Abstract

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

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

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

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

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

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

INTRODUCTION

Bullying is defined as an "aggressive behaviour or intentional harm-doing by peers that is carried out repeatedly and involves an imbalance of power, either actual or perceived, between bully and victim" [1]. Approximately 50% of children and young people (CYP) report being bullied with 10-14% being bullied chronically for more than six months [2,3]. Many CYP experience severe physical, psychosomatic (e.g. headache/abdominal pain), and emotional (e.g. anxiety, depression, suicidal ideation) health consequences. Bullying is therefore a major risk factor for mental health problems in CYP [4]. CYP with a chronic physical illness or disability are especially at risk of being bullied compared to their healthy peers (odds ratio for victims = 1.65) [5]. CYP may disclose information about being bullied during a consultation with their GP [3 6] and recent research suggests CYP and parents (carers) would like GPs to be more involved in identifying and supporting CYP who disclose bullying [7].

National Institute for Health and Care Excellence (NICE) guidelines have made recommendations for primary health care professionals to be trained in the evaluation of psychosocial risk factors for bullying in CYP, with the need for physicians to be knowledgeable about all interventions available [7 8]. Therefore, a key role of GPs is to identify these presenting symptoms and judge whether bullying plays a role [8 9] so that the patient can be offered counselling and/or be referred to specialist services such as the Child and Adolescent Mental Health Service (CAMHS). However, the results of a recent Royal College of General Practitioners (RCGP)/Anti-Bullying Alliance (ABA) survey revealed that 92% of GPs had never received any formal training, resources, or information to help support CYP with health symptoms that relate to bullying in CYP [10]. The survey also revealed that over 90% of GPs had seen adult patients with mental health symptoms relating to childhood bullying [10].

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

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 bulling 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

each interview by the researcher. Each interview was audio-recorded, transcribed, and thematically analysed following the method outlined by Braun & Clarke (2006) [11], until thematic saturation had been achieved [12].

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

RESULTS

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

Table 2 About Here

Remaining clinically vigilant

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

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

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

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

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

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

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

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

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

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

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

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

Bullying in schools

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

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

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

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

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

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

"The head didn't believe that bullying took place in her school, now that's a dangerous and wrong kind of stance because bullying does take place" (GP9, Female).

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

"Education, yes, GPs – no, not really, I think it would be just not in our remit […] you've got to get them at a young age and that's about education." (GP4, Male)

"…education around bullying generally, around cyber bullying, around potentially the impact of bullying […] not only for the person being bullied but future consequences for things like people's digital footprint and future jobs and work and all that aspect of things…" (GP1, Male).

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

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

Training and guidance on dealing with bullying and cyberbullying

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

"…our current role in regard to bullying isn't very well defined at the moment" (GP3, Male)

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

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

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

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

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

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

DISCUSSION

Summary

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

Strengths and limitations

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

Comparison with existing literature

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

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

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

Implications for research and practice

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

range of health and education professionals. Bullying is a key contributor to CYP mental health issues which, if left unnoticed and untreated, contributes to a greater burden of mental health services use in adulthood [20 21]. Therefore, systematic screening of vulnerable CYP for bullying could potentially prevent more serious health events. However, further research is required to ensure that any bullying screening interventions for primary care are not only effective, but also do not increase current GP workload. This in turn needs to be bolstered by clear guidance over the referral pathways to access specialist services, and transparent lines of communication with the education system; which has progressively degraded through the systemic reduction in school nurse roles [22], which have historically acted as liaison between GPs and schools. CYP who disclose a history of cyberbullying is a particular area of concern to GPs because it is an area where research on how GPs can best support these CYP is lacking. As commissioners of services, GPs should be mindful of existing NICE guidance that CYP should be able to access appropriate services [8] and that healthcare professionals should collaborate to prevent bullying and develop anti-bullying strategies in collaboration with CAMHS and education services. The Anti Bullying Alliance is a useful resource for CYP, parents (carers) and others, including online training for GPs (accessed via www.anti-bullyingalliance.org.uk/tools-information/all-about-bullying/gps-and-health-staff).

Box: How This Fits In

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

Abbreviations Children and young people-CYP; General Practitioners-GPs

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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	2nd	10586	12.93	Teaching
2	F	24	Yes	Locum	London & The South	Urban & Rural	-	-	-	Teaching
3	M	8	No	Salaried GP	East Midlands	Rural	9th	24025	21.06	Teaching
4	M	11	Yes	Salaried GP	East Midlands	Urban	1st	4260	28.15	Both
5	M	9	Yes	Salaried GP	East Midlands	Rural	10th	10924	19.11	Both
6	M	9	No	Salaried GP	East Midlands	Urban	5th	7213	21.63	Teaching
7	F	27	Yes	Partner	East Midlands	Rural	9th	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	6th	37982	24.4	Teaching
10	F	8	Yes	Salaried GP	East Midlands	Rural	8th	11,308	19.24	Teaching
11	M	24	No	Salaried GP	East Midlands	Urban	6th	37982	24.4	Research
12	M	14	Yes	Salaried GP	London & The South	Urban	1st	7112	24.87	Both
13	F	8	Yes	Salaried GP	London & The South	Urban	2nd	5349	25.77	Teaching
14	M	17	No	Salaried GP	East Midlands	Urban	6th	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	Dealing with bullying in consultations. Presentation of CYP mental health issues as a consequence of bullying. Time constraints in consultations prevents discussing bullying fully. Ambiguity of GP role in dealing with bullying. Lack of training and guidelines on dealing with bullying in primary care.
Bullying in schools	Role of school nurses as liaison between education system and primary care Need for a joined up approach between schools and primary care for tackling bulling Strength of implementation of anti-bullying policy in schools Pervasive nature of cyberbullying – relentlessness exposure of the CYP to the bullying Lack of guidelines and GP education on the impact of cyberbullying on CYP
Training and guidance on dealing with bullying and cyberbullying	Reduce ambiguity of role Training on how to identify bullying Impact and health consequences of cyberbullying on CYP