research on GPs' views and perceptions on
6 their role in dealing with disclosures of bullying in primary care.

7

8 **Aim** To explore GPs' views about their role in dealing with disclosures of bullying by CYP, especially
9 factors that have an impact on GPs' roles.

10

11 **Design & Setting** Semi-structured interviews were conducted with GPs in primary care in England.

12

13 **Method** Purposive sampling was used to achieve variation in GP age, professional status in practice,
14 profile of the patients served by the practice, practice size and location, and whether the GPs
15 considered themselves to be research/teaching active.

16

17 **Results** Data from 14 semi-structured interviews revealed three main themes: Remaining Clinically
18 Vigilant; Impact of Bullying in Schools vs. Cyberbullying; Training & Guidance on Dealing with Bullying.
19 GP's felt that dealing with disclosures of bullying and cyberbullying came down to their clinical
20 experience rather than guideline recommendations, which do not currently exist, and that bullying was
21 a precipitating factor in presentations of CYP's mental health issues.

22

23 **Conclusion** GPs feel they have a role to play in managing and supporting the health of CYP who disclose
24 bullying during consultations. However, they feel ill equipped in dealing with these disclosures due to
25 lack of professional development opportunities and guidance on treating and managing the health
26 consequences of bullying.

27

28 **INTRODUCTION**

29
30 Bullying is defined as an “aggressive behaviour or intentional harm-doing by peers that is carried out
31 repeatedly and involves an imbalance of power, either actual or perceived, between bully and victim”¹.
32 Approximately 50% of children and young people (CYP) report being bullied with 10-14% being bullied
33 chronically for more than six months^{2,3}. Many CYP experience severe physical, psychosomatic (e.g.
34 headache/abdominal pain), and emotional (e.g. anxiety, depression, suicidal ideation) health
35 consequences. Bullying is therefore a major risk factor for mental health problems in CYP⁴. CYP with a
36 chronic physical illness or disability are especially at risk of being bullied compared to their healthy peers
37 (odds ratio for victims = 1.65)⁵. CYP may disclose information about being bullied during a consultation
38 with their GP^{3,6} and recent research suggests CYP and parents (carers) would like GPs to be more
39 involved in identifying and supporting CYP who disclose bullying⁷.

40
41 National Institute for Health and Care Excellence (NICE) guidelines have made recommendations for
42 primary health care professionals to be trained in the evaluation of psychosocial risk factors for bullying
43 in CYP, with the need for physicians to be knowledgeable about all interventions available^{7,8}.
44 Therefore, a key role of GPs is to identify these presenting symptoms and judge whether bullying plays a
45 role^{8,9} so that the patient can be offered counselling and/or be referred to specialist services such as
46 the Child and Adolescent Mental Health Service (CAMHS). However, the results of a recent Royal College
47 of General Practitioners (RCGP)/Anti-Bullying Alliance (ABA) survey revealed that 92% of GPs had never
48 received any formal training, resources, or information to help support CYP with health symptoms that
49 relate to bullying in CYP¹⁰. The survey also revealed that over 90% of GPs had seen adult patients with
50 mental health symptoms relating to childhood bullying¹⁰.

51
52 The present study therefore aimed to explore GPs views about their role in dealing with disclosures of
53 bullying by CYP during primary care consultations, particularly the factors that GPs felt impacted upon
54 their role.

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METHODS

Study design

This cross-sectional study comprised semi-structured interviews with 14 GPs working in NHS England (Table 1). 3 interviews were conducted face-to-face and 11 were conducted over the phone by one member of the research team who was a medical student (JM).

Participants

GPs were invited to participate in the study by email via distribution lists of two academic departments in the London and East Midlands regions of the UK. . Eighteen GPs agreed to take part in the study, however thematic saturation was reached by participant fourteen so data collection ended at that point. Prior to interview, participants were informed that the purpose of the study was to gain GP’s views about their role when CYP disclose a history of bullying. Purposive sampling was used to achieve variation among all GPs who answered the email invitation in GP age, professional status in practice (e.g. partner/salaried/locum), profile of the patients served by the practice, practice size and location, and whether the GP considered themselves to be active in either research or teaching (Table 1).

Table 1 About Here

Data collection and analysis

A topic guide (see Appendix 1) was created based upon existing literature and through discussion with members of the research team who had experience of dealing with disclosures of bullying in a primary care setting, along with a pilot interview conducted with a GP. The topic guide was flexibly applied and revised throughout data collection to incorporate emerging concepts and improve data quality. Field notes were taken during the interviews and analytic memos were made during coding to aid the data analysis and interpretation of the findings.

Individual semi-structured interviews were conducted using a reflexive discursive approach to explore GPs views of disclosures of bullying by young people and their experiences of recognition, management, and gaining access to specialist services. Interviews lasted between 30-45 minutes and all participants gave written informed consent prior to interview, which was then confirmed verbally at the start of

90 each interview by the researcher. Each interview was audio-recorded, transcribed, and thematically
91 analysed following the method outlined by Braun & Clarke (2006)¹¹, until thematic saturation had been
92 achieved¹².

93
94 The interview transcripts were imported into the software package QSR NVivo 11 which facilitated the
95 organisation of the data, and were then inductively coded by two members of the research team (LC &
96 JM) independently. Both sets of independent codes were generated by identifying units of text both
97 within and between transcripts and then compared to each other to construct a final set of codes which
98 were then organised into emergent themes and subthemes using a constant comparative method. The
99 themes were then revised and reconstructed iteratively through discussion with a third member of the
100 research team (VP) until a final set of themes emerged. Validation of themes was then sought from the
101 research participants who had consented to receive them for comment to ensure that they accurately
102 reflected the views expressed in the interviews. Participant comments and feedback were incorporated
103 and a finalised set of themes was produced.

104

105 **RESULTS**

106 The findings explored GPs' views on their role in dealing with the physical and mental health
107 consequences of bullying once it is disclosed, and the wider societal factors that impact the scope of
108 their role in dealing with these consequences. These are organised around 3 main themes: remaining
109 clinically vigilant, bullying in schools, and training and guidance on dealing with bullying and
110 cyberbullying (See Table 2). Direct quotes are presented here with repetitions and hesitations removed.

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112 -----

113 Table 2 About Here

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115

116 **Remaining clinically vigilant**

117 All of the GPs interviewed could recall experiences of when CYP had disclosed bullying during a
118 consultation and described techniques they had used to identify whether bullying was a contributing
119 factor in the CYP's presenting symptoms at that time. None of the GPs reported asking a child about
120 bullying directly, instead using open-ended questioning about school and friendships to give the CYP an
121 opportunity for disclosure, and being vigilant for signs of distress, uncertainty and non-verbal cues:

122

123 *"I can ask them, "How are things going at school?", if it's bullying at school: "How are you feeling about*
124 *school?", "Do you feel settled?", "Are you making friends?"(GP8, Female).*

125
126 Many GPs mentioned that they had found the school environment and friendship groups to be the main
127 contributing factor in bullying, and some described intuitively spotting trends among CYP who were
128 vulnerable to being bullied:

129
130 *"...bullies attack socially isolated children so one of the ways you can tell if bullying has happened is if*
131 *you've got a child who is vulnerable, so if you've got a child who doesn't have friends, doesn't perceive*
132 *that they've got friends, then you've got a child who is much more likely to be bullied" (GP9, Female).*

133
134 Consequently many of the GPs had gone on to identify bullying as being a precipitating factor to the
135 CYP's mental health difficulties:

136
137 *"I certainly do have experiences of young people who've come to me who are quite distressed, being*
138 *either down or anxious or sometimes suicidal and bullying often is a key part of the reason they feel that*
139 *way." (GP1, Male)*

140
141 Length of consultations due to the pressure on GPs' time was felt to be a challenge in properly
142 identifying and dealing with the extent of the health consequences of bullying, and that this was even
143 more challenging without any training or guidelines:

144
145 *"...it's hard for the GP in ten minutes to work together with them [CYP], with no proper system where we*
146 *work together with support." (GP7, Female).*

147
148 *"You don't have enough time. Instead of having quite a long consultation it has to be addressed in*
149 *chunks essentially" (GP5, Female)*

150
151 *"...if you yourself are feeling a bit under pressure, then you usually close your mind down to those broad*
152 *range of issues so the intensity in general practice probably doesn't benefit you picking up things like*
153 *bullying." (GP 12, Female)*

154

155 However, all of the GPs felt that it was their role to both identify and manage new cases of bullying and
156 to make sure that there were good support networks around the CYP who had declared they were being
157 bullied:

158

159 *“...I supported them socially, getting them to come back and check their mental health but also being*
160 *able to refer them through to CAMHS, that way getting some structured support in place.” (GP10,*
161 *Female).*

162

163 **Bullying in schools**

164 In consideration of the CYP’s school environment as a platform for bullying, several GPs spoke about the
165 importance of the role of the school nurse in identifying whether bullying was a contributing factor in a
166 CYP’s physical and mental health symptoms. The school nurse was seen by these GPs as an important
167 link between the school and the local GP surgeries. However, many of the GPs felt that the decline in
168 the number of school nurses had impacted this joined up way of working:

169

170 *“...each school used to have a school nurse, now it seems to be there’s a school nurse to three schools*
171 *and if you're only there on a Monday and Tuesday, somebody decides they need help on a Friday [...] you*
172 *have got a small window when somebody can think, “I need help and I want to go and get help”” (GP14,*
173 *Female).*

174

175 The absence of one to one school nurses who could liaise on behalf of a school with local GPs was felt to
176 be a critical missing link in helping GP’s to manage the health consequences of bullying. It was felt that
177 having access to such school nurses would help improve the lines of communication that were currently
178 in place:

179

180 *“Principals tend to write letters to us if a child is depressed or has some particular difficulties, so they*
181 *liaise with us in that sense to see if there’s anything further we can do” (GP5, Female).*

182

183 *“...some schools are good and you’ll get feedback from [them], some we don’t really get much feedback,*
184 *you only get one side of the story when you’re seeing the patient and the parent but you don’t know*
185 *about the issues at the school, what’s happening there as well” (GP8, Female)*

186

187 A small number of GPs (2/14) felt strongly that the amount of bullying within a school is a direct
188 consequence of the quality of the anti- bullying policy put in place and how it is upheld:

189 *“The head didn’t believe that bullying took place in her school, now that’s a dangerous and wrong kind*
190 *of stance because bullying does take place” (GP9, Female).*

191
192 Many of the GPs felt that, in terms of prevention, the education system should be taking more
193 responsibility for preventing bullying through educating CYP to understand the consequences of their
194 behaviour and the future impact that it may have on their lives and that GPs shouldn’t be seen as the
195 “front line” for prevention:

196
197 *“Education, yes, GPs – no, not really, I think it would be just not in our remit [...] you’ve got to get them*
198 *at a young age and that’s about education.” (GP4, Male)*

199
200 *“...education around bullying generally, around cyber bullying, around potentially the impact of bullying*
201 *[...] not only for the person being bullied but future consequences for things like people’s digital footprint*
202 *and future jobs and work and all that aspect of things...” (GP1, Male).*

203
204 There was a feeling of concern among many of the GPs about increasing numbers of CYP being the
205 victims of cyberbullying and the lack of guidance for GP’s in how to manage the health consequences of
206 this adequately, especially when there is a mental health crisis:

207
208 *“It has become a big issue [...] it also makes bullying potentially, almost a 24/7 activity that people can’t*
209 *escape from like in days before, before social media and so on, bullying would happen in one particular*
210 *place if that was at school and being away from school, people were able to escape it, at least to some*
211 *degree whereas now I think it’s probably harder to escape.” (GP1, Male)*

212
213 **Training and guidance on dealing with bullying and cyberbullying**

214 All of the GPs stated that they had received no formal training to deal with disclosures of bullying which
215 had created ambiguity in their role:

216
217 *“...our current role in regard to bullying isn’t very well defined at the moment” (GP3, Male)*

218 *“Not any specific training that’s targeted just at bullying, I can think of some general safeguarding*
219 *training that I’ve done recently that has included some basic information about things like cyber bullying*
220 *– but it was just making GPs aware” (GP1, Male).*

221

222 One GP interviewed felt that further training wouldn't benefit them as they felt they were capable in
223 their current skill set of identifying and managing issues related to bullying:

224
225 *"I can think of all sorts of things that are allied to bullying: domestic violence, safeguarding things. All of*
226 *that sort of stuff that we are regularly trained on. I can't think of a bullying course that I am asked to do,*
227 *and to be honest, I suspect, it would be of limited value."* (GP13, Male).

228
229 However, the other GPs interviewed welcomed further training on bullying and saw value in training on
230 cyberbullying in particular:

231
232 *"I think that receiving training might help me identify children that are being bullied, I think that it might*
233 *make GPs more mindful of bullying and perhaps be able to identify it more and potentially I guess might*
234 *help us in how we deal with it, or how we approach it"* (GP3, Male)

235
236 *"...it's a brilliant way of making sure we're up to date as to where the pitfalls are and how people can*
237 *present or ask the right questions"* (GP14-Female).

238 239 **DISCUSSION**

240 241 **Summary**

242 This study highlights that GPs feel they do have a role in dealing with disclosures of bullying but that
243 currently this is poorly defined. The GPs interviewed saw their role as the identification and
244 management of the CYP's associated physical and mental health consequences and to, as far as
245 possible, put in place a network of support for them. Additionally, GPs highlighted the importance in
246 tackling bullying from a joined-up approach which incorporates other specialist clinical services. An
247 approach which hinges upon clear lines of communication with the education system to create a
248 support network involving the school environment. One of the key challenges for GPs in addressing the
249 health consequences of bullying in primary care is the short length of consultation times, which do not
250 allow the extent of the bullying to be discussed fully. Also, guidelines on dealing with bullying are
251 currently lacking, particularly with regard to identifying the contribution that bullying is making to the
252 CYP's presenting symptoms by asking the right questions; the different types of bullying and their
253 impact on CYP health (for example, pervasive cyberbullying); and providing clear direction over referral
254 pathways and specialist services available to manage CYP mental health.

256 **Strengths and limitations**

257 The use of purposive sampling in this study led to a varied sample of GPs despite the limitation of
258 conducting the study over two counties in England. Although the study had a relatively modest sample
259 size, it was sufficient to reach thematic saturation on the topic area. The use of telephone interviews
260 provided the opportunity for flexibility for the GPs to participate within their busy working lives.
261 However, the lack of face-to-face contact meant that nuances of non-verbal communication were not
262 able to be detected which may have added further meaning to the data. The interviews were carried out
263 by a medical student which may have affected the answers given due to assumptions about the
264 interviewer's background knowledge and understanding of the topic area. Our use of distribution lists of
265 academic departments may have skewed our sample towards GPs involved in teaching/research. It is
266 possible that GPs who are not involved in teaching/research may have held different views to this group
267 of GPs. Finally, selecting a sample from a wider geographic area incorporating differing levels of
268 socioeconomic deprivation among the practice populations served may have revealed additional
269 themes to those presented which would allow further generalisability of the findings to a wider
270 demographic.

271

272 **Comparison with existing literature**

273 The study findings have added context to international recommendations by The World Health
274 Organisation (WHO) for integrated approaches to tackling bullying, including primary care and other
275 health services ¹³, for which gaining clarity on the role of GPs is crucial. Specifically in identifying and
276 managing the physical and psychological symptoms of bullying. This corroborates the findings of other
277 studies describing the importance of screening young/vulnerable children on routine GP visits ^{14 15}.
278 Interestingly the GP's interviewed in the current study cited social isolation as an example of
279 vulnerability. However recent research has shown that a proponent of social isolation and indeed
280 bullying can be the presence of chronic illness which limits the daily activities and levels of participation
281 of the CYP ⁵. Thus leading to them being singled out by their peers and being vulnerable to being bullied.
282 Interdisciplinary communication with other specialties such as school nurses, CAMHS, and in severe
283 cases, a child psychiatrist were also mentioned as being important by the GP's interviewed in the
284 current study and has been previously described elsewhere in relation to CYP mental health ^{6 9}. Many of
285 the GPs in the current study also stated the importance of asking open-ended questions about
286 friendships and peer groups which demonstrates an awareness of the importance of providing the CYP
287 with an opportunity to disclose bullying. Nationally, the NICE guideline on depression specifically
288 recommends that training for healthcare professionals should include the evaluation of bullying and
289 that a record should be made of the quality of relationships with friends and peers ⁸.

290 Caudle et al, (2013) have suggested that GPs should take time to educate children and parents about
291 bullying. However, GPs in the current study believe that this should come under the school's
292 responsibility of dealing with bullying and enforcing an anti-bullying policy given that over half of CYP
293 will also disclose bullying to their teachers ¹⁶, which highlights the importance of establishing support
294 networks which include both schools and primary care, and the findings of the current study show GPs'
295 concerns over how the lack of school nurse roles negatively impacts these links. Several authors have
296 described the pervasiveness of cyberbullying in contrast to face-to-face bullying and it's potential to
297 cause serious mental health consequences ¹⁷⁻¹⁹, as well as development for GPs to have increased
298 knowledge of this type of bullying, ⁷ which GPs in the current study also stipulated as a need for
299 professional development; particularly on the nature of cyberbullying and its impact on CYP's mental
300 health.

301 Guidelines on the role of GPs in dealing with disclosures of bullying by CYP are lacking but national
302 guidance on depression in CYP suggests that healthcare professionals should consider and record in the
303 notes information on the quality of interpersonal relationships between the patient and friends or peers
304 ⁸. These guidelines also suggest that healthcare professionals should ask about CYP's experience of
305 being bullied and work collaboratively to develop effective anti-bullying strategies, as well as to prevent
306 bullying ⁸. Surprisingly, neither the current guidelines or the GPs in the current study mentioned the
307 presence or absence of other family members during consultations with CYP as a barrier or facilitator to
308 GPs identifying and addressing bullying.

309

310 **Implications for research and practice**

311 The GP accounts presented in this study demonstrate that they feel a responsibility towards dealing
312 with the physical and mental health consequences of bullying. They showed an eagerness to ensure that
313 referrals are made to the appropriate specialist services but they did not mention referring to local or
314 national anti-bullying organisations or signposting the CYP to the websites of these organisations (ie.
315 The Anti-Bullying Alliance). However, the GPs felt constrained by time-pressured primary care
316 consultations. There was a feeling of uncertainty over the scope of the GP's role, which reveals that
317 further education and guidance is required. However, many of the GPs interviewed reported feeling
318 pressure from the existing mandatory requirements to undertake training on issues, which may be
319 closely allied to bullying, such as safeguarding. Therefore, future training for GPs on bullying should
320 ensure sensitivity to GPs' time constraints and workload, and further research could consider which
321 format of delivery is the most appropriate for further training needs given the constraints on GPs' time.
322 Bullying requires an interdisciplinary approach so interdisciplinary training may address needs for a

323 range of health and education professionals. Bullying is a key contributor to CYP mental health issues
324 which, if left unnoticed and untreated, contributes to a greater burden of mental health services use in
325 adulthood^{20 21}. Therefore, systematic screening of vulnerable CYP for bullying could potentially prevent
326 more serious health events. However, further research is required to ensure that any bullying screening
327 interventions for primary care are not only effective, but also do not increase current GP workload. This
328 in turn needs to be bolstered by clear guidance over the referral pathways to access specialist services,
329 and transparent lines of communication with the education system; which has progressively degraded
330 through the systemic reduction in school nurse roles²², which have historically acted as liaison between
331 GPs and schools. CYP who disclose a history of cyberbullying is a particular area of concern to GPs
332 because it is an area where research on how GPs can best support these CYP is lacking. As
333 commissioners of services, GPs should be mindful of existing NICE guidance that CYP should be able to
334 access appropriate services⁸ and that healthcare professionals should collaborate to prevent bullying
335 and develop anti-bullying strategies in collaboration with CAMHS and education services. The Anti
336 Bullying Alliance is a useful resource for CYP, parents (carers) and others, including online training for
337 GPs (accessed via [www.anti-bullyingalliance.org.uk/tools-information/all-about-bullying/gps-and-](http://www.anti-bullyingalliance.org.uk/tools-information/all-about-bullying/gps-and-health-staff)
338 [health-staff](http://www.anti-bullyingalliance.org.uk/tools-information/all-about-bullying/gps-and-health-staff)).

339
340

341 **Box: How This Fits In**

342 Bullying in children and young people (CYP) is associated with both physical and mental health
343 consequences. CYP who have been bullied are more likely to use health services well into their adult
344 lives. This study explored GPs views about their role in dealing with disclosures of bullying by CYP. GPs'
345 views were encompassed by three main themes. Firstly, GPs reported experience of disclosures of
346 bullying by CYP. Secondly, GPs reported a need for better liaison with schools, which has reduced in
347 recent years due to a lack of school nursing liaison. Thirdly, GPs expressed a need for greater continuing
348 professional development opportunities. However, GPs were aware that constraints on their time and
349 existing training requirements may increase pressures on their workload. In future, GPs should be aware
350 of existing guidance to elicit concerns about bullying in CYP, where this is appropriate, and to record this
351 information and existing services to which they may refer CYP. Healthcare professionals and
352 commissioners of services should be aware of the need to collaborate with healthcare professionals,
353 child and adolescent mental health services and education services (including school nurses) to develop
354 effective anti-bullying strategies.

355
356

357 **Abbreviations** Children and young people-CYP; General Practitioners-GPs
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360 Research Capability Funding Award.
361 **Ethical Approval** This study received approval from the University of Nottingham Public Health and
362 Epidemiology Ethics Committee.
363 **Competing Interests** The authors declare no competing interests.
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367 **References**

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Table 1. Demographic characteristics of GPs and their patient populations

ID	Sex	Years qualified	Paediatric Psychiatry Rotation	Status	Geographic location	Area	Deprivation decile of practice*	Practice size*	% CYP (5-24 years)*	Research/Teaching active
1	M	23	No	Salaried GP	East Midlands	Urban	2 nd	10586	12.93	Teaching
2	F	24	Yes	Locum	London & The South	Urban & Rural	-	-	-	Teaching
3	M	8	No	Salaried GP	East Midlands	Rural	9 th	24025	21.06	Teaching
4	M	11	Yes	Salaried GP	East Midlands	Urban	1 st	4260	28.15	Both
5	M	9	Yes	Salaried GP	East Midlands	Rural	10 th	10924	19.11	Both
6	M	9	No	Salaried GP	East Midlands	Urban	5 th	7213	21.63	Teaching
7	F	27	Yes	Partner	East Midlands	Rural	9 th	14,538	22.5	Both
8	F	32	Yes	Partner	East Midlands	Urban	-	14943	22.5	Teaching
9	F	13	Yes	Salaried GP	East Midlands	Urban	6 th	37982	24.4	Teaching
10	F	8	Yes	Salaried GP	East Midlands	Rural	8 th	11,308	19.24	Teaching
11	M	24	No	Salaried GP	East Midlands	Urban	6 th	37982	24.4	Research
12	M	14	Yes	Salaried GP	London & The South	Urban	1 st	7112	24.87	Both
13	F	8	Yes	Salaried GP	London & The South	Urban	2 nd	5349	25.77	Teaching
14	M	17	No	Salaried GP	East Midlands	Urban	6 th	37982	24.4	Both

*Information obtained from National General Practice Profiles (available at <https://fingertips.phe.org.uk/profile/general-practice/data>. Accessed: 14 June 2018). Deprivation decile score: high = 1–3, medium = 4–6, low = 7–10.

Table 2: Factors affecting the role of GPs: emergent themes and sub-themes

Themes	Sub-themes
Remaining clinically vigilant	<p>Dealing with bullying in consultations.</p> <p>Presentation of CYP mental health issues as a consequence of bullying.</p> <p>Time constraints in consultations prevents discussing bullying fully.</p> <p>Ambiguity of GP role in dealing with bullying.</p> <p>Lack of training and guidelines on dealing with bullying in primary care.</p>
Bullying in schools	<p>Role of school nurses as liaison between education system and primary care</p> <p>Need for a joined up approach between schools and primary care for tackling bullying</p> <p>Strength of implementation of anti-bullying policy in schools</p> <p>Pervasive nature of cyberbullying – relentlessness exposure of the CYP to the bullying</p> <p>Lack of guidelines and GP education on the impact of cyberbullying on CYP</p>
Training and guidance on dealing with bullying and cyberbullying	<p>Reduce ambiguity of role</p> <p>Training on how to identify bullying</p> <p>Impact and health consequences of cyberbullying on CYP</p>