



University of Kentucky  
UKnowledge

---

Theses and Dissertations--Nursing

College of Nursing

---

2015

## CHILDHOOD BULLYING: ASSESSMENT PRACTICES AND PREDICTIVE FACTORS ASSOCIATED WITH ASSESSING FOR BULLYING BY HEALTH CARE PROVIDERS

Vicki Hensley  
University of Kentucky, vrpac0@uky.edu

[Right click to open a feedback form in a new tab to let us know how this document benefits you.](#)

---

### Recommended Citation

Hensley, Vicki, "CHILDHOOD BULLYING: ASSESSMENT PRACTICES AND PREDICTIVE FACTORS ASSOCIATED WITH ASSESSING FOR BULLYING BY HEALTH CARE PROVIDERS" (2015). *Theses and Dissertations--Nursing*. 25.

[https://uknowledge.uky.edu/nursing\\_etds/25](https://uknowledge.uky.edu/nursing_etds/25)

This Doctoral Dissertation is brought to you for free and open access by the College of Nursing at UKnowledge. It has been accepted for inclusion in Theses and Dissertations--Nursing by an authorized administrator of UKnowledge. For more information, please contact [UKnowledge@lsv.uky.edu](mailto:UKnowledge@lsv.uky.edu).

## STUDENT AGREEMENT:

I represent that my thesis or dissertation and abstract are my original work. Proper attribution has been given to all outside sources. I understand that I am solely responsible for obtaining any needed copyright permissions. I have obtained needed written permission statement(s) from the owner(s) of each third-party copyrighted matter to be included in my work, allowing electronic distribution (if such use is not permitted by the fair use doctrine) which will be submitted to UKnowledge as Additional File.

I hereby grant to The University of Kentucky and its agents the irrevocable, non-exclusive, and royalty-free license to archive and make accessible my work in whole or in part in all forms of media, now or hereafter known. I agree that the document mentioned above may be made available immediately for worldwide access unless an embargo applies.

I retain all other ownership rights to the copyright of my work. I also retain the right to use in future works (such as articles or books) all or part of my work. I understand that I am free to register the copyright to my work.

## REVIEW, APPROVAL AND ACCEPTANCE

The document mentioned above has been reviewed and accepted by the student's advisor, on behalf of the advisory committee, and by the Director of Graduate Studies (DGS), on behalf of the program; we verify that this is the final, approved version of the student's thesis including all changes required by the advisory committee. The undersigned agree to abide by the statements above.

Vicki Hensley, Student

Dr. Dorothy Brockopp, Major Professor

Dr. Susan Frazier, Director of Graduate Studies

CHILDHOOD BULLYING: ASSESSMENT PRACTICES AND  
PREDICTIVE FACTORS ASSOCIATED WITH ASSESSING FOR  
BULLYING BY HEALTH CARE PROVIDERS

---

DISSERTATION

---

A dissertation submitted in partial fulfillment of the  
Requirements for the degree of Doctor of Philosophy in the College of Nursing at the  
University of Kentucky

By

Victoria R Hensley  
Lexington, Kentucky

Director: Dr. Dorothy Brockopp, Professor of Nursing

Co-Director: Patricia B Howard, Professor of Nursing

Lexington, Kentucky

2015

Copyright © Victoria R Hensley 2015

## ABSTRACT OF DISSERTATION

### CHILDHOOD BULLYING: ASSESSMENT PRACTICES AND PREDICTIVE FACTORS ASSOCIATED WITH ASSESSING FOR BULLYING BY HEALTH CARE PROVIDERS

Childhood bullying affects over 25% of today's youth and causes up to 160,000 missed school days per year. Bullying causes short and long term adverse effects to both mental and physical health. Many organizations encourage healthcare providers to take an active role in bullying prevention. However, there has been little research into the role of primary healthcare providers regarding childhood bullying and the effectiveness of different approaches to screening and management.

Therefore the purposes of this dissertation were to a) explore childhood bullying and the role of the healthcare provider in bullying prevention, b) develop and evaluate the psychometric properties of Hensley's Healthcare Provider's Practices, Attitudes, Self-confidence, & Knowledge Regarding Bullying Questionnaire. Pediatric healthcare providers were asked to participate in this study if they conducted well-child exams on a weekly basis. Information on the provider's current bullying assessment practices, attitudes, self-confidence, and knowledge regarding bullying was gathered. Results indicated that Approximately one-half (46.6%, n=55) of the healthcare providers reported assessing their patients for bullying behaviors during well-child exams. The strongest predictor of positively assessing for bullying was attitudes, recording an odds ratio of 1.24. This indicated for every one-unit increase in attitudes score, the odds of assessing for bullying will be 24% higher. The odds ratio of self-efficacy or self-confidence was 1.18, indicating that for every one-unit increase in self-efficacy score, the odds of assessing for bullying will be 18% higher.

KEYWORDS: childhood bullying; assessing for bullying; healthcare implications of bullying

Victoria Hensley

---

Student's Signature

12-17-2015

---

Date

CHILDHOOD BULLYING: ASSESSMENT PRACTICES AND  
PREDICTIVE FACTORS ASSOCIATED WITH ASSESSING FOR  
BULLYING BY HEALTH CARE PROVIDERS

By

Victoria R Hensley

Dorothy Brockopp, PhD

---

Co-Director of Dissertation

Patricia B Howard, PhD

---

Co-Director of Dissertation

Susan Frazier, PhD

---

Director of Graduate Studies

---

October 23, 2015

## ACKNOWLEDGEMENTS

There are so many people who made this achievement possible; however, I will only be able to thank a few of you here. First, thank you to God My Father whose plan is always perfect and more than sufficient for all of my needs. The process of getting my PhD has taught me not only about research and but much about my capabilities as nursing faculty and as a woman. Second, thank you to my chair, Dorothy Brockopp. Without her willingness to be my chair and her expertise, encouragement, guidance, and patience this PhD would not have been possible. I also am very grateful to my other committee members for their time and guidance in making this possible as well. There were also several key faculty members and friends at the College of Nursing who also deserve a big thank you. Lee Anne Walmsley, your encouragement and hours of advice and talks, have helped me immeasurably. I listen and consider your words more than you may think. Pat Burkhart, your encouragement and understanding has been so very helpful as I have slowly trudged through this journey. Rebecca Dekker, your willingness to proof read my manuscripts and offer edits and deadlines have been invaluable. Thank you to my outside examiner, Richard Milich, for your time. It is greatly appreciated. Susan Westneat, thank you for your time in helping me setup SPSS and enter my data. Thank you to Hensley Elam for their scholarship which made the data collection in this dissertation possible.

Last, but not least, thank you to my family and friends. I have been blessed with supportive family and friends and cannot express the gratitude I feel for all of them. My

grandmother has always taught me that if something was worth doing, it was worth doing right. My father said it best when he said he didn't know why this was taking so long as I just had to write a one-fourth of a page a day. Both are right in that one should do things right, but not over think it. My mom is forever patient and encouraging me. My sister never pressured me but always there to listen and to help with the boys. My friends were my best cheerleaders and helped me believe that I could do this. Russ encouraged me and supported me through all of my masters, doctoral classes, and my dissertation work. His unique support was often misunderstood and his suggestions were many times a bit off, but through it all, he believed I could do this and helped me believe that as well. Finally, thank you to Zach, Carter, and Benjamin. Thank you for your patience while Mommy has been in school and lacked time and patience. Thank you for trying to understand the importance of this and for believing in me. Thank you for bragging to your friends and thinking and telling me I'm smart and beautiful. Thank you for playing with each other while I worked and getting to bed so I can write. I hope you will look back and know Mommy did this for you as much as for me. I want you all to realize the importance of doing your best and believing in yourself. With an ally on your side, you can do anything and I will always be your ally. And now, I'm finally finished!



## TABLE OF CONTENTS

Acknowledgements.....	iii
List of Tables.....	vii
Chapter One: Introduction	
Background.....	1
Chapter Two: Childhood Bullying: A Review and Implications for Healthcare Professionals	
Introduction.....	8
Overview and Prevalence.....	8
Common Characteristics of the Bully.....	10
Common Characteristics of the Victim.....	12
Consequences of Bullying.....	13
Guidelines.....	18
Nursing Implications.....	19
Research Needs.....	20
Chapter Three: Development and Psychometric Evaluation of the Healthcare Provider's Practices, Attitudes, Self-confidence, & Knowledge Regarding Bullying Questionnaire	
Introduction.....	22
Methods.....	2
5	
Psychometric Evaluation.....	28
Results.....	30
Discussion.....	31
Chapter Four: Childhood Bullying: Assessment Practices and Predictive Factors Associated with Assessing for Bullying by Health Care Providers	
Introduction.....	33
Methods.....	35
Results.....	37
Discussion.....	48

Chapter Five: Summary

Conclusions.....	52
Limitations and Strengths.....	55
Recommendations.....	55

Appendices	
Appendix A: Healthcare Provider’s Practices, Attitudes, Self-confidence, & Knowledge Regarding Bullying Questionnaire.....	57
References.....	63
Vita.....	78

## LIST OF TABLES

TABLE 3.1. Outcomes Associated with Bullying Behavior.....	22
TABLE 3.2. Index of Content Validity for each Section of HCP-PACK.....	30
TABLE 4.1. Provider demographics.....	38
TABLE 4.2. Mean Scores of Scales based on Current Practices.....	40
TABLE 4.3. Mean Scores of Scales based on Healthcare Provider Type.....	41
Table 4.4. Logistic Regression Predicting Likelihood of Assessing for Bullying.....	42
TABLE 4.5. Attitudes of Healthcare Providers regarding bullying.....	43
TABLE 4.6. Self-efficacy of Healthcare Providers regarding assessing for bullying and intervening when necessary.....	45
TABLE 4.7. Healthcare Provider’s Knowledge of Bullying.....	47

## Chapter One

### BACKGROUND

Bullying can include verbally, physically and or psychologically aggressive behavior which is intentionally harmful to another person. Bullying occurs repeatedly over a period of time to an individual who is perceived to be less physically or psychologically powerful (Nansel et al., 2001).

Approximately 25% of children are impacted by bullying at some point in time during their youth. Many will experience adverse short and long term consequences, including depression, sleep problems, headaches, suicidal ideation, and drug and alcohol abuse. In order to help both victims of bullying and the bully, healthcare providers must take a proactive role in off-setting bullying by screening for bullying behavior during well-child examinations. While numerous studies have focused on the effects of bullying, bullying activity and interventions in school systems, very little research exists regarding the role of the healthcare providers in prevention of bullying. Many expert groups, including the American Academy of Pediatrics, suggest that pediatric healthcare providers can contribute to bullying prevention through promotion of strong parenting skills and recognition, screening, and appropriate referrals of patients that are involved in bullying experiences (Committee on Injury, Violence, and Poison Prevention, 2009).

Although individuals identified as “bullies” have existed for decades, only recently in the United States has individuals been recognized as “a real person with complex needs and motives who can inflict great harm on others, not to mention on his or herself”

(Schuster & Bogart, 2013). Nonetheless, bullying is a widespread problem in communities and schools that has perplexed school officials, teachers, parents, students, healthcare providers, as well as researchers for decades. Although child behavior like occasionally teasing, play fighting, and disagreements with peers may not have effects, bullying is a far more serious behavior with potential short and long term academic, physical, and emotional effects on both the victim and the bully. Furthermore, the increasing prevalence of bullying behavior is a growing concern (2013).

An estimated 20.1% of US high school students reported being bullied on school property and 16.2% were bullied with electronic means during the 12 months prior to taking the 2011 Youth Risk Behavior Surveillance Survey (Eaton et al., 2012). In yet another study, 57% of parents identified bullying as a problem of concern for children in their community (Garbutt, Leege, Sterkel, Gentry, Wallendorf & Strunk, 2012). In a study with a sample of 1176 children, Verlinden and colleagues (2014) reported that 15% of children were categorized as bullies, 15.2% as victims, and 9.8% as bully-victims. In another study with a sample of 74, 247 middle and high school students, Radliff, Wheaton, Robinson, and Morris (2012) reported that 29.8% of middle school students and 22.7% of high school students were involved in bullying.

American children ages 8-15, report bullying is a greater problem than racism, pressure to have sexual intercourse, or use of alcohol and other drugs (Kaiser Family Foundation, 2001). In a survey of over 5000 students in grades 7, 8, and 11 in an urban public school district, 26% of students were involved with bullying (Glew, Fan, Katon and

Rivara, 2009). Results of another study of American students in grades 6-10 conducted by the National Institute of Child Health and Human Development the magnitude of bullying was revealed in the finding that 37% of respondents had been victims of verbal harassment; 32% subjected to rumor spreading; 26% experienced social isolation; 13% were physically assaulted, and 10% had been cyber bullied (Wang, Iannotti, and Nansel, 2009).

Bullying is a wide spread problem among our children that leads to adverse consequences. Even so, many children who are bullied do not discuss their experience with anyone. They are reluctant to tell their parents or teachers about their experiences, due to feelings of shame or fear of punishment (Chamberlain, George, Golden, Walker, & Benton, 2010). Up to 50% of children say they would rarely, or never, tell their parents, while between 35% and 60% would not report incidents to their teacher (Radford, Corral, Bradley, & Fisher, 2013). It appears that children are less likely to tell their parents when parents are perceived as harsh or overly protective (Lereya, Samara, & Wolfe, 2013).

While there are many school-wide bullying prevention programs, such as the Olweus Bullying Prevention Program, the effectiveness is debatable. Samara and Smith (2008) report that anti-bullying policies tend to have little effect and most school-based antibullying interventions have only had modest results. The Society for Adolescent Medicine emphasizes pediatric healthcare providers be familiar with the characteristics of youth who may be involved in bullying, sensitive to signs and symptoms of bullying and victimization, and intervene when necessary (Eisenberg & Aalsma, 2005). Strabstein,

the medical director for the Clinic for Health Problems Related to Bullying at Children's National Medical Center, emphasizes that pediatric healthcare providers must take the time to ask patients if their children are being bullied or if they are bullying others (Infectious Diseases in Children, 2011). In addition, the National Center for Mental Health Promotion and Youth Violence Prevention suggests that bullying is best addressed by a comprehensive approach. Health care professionals can play an important role in preventing bullying by taking opportunities, including wellness exams, to assess children for signs of bullying (National Center for Mental Health Promotion and Youth Violence Prevention, 2010).

Given the widespread prevalence of bullying, the adverse consequences it poses, children's reluctance to seek help from parents and school authorities, and the questionable effectiveness of school bullying prevention programs, there is a persuasive argument for primary healthcare providers to assess for bullying and to intervene when needed. Dale, Russell, and Wolke (2014) argue that given the associations between being bullied and experiencing acute mental and physical health problems, it is to be expected that children with bullying experiences are more likely to encounter primary care professionals than do their non-bullied peers. Also, primary healthcare providers are in a unique position to address bullying because they are likely to have already established a trusting relationship with their patients and have contact with them on a regular basis. Primary healthcare providers can view the family as a whole and provide appropriate support and interventions when needed (2014).



The purposes of this dissertation were to a) explore childhood bullying and the role of the healthcare provider in bullying prevention, b) develop and evaluate the psychometric properties of Hensley's Healthcare Provider's Practices, Attitudes, Selfconfidence, & Knowledge Regarding Bullying Questionnaire, and c) Therefore, the specific aims were the following:

1. Examine the current practices, attitudes, confidence level, and knowledge of nurse practitioners and physicians regarding bullying and assessing for bullying during well child exams.
2. Examine the differences in practices, attitudes, confidence level, and knowledge of nurse practitioners (NP) and physicians (MD) regarding bullying and assessing for bullying during well child exams.
3. Examine the differences in attitudes, confidence level, and knowledge of the healthcare providers who assess for bullying and those who do not assess for bullying.
4. Examine the predictability of attitudes, self-efficacy, and knowledge of bullying on the assessment practices of healthcare providers.

The second chapter in this dissertation is a literature review reporting the prevalence and general information about bullying is provide as well as common characteristics of bullies and victims, short and long term consequences of bullying, and the recommendations of various organizations which can help healthcare providers to assess for and provide interventions to children affected by bullying. Over 300 hundred articles were reviewed from 2000-2014. Based on this review a questionnaire was

developed to gather information about healthcare provider's current practices, attitudes, self-confidence, and knowledge regarding bullying.

The third chapter of this dissertation discusses the development and preliminary psychometrics of Hensley's Healthcare Provider's Practices, Attitudes, Self-confidence, & Knowledge Regarding Bullying Questionnaire. Hensley's HCP-PACK consists of 63 items and three subscales. The subscales were developed based on bullying literature and feedback from five bullying experts. Clinical experts evaluated the scale for content validity and health care providers responded to the questionnaire to examine test retest reliability and internal consistency for the questionnaire's subscales. The content validity index for the questionnaire was .97 for relevancy and .96 for clarity. Test-retest analysis on the three subscales: attitudes, self-efficacy, and, knowledge yielded Pearson  $r$  of .80, .81, and .77 respectively. The subscales for attitudes, self-efficacy, and knowledge had Cronbach's alphas of .70, .88, and .84 respectively.

The fourth chapter of this dissertation discusses the results of the research study conducted in the Spring 2015 to examine the assessment practices and predictive factors associated with assessing for bullying by health care providers. Providers (N=118) completed the Healthcare Provider's Practices, Attitudes, Self-Confidence, and Knowledge Questionnaire Regarding Bullying and the Assessment of Bullying. Approximately one-half (46.6%, n=55) of the healthcare providers reported assessing their patients for bullying behaviors during well-child exams. No significant differences were found related to current assessment practices between physicians (51.4%, n=37) and nurse practitioners (40%, n=18),  $X^2 = 4.225$ ,  $p = .121$ . The strongest predictor of

positively assessing for bullying was attitudes, recording an odds ratio of 1.24. This indicated for every one-unit increase in attitudes score, the odds of assessing for bullying will be 24% higher. The odds ratio of self-efficacy or self-confidence was 1.18, indicating that for every one-unit increase in self-efficacy score, the odds of assessing for bullying will be 18% higher.

Finally, the last chapter provides an overview of the main findings from Chapters Two, Three, and Four. Study limitations are discussed and recommendations for future research are made. Implications for clinical practice are explored.

## Chapter Two

### INTRODUCTION

Bullying is a widespread problem in our communities and schools which has perplexed school officials, teachers, parents, students, healthcare providers, as well as researchers for decades. Childhood bullying is certainly not a new concept; however, because of persistently high prevalence rates and the short and long term consequences of bullying, it is demanding more attention. It is normal child behavior to occasionally tease, play fight, and have disagreements with peers; however, bullying is a far more serious behavior which has short and long term academic, physical, and emotional effects on both the victim and the bully. It is crucial for nurses to be knowledgeable about bullying so better assessment of bullying can take place and necessary interventions be made available to those in need.

The purposes of this article are to describe bullying and the prevalence of bullying in the United States, discuss common characteristics, including risk factors, of bullies and victims, discuss short and long term consequences of bullying, and provide recommendations and considerations for assessing and intervening for bullying during childhood.

### BULLYING OVERVIEW AND PREVALANCE

Bullying, which can be described in numerous ways, includes verbally, physically and or psychologically aggressive behavior which is intentionally harmful to another person and occurs repeatedly over a period of time to an individual(s) who is perceived to be

less powerful in a physical and or psychological manner (Nansel, Overpeck, and Pilla, 2001). Bullying can involve physical overt behavior as well as verbal attacks, and nonverbal, non-physical acts which are indirect and subtle. Obvious types of bullying include physical violence or threats, verbal abuse, and taunting or teasing; while, less obvious bullying can include social exclusion, manipulation of friendship, and negative text messages or internet posts about someone. The most common form of bullying is verbal abuse and harassment, followed by social isolation and derogatory comments about physical appearance (Shellard, 2002). Bullying often occurs in area with less adult supervision, such as bathrooms, playgrounds, cafeterias, and bus stops (Shellard, 2002). Often bullies will select someone to bully who they perceive as different from themselves in either a physical, emotional, or intellectual manner. Bullying usually occurs as a way for the bully to deal with their own problems. Bullies may also need to feel more superior than their peers or think bullying will gain them acceptance of their peers and make them feel more popular or important (Aleude, Adeleke, Omoike,, and Afen-Akpaida, 2008)

Both boys and girls are involved in bullying others; however, there is conflicting evidence regarding the differences in bullying behavior between genders. Espelage and Swearer (2004) caution against making definitive conclusions about gender differences in bullying. However, research does support that boys are more likely than girls to be bullies and are themselves also victimized by their peers. Girls are more likely to be victims of bullying during early adolescence (Olweus, 1993; Kim, Boyce, Koh, and Leventhal, 2009). The literature is more conclusive regarding age and ethnicity trends of

bullying. Bullying increases for boys and girls during the late elementary years, peaks during middle school, and decreases in high school (Garrett, 2003). According to the U.S. Department of Justice, Bureau of Justice Statistics' 2009 National Crime Victimization Survey School Crime Supplement, students in higher grades were less likely to report bullying as compared to sixth graders. Students in sixth and seventh grade reported bullying the most and students in 8<sup>th</sup> grade were 50% less likely to report bullying while 12<sup>th</sup> graders were 76% less likely to report bullying when compared to students in sixth and seventh grade. There were no differences found in the prevalence of bullying by race or ethnicity (U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 2009).

American children ages 8-15, report bullying is a greater problem than racism, pressure to have sexual intercourse, or use alcohol and other drugs (Kaiser Family Foundation, 2001). In a survey of over 5000 students in grades 7, 8, and 11 in an urban public school district, 26% of students were involved with bullying (Glew, Fan, Katon, & Rivara, 2008). In another large study conducted by the National Institute of Child Health and Human Development in 2009 of American students in grades 6-10 the magnitude of bullying was revealed by 37% of respondents having been victims of verbal harassment; 32% having been subjected to rumor spreading; 26% having experienced social isolation; 13% having been physically assaulted, and 10% having been cyber bullied.<sup>11</sup>

### **COMMON CHARACTERISTICS OF THE BULLY**

There are common characteristics bullies share. Bullies have aggressive attitudes toward their social encounters and a positive outlook about violence. They are

manipulative, need to dominate others and lack empathy toward others. Bullies lack self-control and are guided by their impulses (Aleude et al., 2008; Carter, 2011).

Children who bully others often come from a family where aggression is modeled (Carter, 2011). In a study involving 704 students aged 11 to 13, Viding, Simmonds, Petrides, and Frederickson (2009) concluded those with higher callous and unemotional traits and conduct disorders were associated with higher levels of direct bullying.

Barboza et al. (2009) examined the risk factors associated with bullying behavior of 9816 adolescents aged 11 to 14 who completed a national health behavior survey in 1997-1998. They concluded bullying increases among children who watch television frequently. Each standard deviation increase in hours of television watched per day increases the odds of being a bully by 21%, holding other variables constant (2009).

Barboza et al. (2009) also concluded students who felt unsupported by their teachers, attended a school with an unfavorable environment, and had teachers and parents who did not place high expectations on their school performance were more likely to be a bully. Finally, those students who had personally been a victim of bullying and felt emotional support from their peers were more likely to be a bully (Barboza et al., 2009). These results are well supported by other research studies (Aleude et al., 2008; Duffy & Nesdale, 2008; Espelage, Bosworth, & Simon, 2000).

While there is significant literature describing bullying, several myths of bullying should be clarified. Bullies are not socially isolated. Research indicates bullies are at

least somewhat popular and the more emotional support they receive regarding bullying, the more likely bullying is to occur (Aleude et al., 2008; Barboza et al., 2009; Nansel et al., 2001). Another common myth regarding bullying is bullies have low self-esteem. Research indicates bullies have average or above average self-esteem and are no more likely than their peers to be characterized as anxious or indecisive (Aleude et al., 2008; O'Moore & Kirkham, 2001). To effectively assess for bullying, nurses need to be cognizant of not only the common characteristics of bullies but also the common characteristics of students who are victims of bullying. The National Association of School Nurses (NASN) state nurses must be able to identify those who bully and those who are at risk for or have experienced bullying (2003).

#### **COMMON CHARACTERISTICS OF THE VICTIM**

Like bullies, victims of bullying share several common characteristics. Victims of bullying are more anxious, depressed, insecure, and have low self-esteem when compared to other students (Viding et al., 2009). Victims of bullying often lack friends at school and may be socially isolated. Children who are less physically attractive, overweight, or who perform poorly in school are more likely to be bullied by others (Sweeting & West, 2001). Children with disabilities such as cerebral palsy, autism, stammering, muscular dystrophy, or diabetes may also be more at risk of being a victim of bullying (Storch et al., 2004). Victims of bullying are often described as not fitting in well with their peers. Shields and Cicchetti<sup>22</sup> surveyed 267 inner city children ages 8 to 12 and concluded children who had experienced maltreatment by a caregiver were more at risk of being bullied. Perren and Alsaker (2006) interviewed 345 5-7 year old



children and their teachers regarding the children's social behavior, bullying, and victimization. Perren and Alsaker (2006) concluded victims were more submissive, had fewer leadership skills, were more withdrawn, more isolated, less cooperative, less sociable, and frequently had no playmates. Children who lack independence and maturity may also be subject to bullying (Nansel et al., 2004). Finnegan et al. (1998) and Cohen and Canter (2003) suggest victimization was associated with those students who were perceived to have an overprotective parent. These students often fail to develop their own coping skills and are more likely to be bullied.

Children may not only bully others but are also victimized by their peers. These students are called bully/victims. Bully/victims demonstrate high levels of both aggression and depression, and have lower academic scores, prosocial behavior, selfcontrol, social acceptance, and self-esteem (Hanish & Guerra, 2004; Nansel et al., 2001; Nansel et al., 2004; Schwartz, 2000). Veenstra et al. (2005) analyzed the results of the Dutch TRAILS study which included 1065 adolescents. They concluded bully/victims were aggressive, had few friends and lower prosocial behavior and were most disliked among students (Veenstra, 2005). Perren and Alsaker state bully/victims were less cooperative, less sociable, and more frequently had no playmates.<sup>23</sup> Being informed about what characteristics a bully, victim, and bully/victim may possess will enable nurses and health care professionals to identify possible children at risk of bullying behavior and provide interventions which could reduce bullying and the consequences thereof.

## CONSEQUENCES OF BULLYING

Bullying can have both short and long-term academic, physical, and emotional consequences on both the bully and the victim. Being aware of the effects of bullying can allow nurses and health care providers to identify children who may be involved in bullying.

### *Short-term consequences*

When children are involved in bullying behavior they are more likely to report increased health-related problems including headaches, abdominal pain, anxiety, depression, and an increase in bed wetting as well as other behavior problems such as school avoidance, a decline in academic performance, poor relationships with peers, poor self-esteem, and loneliness.

A number of studies have shown victimization from bullying is associated with substantial adverse effects on physical and psychological health. In a cross-sectional study of 419 children in grades 1-10 Lohre et al. (2011) children reported emotional and somatic symptoms of sadness, anxiety, stomach aches, and headaches. Children's self-reported frequency of victimization was strongly and positively associated with their reports of emotional and somatic symptoms (Lohre, Lyderson, Paulsen, Maehle, and Vatten, 2011). In another survey conducted by Farrow and Fox (2011) 376 adolescents completed self-report questionnaires on their experiences of bullying, emotional symptoms, and unhealthy eating and shape-related attitudes and behaviors. The findings suggest the experience of bullying is positively correlated with depression and anxiety, restrained eating, and body dissatisfaction in both males and females (Farrow &

Fox, 2011). Glew et al. (2008) examined data collected from 3530 children in grades 3 to 5 and reported both bullies and victims were more likely to report feeling unsafe at school and they feel sad most days. Finally, Fekkes et al. (2006) measured victimization from bullying as well as psychosocial and psychosomatic symptoms in 1118 children aged 9 to 11 years of age. The results of the study indicate children who are victims of bullying have significantly higher changes of reporting psychosomatic and psychosocial problems, including depression, anxiety, bedwetting, headaches, sleeping problems, abdominal pain, poor appetite, and feelings of tension or tiredness than children who were not bullied (Fekkes et al., 2006).

When students are bullied on a regular basis, they may also experience homicidal or suicidal thoughts. The National Threat Assessment Center of the US Secret Service, reviewed 37 school shootings and reported more than two-thirds of the shooters felt “persecuted, threatened, attacked, or injured”(Vossekuil et al., 2000).

Bullying behavior does not just affect the victim, but the bully suffers short term consequences. According to the U.S Department of Justice, bullying is associated with vandalism, shoplifting, school absenteeism, dropping out of school, fighting, and drug and alcohol use (U.S. Department of Justice, Office of Justice Programs, 2001). Vernberg et al. (2011) gathered data on 590 children in grades 3 to 5 by assessing victimization, aggression, and visits made to the school nurse. The results of the study suggest involvement in bullying behavior as a bully or a victim is associated with increased somatic, illness, and injury complaints to the school nurse (Vernberg, Nelson, Fonagy, and Twemlow, 2011). Hemphill et al. (2011) analyzed the results of 5769 students which

completed the International Youth Development Study. Hemphill et al. (2011) concluded victimization of bullying was associated with an increased likelihood of depressive symptoms and bullying others was associated with an increased likelihood of theft, violent behavior, and binge drinking (Hempill et al., 2011).

### *Long-term consequences*

Not only are there short term consequences of being a bully or a victim of bullying, but there are also long term consequences which are evident into adult years of life. Numerous studies have shown childhood bullying was associated with later violence, including criminal acts, alcohol and substance abuse, aggression, and antisocial behavior. Ragatz et al. (2011) studied 960 college students who had reported being a bully, victim, or bully/victim during the last 2 years of high school and asked them about their current psychological characteristics and criminal behavior history. They concluded bullies and bully/victims had significantly higher scores on criminal thinking, psychopathy, and criminal behaviors than victims or controls. Additionally, bully/victims tended to be male, higher in criminal thinking, and higher proactive aggression. In another study by Kim et al. (2011) 957 participants were surveyed yearly from first or second grade to age 21. Kim et al. (2011) concluded childhood bullying was significantly associated with violence, heavy drinking and marijuana use at age 21. Niemela et al.<sup>39</sup> found similar results in a study of 2946 children followed from age 8 to 18. Niemela et al. (2011) state bullying others frequently predicted illicit drug use. Furthermore, many researchers (Bender & Losel, 2011; Falb et al., 2011; Farrington & Ttofi, 2011; Jiang, Walsh, & Augimeri, 2011; Olweus, 2011; Renda, Vassallo, & Edwards, 2011; Sourander

et al., 2007; Ttofi et al., 2011) have found childhood bullying is positively correlated to subsequent criminal offending, including intimate partner violence, later in life. Olweus (2011) states former school bullies were heavily overrepresented in crime registers and 55% of those who bullied others during childhood had been convicted of one or more crimes by the time they were 24 years of age.

Research on the long-term consequences of individuals who have been bullied show negative effects existing into adulthood, and include greater risk for depression, anxiety, loneliness, post-traumatic stress, and problems with interpersonal functioning. In the study conducted by Niemela et al. (2011) as described above, researchers concluded victims were associated with a lower occurrence of illicit drug use; however, victimization may predispose a child to subsequent smoking. Olweus (1994) reported that individuals who were bullied during childhood were more likely to be depressed and have poorer self-esteem at the age of 23 than non-victimized adults. In another study conducted by Jantzer, Hoover, and Narloch (2006) of 170 college students, they concluded victimization was positively correlated with contemporaneous shyness levels and negatively correlated with friendship quality and trust. Finally, in 2005, Newman, Holden, and Delville, surveyed 853 undergraduate college students asking about their bullied experiences and their reactions to them and their current emotional state. The researchers report those who were bullied during childhood had higher levels of stress and felt more isolated than non-victimized adults (Newman, Holden, & Delville, 2005).

Therefore, bullying remains a serious threat to children's physical and emotional health during the time they are involved in bullying behavior, but also may be an

indicator of serious psychiatric, behavior, and psychosocial symptoms and problems which can persist for many years into adulthood.

## **GUIDELINES**

The role of the pediatric healthcare provider regarding bullying assessment, intervention, and prevention is well recognized by many professional organizations, including the American Academy of Pediatrics (AAP). The AAP states pediatric healthcare providers can contribute to bullying prevention through promotion of strong parenting skills and recognition, screening, and appropriate referrals of patients involved in bullying behaviors (Committee on Injury, Violence, and Poison Prevention, 2009).

The Society for Adolescent Medicine emphasizes pediatric healthcare providers should be familiar with the characteristics of youth possibly involved with bullying, sensitive to signs and symptoms of bullying and victimization, and intervene when necessary (Eisenberg & Aalsma, 2005). Srabstein, the medical director for the Clinic for Health Problems Related to Bullying at Children's National Medical Center, states pediatric healthcare providers must take the time to ask patients if they are being bullied or if they are bullying others *Infectious Diseases in Children* (2011). The National Center for Mental Health Promotion and Youth Violence Prevention states bullying is best addressed by comprehensive approach and health care professionals can play a large role in preventing bullying by taking opportunities, including wellness exams, to assess children for signs of bullying (National Center for Mental Health Promotion and Youth Violence Prevention, 2013).

The National Association of School Nurses (NASN) states school nurses need to have the skills to assess students for bullying behavior as well as to identify characteristics of both victims and bullies (National Association of School Nurses, 2003). By being knowledgeable about bullying, those at risk of bullying, and the consequences of bullying, school nurses will be readily able to identify potential students involved with bullying, assess for bullying in these students, and intervene with effective bullying prevention strategies.

### **NURSING IMPLICATIONS**

Nurses are in a unique position to identify potential students at risk of either bullying others or being a victim of bullying and provide interventions to the child which can reduce the prevalence of bullying behaviors. Everyday nurses assess children for a variety of problems and potential threats to their health. School nurses may be the first to identify students at-risk or involved in bullying behaviors. They are in a prime location to assess for bullying and provide interventions for those in need. In a survey of 404 school nurses, Hendershot et al.<sup>55</sup> reported 80% would assess and document injuries and refer to the principle, 77% would refer the students to the school counselor, 74% would make the teachers and staff aware of the situation, 71% would talk to the bully, and 45% would work with the victim about ways to avoid bullying. School nurses also reported they felt effective ways of dealing with bullying included improving supervision, using bullying prevention techniques, assisting students with warning signs of bullying and implementing bullying response activities (Hendershot, et al., 2006).

Victimization causes an increase in health-related symptoms, such as headaches, abdominal pain, anxiety, and depression. When health care providers see clients with these ailments, the practitioner should be cognizant that bullying could be contributing to these issues and ask the patient if they have experienced anyone bullying them.

Health care providers should also routinely screen their patients for bullying behavior. The well-child exam may provide an opportunistic time in which to ask patients if they bully others or are being bullied by someone else. When bullying behaviors are confirmed, the health care provider can provide many interventions to the patient, including management of the behavior, whether it be bullying others or victimization. This is best done through a multidisciplinary effort involving parents, teachers, school counselors and administrators, and mental health professionals. The health care provider should provide education and support for the patient and family, help parents locate and use resources regarding bullying, refer the patient for counseling if needed, and secure help from the child's school to help stop the bullying behavior.

In order to foster the assessment of bullying, the healthcare provider should have a list of simple, direct questions to ask the child and parent. These questions can provide the healthcare provider with insight regarding if the child has been bullied or involved with bullying behaviors.

### **RESEARCH NEEDS**

Given the high number of children who are bullied and the lack of effective interventions to reduce bullying behavior, additional research is needed regarding



childhood bullying. Research targeting health care professional and assessing their current beliefs and practices regarding bullying assessment and interventions would provide the foundation for further intervention studies regarding healthcare providers addressing bullying behaviors. A survey instrument which can be used by healthcare providers during well-child exams or by the school nurse would be an effective method for healthcare providers to assess for bullying. The instrument would need to be easily administered and scored.

Other areas of research are needed to test appropriate interventions healthcare providers can employ regarding bullying reduction and prevention. Research focusing on students who are bully/victims is also an important area of research to facilitate better understanding of this phenomena and the consequences. Longitudinal studies would also be helpful in understanding the long-term implications of being a bully, and because the research is minimal, of being bullied and being a bully/victim. Lastly, studies involving the relationship between victimization and psychosocial and healthrelated symptoms would provide insight to potential interventions to help protect these individuals and reduce the consequences of bullying.

## INTRODUCTION

Childhood bullying is increasingly recognized as a major public health concern (Scrabstein & Merrick, 2012) and a significant problem for schools, parents, and public policy makers (Wolke, Copeland, Angold, & Costello, 2013). Bullying is defined as verbally, physically and or psychologically aggressive behavior which is intentionally harmful to another person. Bullying occurs repeatedly over a period of time to an individual who is perceived by their peers to be less physically or psychologically powerful (Nansel et al., 2001).

An estimated 20.1% of US high school students reported being bullied on school property, and 16.2% were bullied through electronic means during the 12 months prior to taking the 2011 Youth Risk Behavior Surveillance Survey (Eaton et al., 2012). Results of another study of American students in grades 6-10 conducted by the National Institute of Child Health and Human Development reported that 37% of respondents had been victims of verbal harassment; 32% subjected to rumor spreading; 26% experienced social isolation; 13% were physically assaulted, and 10% had been cyber bullied (Wang, Iannotti, and Nansel, 2009).

Researchers have reported substantial short and long-term physical and psychological adverse effects for both the child who is being bullied and for the child who is bullying others. See Table 1 below for a summary of the outcomes associated with bullying behavior.

TABLE 3.1: Outcomes Associated with Bullying Behavior

<b>Affected</b>	<b>Short and Long-term Adverse Effects</b>
<b>Persons</b>	
<b>Bullies</b>	<p><b>Short Term</b></p> <ul style="list-style-type: none"><li>-Associated with vandalism, shoplifting, school absenteeism, school dropout, fighting, and drug and alcohol use</li><li>-Increased complaints of somatic symptoms, illnesses, and injury</li></ul> <p><b>Long Term</b></p> <ul style="list-style-type: none"><li>-Associated with violence, including criminal acts, alcohol and substance abuse, aggression, and antisocial behavior.</li><li>-Criminal thinking, psychopathy, criminal behavior; Intimate partner violence</li></ul>
<b>Victims</b>	<p><b>Short Term</b></p> <ul style="list-style-type: none"><li>-Symptoms of sadness, anxiety, stomach aches, and headaches</li><li>-Depression, restrained eating, and body dissatisfaction</li><li>-Feelings of being unsafe at school and sadness</li><li>-Bedwetting, sleeping problems, feelings of tension or tiredness</li><li>-May have homicidal or suicidal thoughts.</li></ul> <p><b>Long Term</b></p> <ul style="list-style-type: none"><li>-Shyness; Poor friendship quality and trust</li><li>-More at risk of self-harm</li><li>-Aggressive behaviors, such as hitting walls, intentionally breaking things, and pushing/shoving a partner</li></ul>

Many children who are bullied do not discuss their experience with anyone. They are reluctant to tell their parents or teachers about their experiences, due to feelings of shame or fear of punishment (Chamberlain, George, Golden, Walker, & Benton, 2010). Up to 50% of children say they would rarely, or never, tell their parents, while between 35% and 60% would not report incidents to their teacher (Radford, Corral, Bradley, & Fisher, 2013). Research suggests that children are less likely to tell their parents when parents are perceived as harsh or overly protective (Lereya, Samara, & Wolfe, 2013).

Given the widespread prevalence of bullying, the adverse consequences it poses, children's reluctance to seek help from parents and school authorities, and the questionable effectiveness of anti-bullying programs, there is a persuasive argument for primary healthcare providers to assess for bullying and to intervene when needed. Dale, Russell, and Wolke (2014) argue that given the associations between being bullied and experiencing acute mental and physical health problems, it is to be expected that children with bullying experiences are more likely to encounter primary care professionals than do their non-bullied peers.

Even though it is well established that bullying adversely affects the health of children, there appears to be a void between knowledge of the established adverse consequences of bullying and the assessment and intervention by healthcare providers (Dale, Russell, & Wolke, 2014). While numerous studies have focused on the effects of bullying, bullying activity and interventions in school systems, very little research exists regarding the role of healthcare providers in prevention of bullying. To date there has been little research into the role of primary healthcare providers regarding childhood

bullying and the effectiveness of different approaches to screening and management. Many expert groups, including the American Academy of Pediatrics, suggest that pediatric healthcare providers can help prevent bullying through the recognition, screening, and appropriate referrals of children who are involved in bullying experiences (Committee on Injury, Violence, and Poison Prevention, 2009).

There is an abundance of existing literature providing an excellent guidelines in scale development. Questionnaire design and development must be supported by a logical, systematic and structured approach. The guidelines written by Streiner and Norman (2003), DeVellis (2012), and Waltz, Strickland, & Lenz (2010) have been particularly helpful during the construction of my survey. The following guidelines are considered essential in order for a well-constructed measure to be developed to assess healthcare providers regarding bullying. These guidelines are outlined in Figure 1.

## **METHODS**

### **INSTRUMENT DEVELOPMENT**

The development of the Healthcare Provider's Practices, Attitudes, Self-Confidence, and Knowledge (HCP-PACK) Questionnaire Regarding Bullying and the Assessment of Bullying (see Appendix A) began with the identification of the conceptual definition of bullying. Conceptual bullying was defined as verbal, physical and or psychologically aggressive behavior which is intentionally harmful to another person. Next, areas of interest related to bullying and the assessment of bullying during well-child exams in were identified.

An extensive review of the literature revealed over 300 articles from 2000 to 2014 (Hensley, 2013). The results of this review suggested that an instrument should contain items on attitudes, perceived capabilities, knowledge of bullying, and impact on the provider's current practices. These items, as well as basic questions about demographics and future training needs, were included in the questionnaire. Bandura's guidelines for constructing self-efficacy questions served as the foundation for the self-efficacy subscale (Bandura, 2006).

Item development consisted of four steps. Initially, Streiner and Norman's (2003) recommendation to base the subject content of items on a maximum of five different sources was used. Those five sources for this instrument were: patients, clinical observation, theory, research, and expert opinion (2003). Items were then revised and clarified based on feedback received from colleagues, including pediatric nurse practitioners, pediatricians, and a school guidance counselor. The healthcare providers gave helpful advice regarding clinical practice and incorporating bullying assessment during a well-child exam, while the guidance counselor provided valuable insight into bullying behavior. Next, the questionnaire was sent to 13 bullying experts to elicit their feedback and establish content validity. Experts were chosen based on their published work and expertise in bullying. Five experts returned the questionnaire with their comments. These five individuals include the following: a child psychiatrist who has extensively published in the area of bullying; a psychology research fellow whose focus is bullying and has published in the area of bullying; a pediatrician whose specialty is in pediatric developmental and behavioral medicine; a professor in the department of

health promotion and behavior and has published extensively in the area of bullying; and a medical doctor and professor of psychiatry who has also published extensively in the area of bullying. The questions were revised based on this feedback. Finally, a 63 item questionnaire was generated.

Hensley's HCP-PACK questionnaire consists of the following six areas: demographics, current assessment practices, attitudes, knowledge, self-efficacy, and training needs. Scores are available for three subscales: attitudes, knowledge, and self-efficacy. Each question on the subscales had four answer selections: strongly agree, agree, disagree, and strongly disagree. Four points were given for each answer marked as strongly agree; three points were given for each answer marked as agree; two points were given for each answer marked as disagree, and one point was given for each answer marked as strongly disagree.

The demographic section consisted of questions concerning the healthcare professional's title, number of years working with children as a healthcare provider, if they see children for well-child exams, and type of setting where they currently practice. Next participants are asked questions regarding their current screening practices for assessing for bullying. In order to understand the extent of screening activities provided by of healthcare professionals, participants were asked about possible areas in which they screen for other adverse health conditions such as lead toxicity and anemia. Lastly they are then asked why they do or do not assess for bullying.

The third area addresses the healthcare provider's attitude regarding bullying. As stated previously, many organizations recommend that healthcare providers assess

their patients for bullying. However healthcare providers' attitudes toward assessing patients for bullying are not available. This section contains six questions and a total section score was calculated, with possible scores ranging from 6 to 24.

The fourth section concerns the healthcare provider's self-confidence or self-efficacy in relation to assessing for bullying. Knowledge and skills regarding assessing and intervening related to bullying are necessary if healthcare providers are to be effective. This section contains eight questions, with possible scores ranging from 8 to 32.

The fifth section assesses the knowledge that healthcare providers possess regarding bullying. The knowledge section contains 16 questions and possible scores ranging from 16 to 64. The final section of the questionnaire asks healthcare providers their opinion about needed training regarding bullying.

## **PSYCHOMETRIC EVALUATION**

### **VALIDITY AND RELIABILITY**

The psychometric properties of Hensley's HCP-PACK were evaluated as follows: 1) content validity was established by content expert feedback; 2) stability-reliability was established through test-retest reliability analysis using Pearson's correlations; and 3) internal consistency reliability of the three scored subscales was established through scale reliability analysis using Cronbach's alpha. Data analyses were conducted using SPSS v.22. Content validity is defined as the relevance and representativeness of the instrument to the targeted construct and is usually established by experts in the field (Haynes, Richard, and Kubany 1995). Because the items on the HCP-PACK were derived from the literature on bullying, most of the experts were researchers who authored



articles from which question content was drawn. Additionally, several pediatric healthcare providers were included in the expert panel, based on their expertise in childhood bullying, pediatric medicine, or childhood growth and development. The questionnaire was sent to 13 experts. Five of the 13 experts participated in the review of the initial items.

The expert panel was asked to rate each item based on clarity and relevancy to the purpose of the instrument. Relevancy and clarity were rated separately for each item on a three point scale (1) not relevant/ not clear, (2) relevant/clear but needs revision, (3) very relevant/ very clear. There was space for additional comments for each question on the instrument. Based on their responses, a content validity index was calculated for each item (item-CVI), each section (section-CVI), and the entire scale (scale-CVI). The item-CVI was calculated by dividing the number of times an item was rated two or three by the total number of experts who rated the item. Modifications were made based on CVI scores and expert feedback.

To establish stability reliability, the instrument was completed by 16 healthcare providers that included 10 pediatric resident physicians and 6 pediatric nurse practitioner students. The survey was given to each group at one point in time and then again two weeks later. Finally, there were 118 healthcare providers who completed Hensley's HCP-PACK and whose answers were included in the internal consistency of the scored sections of the questionnaire.

## RESULTS

### INSTRUMENT VALIDITY

#### CONTENT VALIDITY

The results of the item-CVI results range from .87 to 1.0. The items with a score below a .90 were revised based on expert feedback. The CVI for each section are listed below in table 2. Lastly, the CVI for the entire questionnaire or scale for relevancy was .97 and .96 for clarity. Acceptable levels for an instrument are a .90 or above (Grant & Davis, 1997 and Lynn, 1986).

TABLE 3.2: Index of Content Validity for each Section of HCP-PACK

	Relevance	Clarity
Demographics	1.0	1.0
Practices	1.0	1.0
Attitudes	1.0	1.0
Knowledge	.93	.90
Self-Efficacy	1.0	1.0
Training	1.0	1.0

### INSTRUMENT RELIABILITY

#### STABILITY RELIABILITY

The scores on the attitude, self-confidence, and knowledge scales were compared at baseline and follow-up. Pearson's r was .80, .81, and .77 respectively. The questionnaire took approximately 15 minutes to complete.

## Internal Consistency

With final testing, the survey was administered to 118 health care providers for internal consistency testing. Cronbach's alphas were 0.70 for the attitudes subscale, 0.88 for self-efficacy subscale, and 0.76 for the knowledge subscale, indicating sufficient reliability.

## **DISCUSSION**

On initial testing, the HCP-PACK appears to have acceptable validity and reliability. The development of this questionnaire is important in that although involvement of pediatric healthcare professionals in assessing and treating bullying is considered important, little is known regarding their practices in this area. The literature describes a gap between healthcare providers understanding of the negative effects of bullying on children as well as their involvement in assessing for bullying. Although data are limited, there is evidence to suggest that healthcare professionals are not involved in activities related to bullying. In their study of 1350 professionals, Borrowsky and Ireland reported 55% of the pediatricians never or rarely screen for family and community violence, peer violence, and weapons (1999).

Hensley's HCP-PACK can be used to gather information about what healthcare providers are doing about bullying, what they know about bullying, their attitudes toward bullying, and their confidence of assessing for bullying in the clinical setting.

This is the first instrument designed to collect data regarding current practices, attitudes, self-confidence or self-efficacy, and knowledge of healthcare providers regarding bullying and assessing for bullying during well-child examinations.

## CHAPTER FOUR

### INTRODUCTION

Bullying is a global, multi-faceted issue which negatively affects children. It is defined as verbally, physically and or psychologically aggressive behavior which is intentionally harmful to another person and occurs repeatedly over a period of time to an individual who is perceived to be physically or psychologically less powerful (Nansel et al., 2001). Bullying involves direct physical harm, verbal harassment, and more subtle abuse such as rumor spreading, social exclusion, and manipulation of friendship. Despite a dramatic increase in public awareness and anti-bullying legislation nationwide, the prevalence of bullying is still one of the most pressing issues facing our nation's youth (Limber, Olweus, & Luxenberg, 2013).

Many youth are involved in bullying. In a recent study, 22 percent of school children report that they are bullied two or three times or more per month (Limber, Olweus, & Luxenberg, 2013). Results of another study of American students in grades 6-10 conducted by the National Institute of Child Health and Human Development 6-10 the magnitude of bullying was revealed showed that 37% of respondents had been victims of verbal harassment; 32% subjected to rumor spreading; 26% experienced social isolation; 13% were physically assaulted, and 10% had been cyber bullied (Wang, Iannotti, and Nansel, 2009).

The negative consequences of childhood bullying are reported in the literature and include both short and long term effects to the victim and the bully. The adverse effects of bullying include an increase in depression, negative emotions, self-harm, and suicidal thoughts which can extend into adult years of life (Zwierzynska, Wolke, and Lereya, 2013) (Lereya et al, 2013; Fisher et al., 2012) and higher chances of reporting psychosomatic and psychosocial problems, including depression, anxiety, bedwetting, headaches, sleeping problems, abdominal pain, poor appetite, and feelings of tension or tiredness (Lohre et al, 2011; Fekkes et al., 2006). Bullying others is associated with an increased likelihood of theft, violent behavior, and binge drinking (Hemphill et al., 2011) and can jeopardizes the child's well-being later in life through an association **with violence, including criminal acts, alcohol and substance abuse, aggression, and antisocial behavior.** (Ragatz et al, 2011; Niemela et al, 2011). Being involved in bullying during childhood also predicts greater inflammation, as measured by CRP levels, when compared to those uninvolved in bullying (Copeland, Wolke, Lereya, Shanahan, Worthman, & Costello, 2014).

Many agencies, including the American Academy of Pediatrics, the Society of Adolescent Medicine, and The National Center for Mental Health Promotion and Youth Violence Prevention have encouraged healthcare providers to take an active role in bullying prevention (Committee on Injury, Violence, and Poison Prevention, 2009; Eisenberg & Aalsma, 2005; The National Center for Mental Health Promotion and Youth Violence Prevention, 2010). However, as Dale, Russell, and Wolke state, there is little

research into the role that healthcare professionals have in regards to screening and management of bullying (2014).

Social cognitive theory suggests that ones' knowledge, self-efficacy (confidence in one's ability to do a given behavior), outcome expectations (a person's expectations that an action will lead to a specific result), and perceived environmental barriers and facilitators can influence behavior (Bandura, 2004). Using this theory as a framework, the aim of this research study was to examine the current practices, attitudes, confidence level, and knowledge of healthcare providers regarding bullying and the assessment of bullying. A secondary aim of the study was to determine whether the healthcare provider's attitude, confidence, and knowledge of bullying are predictors of whether or not healthcare providers routinely assess for bullying during well-child exams.

## **METHODS**

### **DESIGN AND SAMPLE**

A descriptive cross-sectional design was used in this study. The Healthcare Provider's Practices, Attitudes, Self-Confidence, and Knowledge Regarding Bullying (HCP-PACK) was used to assess aspects of bullying. The convenience sample consists of physicians and nurse practitioners who provide care for children in the state of Kentucky and conduct pediatric well-child checkups at least weekly.

### **MEASURE**

The HCP-PACK questionnaire measures healthcare provider's practices, attitudes, self-efficacy, and knowledge regarding bullying (see Appendix A). The questionnaire

consists of six sections with three specific subscales to gather information concerning the assessment and intervention of bullying behavior during well child checkups. The three subscales of the questionnaire are attitudes, self-efficacy, and knowledge. There were six attitude questions; eight self-efficacy questions; and 16 knowledge questions. Each question had four answer selections: strongly agree, agree, disagree, and strongly disagree. Four points were given for each answer marked as strongly agree; three points were given for each answer marked as agree; two points were given for each answer marked as disagree, and one point was given for each answer marked as strongly disagree. The additional areas of the questionnaire include demographics, practices, and training needs.

### **DATA COLLECTION**

After receiving University of Kentucky Institutional Review Board approval, 417 healthcare providers were identified from databases obtained from the Kentucky Medical Association and Kentucky Coalition of Nurse Practitioners and Nurse Midwives who saw children in the acute care setting. A questionnaire packet was mailed to each provider, which contained a cover letter, questionnaire, self-addressed stamped envelope to return the questionnaire and an address disclosure form. On the address disclosure form, the participants could provide an address for a \$10.00 Wal-Mart gift card to be mailed back to them as an incentive for completing the questionnaire. Initially, there were 78 eligible respondents who returned completed questionnaires. Two months after mailing the first questionnaire, a second mailing was done. Wording in the cover letter was added to explain the questionnaire had been mailed to them

previously and if already completed do not complete the questionnaire again. This yielded an additional 30 completed questionnaires which were included in the study.

### **DATA ANALYSIS**

Data analysis was conducted with SPSS v 22. Descriptive statistics, including frequencies, means and standard deviations, were used to summarize the data and describe the current practices, attitudes, confidence level, and knowledge of nurse practitioners and physicians regarding bullying and assessing for bullying during well child exams. Chi-square was calculated to examine the differences in assessment practices between nurse practitioners and physicians. Independent t-tests were conducted to examine the differences between those who assess for bullying and those who did not assess for bullying as well as to examine the differences between nurse practitioners and physicians. Lastly, logistic regression was performed to determine if the level of self-confidence, attitudes, and knowledge predicts a provider's current practice of assessing for bullying during well-child exams.

### **RESULTS**

#### **SAMPLE DEMOGRAPHICS**

Provider demographics are listed in Table 1. Approximately two-thirds of the providers in this study are pediatricians (61.9%, n=73) and 38.1% (n=45) are nurse practitioners. Provider length of practice was diverse, ranging from 1 to 47 years, with a mean of 17.5 years and standard deviation of  $\pm 10.93$ . Most providers were female (59.3%, n=70) and practice in a private setting (72%, n=85) as compared to those providers who work in a community health clinic (20.3%, n=24).



TABLE 4.1. Provider demographics (N=118)	
Characteristic	% (n)
Pediatrician	61.9 (73)
Nurse Practitioner	38.1 (45)
Average years as healthcare provider	17.5 years
Gender	
Male	40.7 (48)
Female	59.3 (70)
Practice Setting	
Community health clinic	20.3 (24)
Private practice	72 (85)

### **ASSESSMENT PRACTICES**

Providers who completed the HCP-PACK screened their patients for anemia (90.7%, n=107); tuberculosis (57.6%, n=68); lead (91.5%, n=108); and attention deficient hyperactivity disorder (81.4%, n=96). However, only 46.6% (n=55) of the healthcare providers assessed their patients for bullying. These participants listed the following reasons they assessed their patients for bullying: agency's recommendations (74.1%, n=40); prevalence of bullying among their patients (90.7%, n=49); and the belief that assessing for bullying is important (100%, n=55). Interventions that these providers suggest to their patients who are involved in bullying activities include the following:

provide counseling to the patient (94.4%, n=51); refer them to a mental health professional (90.6%, n=48); contact the child's school guidance counselor (44.5%, n=24); and provide reading materials to the patient and family regarding anti-bullying (46.5%, n=25). Almost 2% (n=2) of these providers file a police report when a child reports being bullied.

The 53.4% (n=63) of the surveyed participants who were not assessing for bullying activities among their patients listed the following two reasons: lack of resources and time (72.6%, n=45) and the fact that office well-child checkup templates do not include questions about bullying (79.3%, n=46).

A chi-square test of independence was performed to examine the differences in assessment practices between nurse practitioners and physicians. Even though pediatricians were more likely to assess their patients for bullying when compared to nurse practitioners (51.4%, n= 37 and 40%, n= 18 respectively); significant was not reached ( $X^2 = 4.225$ ,  $p=.121$ ).

### **IMPACT OF ATTITUDES, SELF-EFFICACY,, AND KNOWLEDGE ON PRACTICE**

An independent t-test was conducted to determine the differences in bullying assessment practices in regard to self-efficacy, knowledge, and attitudes. Independent t-test were also used to examine the differences in self-efficacy, knowledge, and attitudes between nurse practitioners and physicians. The mean scores in each area for those who were currently assessing for bullying were higher than those who were not assessing for bullying. See table 2. This study found that providers who were assessing for bullying had statistically significantly ( $t(115) = -2.739$ ,  $p=0.007$ ), higher attitudes

scores compared to providers who were not assessing for bullying. Providers who were assessing for bullying also had statistically significantly ( $t(115) = -3.216, p=0.002$ ), higher self-efficacy scores compared to providers who were not assessing for bullying. While this is true, there was not a meaningful difference in the mean attitude or self-efficacy score between those assessing for bullying and those not assessing for bullying. There was not a statistically significant difference in knowledge scores of those providers who was assessing for bullying compared to providers who were not assessing for bullying ( $t(115)= -.385, p=.701$ ). Physicians and nurse practitioners had similar mean scores in each scale area and no significant difference was found in attitudes ( $t(114)= -1.33, p=.186$ ), self-efficacy ( $t(114)= -1.009, p=.316$ ), and knowledge ( $t(114)= 1.65, p=.102$ ) between the two groups. See table 3 for mean scores.

TABLE 4.2. Mean Scores of Scales based on Current Practices (N=118)		
Scale	Mean (SD) Providers Assessing for Bullying (n=55)	Mean (SD) Providers Not Assessing for Bullying (n=62)
Attitudes	19.27 (2.42)	18.05 (2.41)
Self-efficacy	21.67 (3.69)	19.47 (3.71)
Knowledge	48.15 (4.93)	47.81 (4.59)
TABLE 4.3. Mean Scores of Scales based on Healthcare Provider Type (n=116)		
Scale	Mean (SD) Physicians (n=72)	Mean (SD) Nurse Practitioners (n=44)

Attitudes	18.35 (2.42)	18.98 (2.5)
Self-Efficacy	20.13 (3.5)	20.86 (4)
Knowledge	48.49 (4.49)	46.98 (4.94)

A logistic regression was conducted to assess the impact of a number of factors on the likelihood that healthcare providers would report that they assess for bullying. The model contained six independent variables (type of healthcare provider, years as a healthcare provider, provider's attitudes, self-efficacy, and knowledge of bullying and clinic bullying assessment policy). The full model containing all predictors was statistically significant,  $\chi^2(6, n=117) = 19.94$ ,  $p < .005$ , indicating that the model was able to distinguish between healthcare providers who reported assessing for bullying and not assessing for bullying. The model as a whole explained between 15.7% (Cox and Snell R square) and 20.9% (Nagelkerke R Squared) of the variance in bullying assessment practices, and correctly classified 68.4% of the cases. As shown in table 7, two of the independent variables made a statistically significant contribution to the model (attitudes and self-efficacy). The strongest predictor of positively assessing for bullying was attitudes, recording an odds ratio of 1.24. This indicated for every one-unit increase in attitudes score, the odds of assessing for bullying will be 24% higher. The odds ratio of self-efficacy or self-confidence was 1.18, indicating that for every one-unit increase in self-efficacy score, the odds of assessing for bullying will be 18% higher See Table 4.

Table 4.4. Logistic Regression Predicting Likelihood of Assessing for Bullying

	B	S.E.	Wald	Df	P value	Odds Ratio	95% C.I for Odds Ratio	
Years as HCP	-.027	.020	1.732	1	.188	.974	.936	1.013
Job Title	.812	.426	3.634	1	.057	2.253	.977	5.192
Attitude Score	.214	.101	4.475	1	.034	1.238	1.014	1.510
Self-Efficacy Score	.162	.061	7.015	1	.008	1.176	1.043	1.327
Clinic Policy	.008	.073	.012	1	.914	1.008	.874	1.163
Knowledge Score	-.072	.049	2.188	1	.139	.930	.845	1.024

### **ATTITUDES**

Participants (N=118) were asked questions to ascertain their attitude regarding assessing for bullying during well-child exams. Respondents either strongly agreed or agreed that healthcare providers should routinely assess their patients for bullying (89.9%, n=106). Most respondents (89%, n=105) believed that childhood bullying is a primary healthcare problem. Almost one-third (32.2%, n=38) of the respondents did not believe that childhood bullying is a public health problem and 44% (n=52) of the

providers believe that some parts of bullying are part of growing up. Ninety-four and nine tenths percent (n=111) of the providers believe adults should intervene when they suspect bullying activities and 90.6% (n=107) believe healthcare providers have an important role in helping to reduce childhood bullying. The attitudes subscale scores can range from 6 to 24. The group had scores ranging from 11 to 24. The mean score for this section was 18.6 and standard deviation of  $\pm 2.48$ .

TABLE 4.5. Attitudes of Healthcare Providers regarding bullying (N=118)				
Question Summary	Strongly Agree (%)	Agree (%)	Disagree (%)	Strongly Disagree (%)
HCPs should routinely assess for bullying	28	61.9	10.2	—
Childhood bullying is a primary healthcare problem	24.6	64.4	11	—
Childhood bullying is a public health problem and needs more attention	11	56.8	32.2	—
Some parts of bullying are part of growing up	2.5	41.5	44.1	11.9
Adults should intervene when a child is bullied	47.5	46.6	4.2	0.8
HCP have important role in helping to reduce childhood bullying.	23.7	66.9	9.3	—

### **PROVIDER'S SELF-EFFICACY REGARDING ASSESSING FOR BULLYING**

Participants (N=118) were asked about their self-efficacy or confidence regarding assessing for bullying and intervening when needed. There were 118 healthcare providers who completed this section of the questionnaire. Slightly over half (58.5%, n=69) of the providers answered they were confident they could recognize the signs and symptoms of bullying and victimization. Slightly more (62.4%, n=73) of the participants were confident they could screen their patients for bullying and 53% (n=61) of the providers were certain they could intervene effectively with their patients when they report being bullied. Likewise, 52.2% (n=60) felt they had the skills to counsel patients who are bullied. Healthcare providers answered similarly when asked about assessing their patients about bullying activities they may do to others. There were 56.1% (n=68) of healthcare providers who felt they knew what to do when a child reports bullying others and 47.4% (n=55) of healthcare providers were confident they could intervene with those children who bullies others. Only 41% (n=48) of the healthcare providers believed they possessed the skills to counsel patients who bully others. The answers in this section were able to be calculated into a final score. Self-efficacy subscale scores can range from 8 to 32. The group had scores ranging from 10 to 32. The mean score was 20.5 and standard deviation was  $\pm 3.85$ .

TABLE 4.6. Self-efficacy of Healthcare Providers regarding assessing for bullying and intervening when necessary (N=118)

Question Summary	Strongly Agree (%)	Agree (%)	Disagree (%)	Strongly Disagree (%)
Confident can recognize signs & symptoms of bullying & victimization	5.1	53.4	40.7	.8
Know what to do if child tells me he/she been bullied	7.7	70.1	21.4	.9
Confident in ability to screen my pts for bullying	7.7	54.7	35	2.6
Confident I can intervene effectively w pts who are bullied	5.2	47.8	45.2	1.7
Have skills to counsel pts who are bullied	6.1	46.1	44.3	3.5
Know what to do if children tell me they bully others	5.1	53	38.5	3.4
Confident can intervene w/ pts who are bullying others	2.6	44.8	48.3	4.3
Have skills to counsel pts who are bullying others	3.4	37.6	55.6	3.4

#### **PROVIDER'S KNOWLEDGE REGARDING BULLYING**

Table four displays how healthcare providers answered knowledge based questions regarding bullying. Overall, healthcare providers were knowledgeable about bullying.



There were several questions where 70% of providers answered correctly. However, three questions that participants scored poorly on included the following: younger children were more likely to report bullying to an adult (40.2%, n=47, answered correctly); in order for bullying to occur there has to be an imbalance of power (69.5%, n=82, answered correctly); and in order for bullying to occur the actions of the bully have to be intentional (11.9%, n=14, answered correctly).

The scores of the knowledge section can range from 16 to 64. There were 118 healthcare providers who completed this section of the questionnaire. The group had scores ranging from 33 to 58. The mean for this section was 48 and standard deviation was  $\pm 4.74$ .

TABLE 4.7. Healthcare Provider's Knowledge of Bullying (N=118)				
Question Summary	Strongly Agree (%)	Agree (%)	Disagree (%)	Strongly Disagree (%)
Bullying is verbally, physically, psychologically aggressive behavior	33.9	63.6	1.7	.8
Younger children are more likely to report bullying to an adult	3.4	36.8	54.7	5.1

To be bullied, there has to be perceived imbalance of power	8.5	61	29.7	.8
To be considered victim, actions of bully have to be intentional	—	11.9	74.6	13.6
Victims of bullying are often insecure	8.5	62.7	25.4	3.4
Children victims of bullying often difficulty sleeping	19.7	73.5	6	.9
Girl bullies use subtle/psych manipulating behaviors	22.4	69.8	7.8	—
Children considered different more at risk of being bullied	39	58.5	2.5	—
Boys more likely to physically and verbally bully	15.5	65.5	16.4	2.6
Victims of bullying complain abdominal pain/headaches	44.1	55.1	.8	—
Children overweight more likely bullied	35.6	57.6	6.8	—
Children who bully others more likely violent later in life	22	65.3	12.7	—
Children victims of bullying at risk for depression/poor self-esteem later	37.3	61.9	—	.8

Children exposed to violence at home are more likely bully	29.1	65.8	5.1	—
Autistic/ADHD/different sexual orientation more likely be bullied	34.5	61.2	4.3	—
Familiar with AAP recommendation re: bullying	13.6	57.6	25.4	3.4

## DISCUSSION

### ASSESSMENT PRACTICES

Approximately 47% (n=55) healthcare providers in the sample assessed their patients for bullying behavior. In a study conducted by Borowsky, Mozayeny, Stuenkel, and Ireland the efficacy of primary care violence prevention strategies were tested and found to reduce future violent behavior, including bullying behaviors (2004). Furthermore, numerous national and global organizations stress the importance of primary care providers screening and intervening for bullying behaviors. Despite empirical evidence supporting bullying screening, recommendations by organizations, and adversity caused by bullying, healthcare providers do not consistently consider a child is being bullied or take a proactive role in bullying prevention (Dale, Russell, & Wolke, 2014). Findings in this study are consistent with that statement and show that less than half of healthcare providers are assessing for bullying.

### FACTORS WHICH IMPACT PRACTICE

With respect to predictive factors for bullying assessment practices, healthcare providers were more likely to assess for bullying if they believed bullying was an adverse problem affecting youth and were confident to assess and intervene in bullying. These

findings are consistent with social cognitive theory, suggesting that social cognitive theory may be a useful framework in describing healthcare provider's behavior in regards to assessing for bullying. These findings also provide initial support to design and evaluate an intervention training program to increase attitudes and self-efficacy of healthcare providers regarding assessing for childhood bullying during well-child checkups

### **SELF-EFFICACY**

Feeling confident to assess for and intervene in bullying are important factors for healthcare providers to have so that they be engaged in bullying prevention.

Participants did not feel particularly confident to recognize, assess, and intervene when necessary for bullying behaviors among their patients. The only question that received greater than 70% agreement was healthcare providers knew what to do if a child tells them they have been bullied. Otherwise, self-efficacy for the participants was not very high with self-efficacy lowest regarding intervening and counseling patients who bully others.

### **ATTITUDES**

In agreement with national guidelines, most healthcare providers who responded to this questionnaire, indicated that bullying is a primary care problem and healthcare providers should be assessing for bullying on a routine basis and intervene when they suspect bullying is a problem. It is encouraging that healthcare providers are aware of the need to screen for bullying and believe that they have an important role in stopping bullying. However, almost half of the healthcare providers believed that at least some

bullying was part of growing up and less than half of healthcare providers actually assess patients on a routine basis for bullying. There are numerous adverse health consequences of bullying and therefore, it is essential that screening for bullying be included in the routine assessment of children.

### **KNOWLEDGE**

Of the 16 questions ascertaining healthcare provider's knowledge of childhood bullying, three questions had scores less than 70%. Only 40.2% (n=47) of the respondents thought that younger children were more likely to report bullying to an adult. In fact, bullying was reported the most by students in sixth and seventh grade whereas students in grade eight were 50% less likely to report bullying while students in grade 12 were 76% less likely to report bullying when compared to sixth and seventh grade students ( U.S. Department of Justice, 2009).

Likewise, 30.5% (n=36) of providers did not agree that there had to be an imbalance of power in order for bullying to occur. Few healthcare providers (11.9%, n=14) believed that in order for bullying to occur, the actions of the bully have to be intentional. However, bullying is defined as verbally, physically and or psychologically aggressive behavior which is intentionally harmful to another person and occurs repeatedly over a period of time to an individual(s) who is perceived to be less powerful in a physical and or psychological manner (Nansel, Overpeck, Pilla, et al., 2001).

Encouragingly, most (87.9%, n=102) of the participants in this study indicated that they are interested in learning more about bullying and indicated that conference

seminars (67.8%, n=80) and CEU offerings (70.3%, n=83) were the preferred method of receiving this information.

This study has two key findings: 1) Less than half of pediatric healthcare providers are assessing for bullying; and 2) provider's attitudes and self-efficacy are positively associated with healthcare providers assessing their patients for bullying behaviors.

(Copyright@VictoriaRHensley2015)

## CHAPTER FIVE

### CONCLUSIONS

The impact of bullying is astounding. Bullying is not only detrimental to the victim, but also the bully as well. Approximately, 160,000 teens report skipping school each day because they are bullied and 1 in 10 teens drop out of school because of repeated bullying. Most bullying occurs in schools; however, the effectiveness of bullying intervention programs is debatable. Healthcare providers should be doing more to help reduce the prevalence of bullying behaviors in children as well as to help reduce the consequences bullying behavior. Many recognize the important role of the pediatric healthcare provider in bullying assessment, intervention, and prevention. The American Academy of Pediatrics states pediatric healthcare providers can contribute to bullying

prevention through promotion of strong parenting skills and recognition, screening, and appropriate referrals of patients involved in bullying behaviors (Committee on Injury, Violence, and Poison Prevention, 2009). The Society for Adolescent Medicine emphasizes pediatric healthcare providers should be familiar with the characteristics of youth possibly involved with bullying, sensitive to signs and symptoms of bullying and victimization, and intervene when necessary (Eisenberg & Aalsma, 2005).

While many surveys exist to measure the prevalence and associated factors of bullying in school age children, an instrument designed to elicit information from healthcare providers regarding bullying was not able to be found. Therefore the purposes of this dissertation were to a) develop and evaluate the psychometrics of a survey to measure healthcare provider's practices, attitudes, capability assessment (self-efficacy), and knowledge (HCP-PACK) regarding bullying and b) examine the current practices, attitudes, confidence level, and knowledge of pediatric healthcare providers regarding bullying and assessing for bullying during well child exams using the HCP-PACK.

In Chapter Two the current literature regarding childhood bullying was explored and presented. It is clear that not only is childhood bullying a problem our youth face today, but the harmful effects of bullying can be immediate and last for many years in the future. It is imperative healthcare professionals, including pediatricians, nurse practitioners, physician assistants, and nurses alike, be knowledgeable about the multi dimensions of bullying and begin assessing children for this type of violence. Direct questions about being bullied should be asked at each well-child visit as well at acute visits where children present with symptoms which could be caused by bullying.

Questioning will not only identify if problems exist but will also allow for dialogue to happen between child and parent. Furthermore, this will also identify those patients which need interventions to help reduce the consequences of bullying behavior.

In Chapter Three the development of the HCP-PACK was discussed and the psychometrics of the questionnaire was presented. These results provide preliminary evidence of the validity and reliability of Hensley's HCP-PACK. With additional psychometric testing, Hensley's HCP-PACK instrument has potential for measuring current practices, attitudes, confidence level, and knowledge of pediatric healthcare providers regarding bullying and assessing for bullying during well child exams. Furthermore, the questionnaire could be slightly modified to assess other populations, such as teachers or counselors. Lastly, the information gained during the collection of data can aid in the development of provider interventions to those involved in bullying behaviors.

Chapter Four explored the findings from the quantitative research of the principal investigator's study. Conclusions from the study included healthcare providers' who are confident in their ability to assess for bullying and intervene as necessary are more likely to assess that bullying has occurred. Attitudes are also important as healthcare providers who have more positive attitudes regarding bullying are also more likely to assess for bullying. Measures need to be taken to increase healthcare providers' confidence and improve attitudes related to bullying so that primary care providers can help negate the effects of childhood bullying. Continuing education could help strengthen self-efficacy and influence attitudes that may result in more active



participation in childhood bullying. In other areas of clinical practice, such as tobacco treatment, training has been shown to increase the frequency, quality, and effectiveness of providers delivering tobacco treatment, confidence to perform those clinical activities, and related attitudes regarding the value of the treatment (Payne et al., 2014). Attitudes and beliefs need to be discussed and strategies implemented so that bullying assessment is conducted by all healthcare providers on a routine basis. Providers could also benefit from additional training on current bullying recommendations and assessment guidelines. By incorporating the assessment of bullying into well-child exams, primary healthcare providers may decrease the prevalence of childhood bullying; therefore, increasing children's health and well-being.

#### LIMITATIONS AND STRENGTHS

There were a number of limitations to this study. First, the study participants primarily worked in Kentucky; therefore, further psychometric testing of Hensley's HCP-PAACK with a larger, more diverse sample is recommended. The study also used an investigator designed questionnaire, which has had limited reliability and validity testing. The response rate for this study was 28.3%.

In terms of strengths, this is the first study of to examine healthcare provider childhood bullying assessment practices and factors that predict the probability of healthcare providers assessing for bullying. Findings from the current study add to the body of literature concerning childhood bullying, assessing for bullying in the primary care setting, and factors that may increase the likelihood of healthcare providers assessing for bullying.

## RECOMMENDATIONS

Future research is needed to further explore the phenomena of the healthcare provider's role in bullying prevention and intervention. Researchers should focus on repeating this study in a larger population. Results of this study could then be used to develop an intervention to increase healthcare provider's assessment of bullying.

Preliminary data suggest that higher levels of self-efficacy and attitudes regarding bullying and assessing for bullying may improve health care providers' adherence to current bullying screening recommendation. Therefore additional research could be done to design interventions to increase healthcare provider's self-efficacy and attitudes regarding bullying and bullying assessment.

It might also be of value to test the psychometric properties of this questionnaire with different populations such as school teachers. Teachers' self-confidence, attitudes, knowledge of bullying as well as their ability to assess for bullying could provide information that could begin to diminish bullying activities in the school system.

## Appendix A

### Healthcare Provider's Practices, Attitudes, Self-Confidence, and Knowledge Questionnaire Regarding Bullying and the Assessment of Bullying

Please answer the following items related to the provision of healthcare for children

#### A. Demographics

A1. I am a:

- Pediatrician
- Pediatric Nurse Practitioner
- Family Nurse Practitioner
- Other \_\_\_\_\_

A2. How many years have you worked as a healthcare provider to children?

-----years

A3. I am a:

- Male
- Female

A4. I currently see children (0-18 years) for well child check-ups on a regular (at least weekly basis).

- Yes  No

A5. What is your primary practice setting?

- Hospital
- Community health clinic
- Private practice
- Free health clinic or mobile van
- Local health department

A6. Which of the following best describes your race/ethnicity?

- African American
- Asian
- Caucasian
- Hispanic or Latino
- Middle Eastern
- Other \_\_\_\_\_

#### B. Practices

B1. If applicable for my patient's age, I currently screen my patients for anemia.

- Yes
- No

B2. If applicable for my patient's age, I currently screen my patients for tuberculosis.

- Yes
- No

B3. If applicable for my patient's age, I currently screen my patients for lead.

- Yes
- No

B4. If applicable for my patient's age, I currently screen my patients for ADHD.

- Yes
- No

B5. If applicable for my patient's age, I currently screen my patients for bullying.

- Yes
- No, GO TO B17

B6. My practice assesses for bullying because of the recommendations by an official agency (AAP, Bright Futures, etc.)

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

B7. My practice assesses for bullying because current patients have or have had problems with bullying.

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

B8. My practice assesses for bullying because we believe the matter is important.

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

B9. My practice assesses for bullying because of other reasons not listed above. Please share those reasons below. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

B10. I intervene with my patients when I suspect bullying is a problem:

- Very Frequently
  - Frequently
  - Occasionally
  - Rarely  Never,
- GO TO B17.

B11. I provide counseling to the patient and family when a patient is being bullied or bullying others.  Strongly Disagree

- Disagree
- Agree
- Strongly Agree

B12. I refer patients to a mental health counselor when a patient is being bullied or bullying others.  Strongly Disagree

- Disagree
- Agree
- Strongly Agree

B13. I contact the school's guidance counselor when a patient is being bullied or bullying others.  Strongly Disagree

- Disagree
- Agree
- Strongly Agree

B14. I provide reading materials to the patient and family when a patient is being bullied or bullying others.  Strongly Disagree

- Disagree

- Agree
- Strongly Agree



B15. I make documentation in the patient's chart when a patient has been bullied or bullying others.

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

B16. If there are other things that you do when a patient has been bullied or bullying others, please share those things below: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

The following questions regard reasons why you do not assess for bullying. If you DO assess for bullying, then please GO TO SECTION C.

B17. I do not assess for bullying because of lack of resources or time.

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

B18. I do not assess for bullying because it is not viewed as a primary healthcare matter.

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

B19. I do not assess for bullying because it is not part of the question template that the office uses.  Strongly Disagree

- Disagree
- Agree
- Strongly Agree

B20. I do not assess for bullying because of other reasons not listed above. Please share those reasons below.

---

–

---

–

### C. Attitudes

C1. I believe healthcare providers should routinely assess for childhood bullying.

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

C2. I believe that childhood bullying is a primary healthcare problem.

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

C3. I believe childhood bullying is a public health problem and needs more attention and interventions.  Strongly Disagree

- Disagree
- Agree
- Strongly Agree

C4. I believe that some forms of childhood bullying are part of growing up.

- Strongly Disagree
- Disagree

- Agree
- Strongly Agree

C5. I believe adults should intervene when they suspect a child is being bullied.

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

C6. I believe that healthcare providers have an important role in helping to reduce childhood bullying.  Strongly Disagree

- Disagree
- Agree
- Strongly Agree



### D. Self-confidence

D1. I am confident I can recognize the signs and symptoms of bullying and victimization.

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

D2. I know what to do if a child tells me he/she has been bullied.  Strongly Disagree

- Disagree
- Agree
- Strongly Agree

D3. I am confident in my ability to screen my patients for bullying.

- Strongly Disagree

- Disagree
- Agree
- Strongly Agree

D4. I am confident that I can intervene effectively with my patients who are bullied.

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

D5. I have the skills to counsel patients who are bullied.  Strongly Disagree

- Disagree
- Agree
- Strongly Agree

D6. I know what to do if children tell me they bully others.  Strongly Disagree

- Disagree
- Agree
- Strongly Agree

D7. I am confident that I can intervene effectively with my patients who are bullying others.

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

D8. I have the skills to counsel patients who are bullying others.

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

(Copyright@VictoriaRHensley2015)



### E. Knowledge

E1. Bullying is considered verbally, physically or psychologically aggressive behavior.

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

E2. In order for a child to be bullied there has to be a perceived imbalance of power.

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

E3. The younger a child is the more likely they are to report bullying behaviors to an adult.

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

E4. In order for a child to be a victim of bullying, the actions of the bully have to be intentional.

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

E5. Children who are victims of bullying are often insecure.

- Strongly Disagree
- Disagree

- Agree
- Strongly Agree

E6. Children who are victims of bullying often having difficulty sleeping.

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

E7. Girls are more likely to use subtle and psychologically manipulative behaviors when bullying, compared to boys.

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

E8. Children who are perceived as being different are more at risk of being bullied.

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

E9. Compared to girls, boys are more likely to physically and verbally bully others.

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

E10. Children who are victims of bullying may often complain about abdominal pain and headaches.

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

E11. Children who are overweight are more likely to be bullied.

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

E12.Children who bully others are more likely to be involved in violence later in life.

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

E13.Children who are victims of bullying are at risk for depression and poor self-esteem later in life.

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

E14.Children who are exposed to violence at home are more likely to bully others.

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

E15.Children who are autistic, have ADHD, or have a different sexual orientation are more likely to be bullied.

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

E16.The American Academy of Pediatrics states pediatric healthcare providers can contribute to bullying prevention through promotion of strong parenting skills and recognition, screening, and appropriate referrals of patients involved in bullying behaviors. I am familiar with this recommendation concerning bullying.

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree



## F. Training Needs

F1. To your knowledge, does your workplace have written guidelines on screening for bullying?

- Yes
- No
- Not sure

F2. Are patient education materials about bullying (brochures, posters, etc.) available at your practice site?

- Yes
- No
- Not sure

F3. Do you feel you have adequate knowledge regarding how to help your patients who are a victim of a bullying?

- Yes
- No



Not sure

F4. Do you feel you have adequate knowledge regarding how to help your patients who bullying others?

Yes

No

Not sure

F5. Where have you learned about bullying? (select all that apply)

Conference seminar

CEU offering

Journal publication

Information in textbook

Mailed information

Part of medical or nursing education

F6. Do you think healthcare providers need additional educational opportunities to learn about bullying?

Yes

No

Not sure

F7. Which of the following would you recommend to increase the healthcare provider's knowledge about bullying? (select all that apply)

Conference seminar

CEU offering

Journal publication

Information in textbook

Mailed information

Part of medical or nursing education

### References: Chapter One

Aleude, O., Adeleke, F., Omoike, D., and Afen-Akpaída, J. (2008). A Review of the Extent, Nature, Characteristics and Effects of Bullying Behavior in Schools. *Journal of Instructional Psychology*, 35 (2), 151-158.

Barboza, G.E., Schiamberg, L.B., Oehmke, J, Korzeniewski, S.J., Post, L.A., & Heraux, C.G. (2009). Individual characteristics and the multiple contexts of adolescent bullying: an ecological perspective. *Journal of Youth and Adolescence*, 38, 101-121.

Bender, D., & Losel, F. (2011). Bullying at school as a predictor of delinquency, violence and other anti-social behavior in adulthood. *Criminal Behavior and Mental Health*, 21, 99-106.

Carter, S. (2011). Bullies and power: a look at the research. *Issues in Comprehensive Pediatric Nursing*, 34, 97-102.

- Cohen, A., and Canter, A. (2003). Bullying: Facts for schools and parents. *National Association of School Psychologists*. Retrieved August 19, 2011 from <http://naspcenter.org>.
- Committee on Injury, Violence, and Poison Prevention. (2009). Role of the Pediatrician in Youth Violence Prevention. *Pediatrics*, 124, 393-402.
- Duffy, A.L., & Nesdale, D. (2008). Peer groups, social identity, and children's bullying behavior. *Social Development*, 18, 121-139.
- Eisenberg, M.E., & Aalsma, M.C. (2005). Bullying and peer victimization: Position paper of the society for adolescent medicine. *Journal of Adolescent Health*, 36(1), 88-91.
- Espelage, D.L., Bosworth., & Simon, T.R. (2000). Examining the social context of bullying behaviors in early adolescence. *Journal of Counseling and Development*, 78(3), 326-333.
- Espelage, D.L., & Swearer, S.M. (2004). Gender differences in bullying: Moving beyond mean level differences. In D.L. Espelage & S.M. Swearer (Eds.), *Bullying in American schools: A social-ecological perspective on prevention and intervention* (pp. 15-35). Mahwah, NJ: Erlbaum.
- Falb, K.L., McCauley, H.L., Decker, M.R., et al. (2011). School bullying perpetration and other childhood risk factors as predictors of adult intimate partner violence perpetration. *Arch Pediatr Adolesc Med*, 165(10), 890-894.
- Farrington, D.P., & Ttofi, M.M. (2011). Bullying as a predictor of offending violence and later life outcomes. *Criminal Behavior and Mental Health*, 21, 90-98.
- Farrow, C.V., & Fox, C.L. (2011). Gender differences in the relationships between bullying at school and healthy eating and shape-related attitudes and behaviors. *British Journal of Educational Psychology*, 81, 409-420.

- Fekkes, M., Pijpers, F.I.M., Fredriks, M., et al. (2006). Do bullied children get ill, or do ill children get bullied? A Prospective cohort study on the relationship between bullying and healthrelated symptoms. *Pediatrics*, 117, 1568-1574.
- Finnegan, R.A., Hodges, E.V.E., & Perry, D.G. (1998). Victimization by peers: Associations with children's reports of mother-child interaction. *Journal of Personality and social psychology*, 75, 1076-1086.
- Garrett, A.G. (2003). *Bullying in American schools*. Jefferson, NC: McFarland.
- Glew G.M., Fan M.Y., Katon W., and Rivara F.P. (2008). Bullying and school safety. *Journal of Pediatrics*, 152(1), 123-8.
- Hanish, L.D., & Guerra, N.G. (2004). Aggressive victims, passive victims, and bullies: Developmental continuity or developmental change? *Merrill-Palmer Quarterly*, 50, 17-38.
- Infectious Diseases in Children (2011). Bullying: What a pediatrician should know. Retrieved from <http://www.healio.com/Pediatrics/news/print>.
- Hemphill, S.A., Kotevski, A., Herrenkohl, T.I., Bond, L., Kim, M.J., Toumbourou, J.W., & Catalano, R.F. (2011). Longitudinal consequences of adolescent bullying perpetration and victimization: A study of students in Victoria, Australia. *Criminal Behaviour and Mental Health*, 21, 107-116.
- Hendershot, C., Dake, J.A., Price, J.H., et al. (2006). Elementary school nurses' perceptions of student bullying. *The Journal of School Nursing*, 22(4), 229-236.
- Jantzer, A. M., Hoover, J. H., & Narloch, R. (2006). The relationship between schoolaged bullying and trust, shyness, and quality of friendships in young adulthood: A preliminary research note. *School Psychology International*, 27, 146-156.
- Jiang, D., Walsh, M., & Augimeri, L.K. (2011). The linkage between childhood bullying behavior and future offending. *Criminal Behavior and Mental Health*, 21, 128-135.

- Kaiser Family Foundation and Children Now (2001). Bullying, Discrimination and Sexual Pressures "Big Problems" for Today's Tweens and Younger Kids; Parents Often Wait for Their Kids to Raise Tough Issues. Retrieved from <http://www.kff.org/mediapartnerships/3105-index.cfm>.
- Kim, M.J., Catalano, R.F., Haggerty, K.P., et al. (2011). Bullying at elementary school and problem behavior in young adulthood: a study of bullying, violence and substance use from age 11 to age 21. *Criminal behavior and mental health*, 21, 136-144.
- Kim, Y.S., Boyce, W.T., Koh, Y.J., Leventhal, B.L. (2009). Time trends, trajectories, and demographic predictors of bullying: a prospective study in Korean adolescents. *Journal of Adolescent Health*, 45(4), 360-367.
- Lohre, A., Lyderson, St., Paulsen, B., Maehle, M., & Vatten, L.J. (2011). Peer victimization as reported by children, teachers, and parents in relation to children's health symptoms. *BMC Public Health*, 11: 278.
- Nansel, T.R., Overpeck, W., Overpeck, M.D., et al. (2004). Cross-national consistency in the relationship between bullying behaviors and psychosocial adjustment. *Archives of Pediatrics & Adolescent Medicine*, 158, 730-736.
- Nansel, T. R., Overpeck, M., Pilla, R.S., et al. (2001). Bullying behaviors among US youth: Prevalence and association with psychosocial adjustment. *Journal of American Medical Association*, 285 (16), 2094-2100.
- National Association of School Nurses (NASN). (2003). Peer bullying. Retrieved August 19, 2011, from <http://www.nasn.org>.
- National Center for Mental Health Promotion and Youth Violence Prevention (2013). (<http://www.promoteprevent.org/publications/prevention-briefs/preventing-bullyingschools-and-community>).

- Newman, M. L., Holden, G. W., & Delville, Y. (2005). Isolation and the stress of being bullied. *Journal of Adolescence*, 28, 343-357.
- Niemela, S., Brunstein-Klomek, A., Sillanmaki, L., et al. (2011). Childhood bullying behaviors at age eight and substance use at age 18 among males. A nationwide prospective study. *Addictive Behavior*, 36, 256-260.
- Olweus, D. (1993). *Bullying at school: what we know and what we can do*. Cambridge, MA: Blackwell Publishing, Inc.
- Olweus, D. (1994). Bullying at school: long-term outcomes for the victims and an effective school-based intervention program. In Huesmann LR, ed. *Aggressive Behavior: current perspectives*. New York: NY: Plenum Press, 97-130.
- Olweus, D., Limber, S., & Mihalic, S. (1999). *Blueprints for Violence Prevention, Book Nine: Bullying Prevention Program*. Boulder, CO: Center for the Study and Prevention of Violence.
- Olweus, D. (2011). Bullying at school and later criminality: findings from three Swedish community samples of males. *Criminal Behavior and Mental Health*, 21, 151-156.
- O'Moore, M., and Kirkham, C. (2001). Self-esteem and its relationships to bullying behaviour. *Aggressive Behavior*, 27, 269-283.
- Parren, S. & Alsaker, F.D. (2006). Social behavior and peer relationships of victims, bullyvictims, and bullies in kindergarten. *Journal of Child Psychology and Psychiatry*, 47(1), 45-57.
- Ragatz, L.L., Anderson, R.J., Fremouw, W., et al. (2011). Criminal thinking patterns, aggression styles, and the psychopathic traits of late high school bullies and bully-victims. *Aggressive Behavior*, 37, 145-160.

- Renda, J., Vassallo, S., & Edwards, B. (2011). Bullying in early adolescence and its association with anti-social behavior, criminality and violence 6 and 10 years later. *Criminal Behavior and Mental Health*, 21, 117-127.
- Schwartz, D. (2000). Subtypes of victims and aggressors in children's peer groups. *Journal of Abnormal Child Psychology*, 28, 181-192.
- Shellard, E. (2002). Recognizing and preventing bullying. The informed Educator Series. Arlington, VA: Educational Research Service.
- Shields, A., & Cicchetti, D. (2001). Parental maltreatment and emotion dysregulation as risk factors for bullying and victimization in middle childhood. *Journal of Clinical Child Psychology*, 30, 349-363.
- Sourander, A., Jensen, P., Ronning, J.A., et al. (2007). Childhood bullies and victims and their risk of criminality in late adolescence. *Arch Pediatr Adolesc Med*, 161, 546-552
- Storch, E., Lwein, A., Silverstein, J., Heidgerken, A., et al. (2004). Social-psychological correlates of peer victimization in children with endocrine disorders. *The Journal of Pediatrics*, 145(6), 784.
- Sweeting, H., West, P. (2001). Being different: Correlates of the experience of teasing and bullying at age 11. *Research Papers in Education*, 16(3), 225-246.
- Ttofi, M.M., Farrington, D.P., Losel, F., et al. (2011). The predictive efficiency of school bullying verses later offending: a systematic/meta-analytic review of longitudinal studies. *Criminal Behavior and Mental Health*, 21, 80-89.
- U.S. Department of Justice, Office of Justice Programs. (2001). Addressing the Problem of Juvenile Bullying. OJJDP Fact Sheet. Retrieved online from <https://www.ncjrs.gov/pdffiles1/ojjdp/FS200127.pdf> on August 19, 2011.

- U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. (2009). *National Crime Victimization Survey School Crime Supplement, 2009 [Codebook]*. Ann Arbor, MI: Interuniversity Consortium for Political and Social Research.
- Veenstra, R., Lindenberg, S., Oldehinkel, A.J., et al. (2005). Bullying and victimization in elementary schools: a comparison of bullies, victims, bully/victims, and uninvolved preadolescents. *Developmental Psychology*, 41(4), 672-682.
- Vernberg, E.M., Nelson, T.D., Fonagy, P., & Twemlow, S.W. (2011). Victimization, Aggression, and Visits to the school nurse for somatic complaints, illnesses, and physical injuries. *Pediatrics*, 127(5), 842-848.
- Viding, E., Simmonds, E., Petrides, K., et al. (2009). The contribution of callous-unemotional traits and conduct problems to bullying in early adolescence. *J Child Psychol Psyc*, 50(4) 471481.
- Vossekuil, B., Reddy, M., Fein, R., et al. (2000). *Safe school initiative: an interim report on the prevention of targeted violence in schools*. U.S. Secret Service National Threat Assessment Center in collaboration with the U.S. Department of education and with support from the National Institute of Justice.
- Wang, J., Iannotti, R.J., & Nansel, T.R. (2009). School Bullying among US Adolescents: Physical, Verbal, Relational, and Cyber. *Journal of Adolescent Health*, 45(4), 368-375.

## References: Chapter Two

- Bandura, A. (2006). Guide for constructing self-efficacy scales. In F. Pagares & T. Irdan (Eds.) *Self-efficacy beliefs of adolescents*. Greenwich, CT: Information Age Publishing.
- Borrowsky, I.W. & Ireland, M. (1999). National survey of pediatricians' violence prevention counseling. *Archives of Pediatrics and Adolescent Medicine* 153, 1170-1176.
- Chamberlain, T., George, N., Golden, S., Walker, F., & Benton, T. (2010). *Tellus4 national report*. Colchester, Essex: UK Data Archive.
- Cook, DA., & Beckman, TJ. (2006). Current Concepts in Validity and Reliability for Psychometric Instruments: Theory and Application. *American Journal of Medicine*, 119(2), 116.e7-116.e16.
- Committee on Injury, Violence, and Poison Prevention. (2009). Role of the Pediatrician In Youth Violence Prevention. *Pediatrics*, 124, 393-402.
- Dale, J., Russel, R., & Wolke, D. (2014). Intervening in Primary Care Against Childhood Bullying: An Increasing Pressing Public Health Need, *Journal of Royal Society Medicine*, 107(6) 219-223.
- DeVellis, R.F. (2012). *Scale development: theory and application* (3<sup>rd</sup> ed.). Los Angeles: Sage Publications, Inc.
- Eaton, D.K., Kann, L., Kinchen, S., Shanklin, S., Flint, K.H., Hawkins, J., Wechsler, W. (2012). Youth Risk Behavior Surveillance: United States, 2011. (2012). *MMWR Surveillance Summary*, 61, 1-162.



- Eisenberg, M.E., & Aalsma, M.C. (2005). Bullying and peer victimization: Position paper of the society for adolescent medicine. *Journal of Adolescent Health, 36*(1), 88-91.
- Frank-Stromborg, M., & Olsen, S.L. (eds) (2004). *Instruments for Clinical Health-care Research* (3<sup>rd</sup> edition.). Sudbury, MA.
- Grant, J.S., & Davis, L.L. (1997). Selection and use of the content experts for instrument development. *Research in Nursing & Health, 20*(3), 269-274.
- Haynes, S.N., Richard, D.C.d., & Kubany, E.S. (1995). Content Validity in Psychological Assessment: A Functional Approach to Concepts and Methods. *Psychological Assessment, 7*(3) 238-247.
- Hensley, V. (2013). Childhood bullying: a review and implications for healthcare professionals. *Nursing clinics of North America, 48*(2), 203-213.
- Infectious Diseases in Children (2011). Bullying: What a pediatrician should know. Retrieved from <http://www.healio.com/Pediatrics/news/print>.
- Lereya, S.T., Samara, M., & Wolke, D. (2013). Parenting behavior and the risk of becoming a victim and a bully/victim: a meta-analysis study. *Child Abuse Neglect, 37*, 1091-1108.
- Lynn, M. R. (1986). Determination and quantification of content validity. *Nursing Research, 35*(6), 382-385.
- Nansel, T. R., Overpeck, M., Pilla, R.S., Ruan, W.J., Simons-Morton, B., & Scheidt, P. (2001). Bullying behaviors among US youth: Prevalence and association with psychosocial adjustment. *Journal of American Medical Association, 285* (16), 2094-2100.

- National Center for Mental Health Promotion and Youth Violence Prevention. Retrieved from <http://www.promoteprevent.org/publications/prevention>.
- O'Brien, H.L. & Toms, E.D. (2010). The Development and evaluation of a Survey to Measure User Engagement. *Journal of the American Society of Information Science Technology*, 61(1), 50-69.
- Radford, L., Corral, S., Bradley, C., & Fisher, H.L. (2013). The prevalence and impact of child maltreatment and other types of victimization in the UK: findings from a population survey of caregivers, children and young people and young adults. *Child Abuse Neglect*, 37, 801-813
- Scrabstein, J.C., & Merrick, J. (2012). Bullying is Everywhere: An Expanding Scope of Public Health Concerns, *International Journal of Adolescent Medicine and Health*, 24:1.
- Sireci, S.G. (1998). The Construct of Content Validity, *Social Indicators Research*, 45, 83-117.
- Smith, P.K., Mahdavi, J., Carvalho, M., Fisher, S., Russell, S., & Tippett, N. (2008). Cyberbullying: its Nature and Impact in Secondary School Pupils. *Journal of Child Psychology and Psychiatry*, 49, 376-385.
- Spector, P. (1992). *Summated Rating Scale Construction*. Thousand Oaks, CA: Sage.
- Streiner, D.L. & Norman, G.R. (2003). *Health Measurement Scales: a practical guide to their development and use* (3<sup>rd</sup> ed.). New York: Oxford University Press.
- Waltz, C.F., Stickland, O.L., & Lenz, E.R. (2010). *Measurement in Nursing and Health Research* (4<sup>th</sup> ed.). New York; Springer Publishing Company.

Wang, J., Iannotti, R.J., Nansel, T.R. (2009). School Bullying among US Adolescents: Physical, Verbal, Relational, and Cyber. *Journal of Adolescent Health*, 45(4), 368-375.

Wolke, D., Copeland, W.E., Angold, A., & Costello, E.J. (2013). Impact of Bullying in Childhood on Adult Health, Wealth, Crime and Social Outcomes. *Psychology Science*, 24 (10), 1958-1970.

## References: Chapter Four

- Bandura, A. (2004). Health Promotion by Social Cognitive Means. *Health Education & Behavior*, 31(2), 143-164.
- Borowsky, I.W., Mozayeny, S., Stuenkel, K, and Ireland, Moarjorie. (2004). Effects of a primary care-based intervention on violent behavior and injury in children. *Pediatrics*, 114, 3392-e399.
- Committee on Injury, Violence, and Poison Prevention. (2009). Role of the Pediatrician in Youth Violence Prevention. *Pediatrics*, 124, 393-402.
- Copeland, W.E., Wolke, D., Lereya, S.T., Shanahan, L., Worthman, C., and Costello, E.J. (2014). Childhood bullying involvement predicts low-grade systemic inflammation into adulthood. *PNAS*, 111(21), 1570-1575.
- Dale, J., Russell, R., and Wolke, D. (2014). Intervening in primary care against childhood bullying: an increasing pressing public health need. *Journal of the Royal Society of Medicine*, 107(6),219-223.
- Eisenberg, M.E., & Aalsma, M.C. (2005). Bullying and peer victimization: Position paper of the society for adolescent medicine. *Journal of Adolescent Health*, 36(1), 8891.
- Fekkes, M., Pijpers, F.I.M., Fredriks, M., et al. (2006). Do bullied children get ill, or do ill children get bullied? A Prospective cohort study on the relationship between bullying and health-related symptoms. *Pediatrics*, 117, 1568-1574.
- Fisher, H.L., Moffitt, T.E., Houts, R.M., Belsky, D.W., Arseneault, L, & Caspi, A. (2012). Bullying victimization and risk of self harm in early adolescence: longitudinal cohort study. *British Medical Journal*, 344, 1-9.

Hemphill, S.A., Kotevski, A., Herrenkohl, T.I., Bond, L., Kim, M.J., Toumbourou, J.W., & Catalano, R.F. (2011). Longitudinal consequences of adolescent bullying perpetration and victimization: A study of students in Victoria, Australia. *Criminal Behaviour and Mental Health*, 21, 107-116.

Jansen, P.W., Verlinden, M., Berkel, A.D., Mieloo, C., Van der Ende, J., Veenstra, R.....& Tiemeier, H. (2012). Prevalence of bullying and victimization among children in early elementary school: do family and school neighborhood socioeconomic status matter? *BMC Public Health*, 12: 494.

Lereya, S.T., Winsper, C., Heron, J., Lewis, G., Gunnell, D., Fisher, H.L., & Wolke, D. (2013). Being bullied during childhood and the prospective pathways to self-harm in late adolescence clinical guidance. *Journal of the American Academy of Child & Adolescent Psychiatry*, 52(6), 608-618.

Limber, S. P., D. Olweus, and H. Luxenberg. 2013. "Bullying in U.S. Schools: 2012 Status Report." Retrieved from [http://www.violencepreventionworks.org/public/document/obpp\\_bullying\\_in\\_us\\_schools\\_2012report.pdf](http://www.violencepreventionworks.org/public/document/obpp_bullying_in_us_schools_2012report.pdf).

Lohre, A., Lyderson, St., Paulsen, B., Maehle, M., & Vatten, L.J. (2011). Peer victimization as reported by children, teachers, and parents in relation to children's health symptoms. *BMC Public Health*, 11: 278.

Nansel, T. R., Overpeck, M., Pilla, R.S., et al. (2001). Bullying behaviors among US youth: Prevalence and association with psychosocial adjustment. *Journal of American Medical Association*, 285 (16), 2094-2100.

National Center for Mental Health Promotion and Youth Violence Prevention (<http://www.promoteprevent.org/publications/prevention-briefs/preventing-bullyingschools- and-community>).

Niemela, S., Brunstein-Klomek, A., Sillanmaki, L., et al. (2011). Childhood bullying behaviors at age eight and substance use at age 18 among males. A nationwide prospective study. *Addictive Behavior*, 36, 256-260.

Payne, T.J., Gaught, N.W., Sutton, M.J., Sheffer, C.E., Elci, O.U., Taylor, S.....&

Crews, K.M (2014). The impact of tobacco treatment training on practice behaviors, self-efficacy, and attitudes among healthcare providers. *International Journal of Clinical Practice*, 68(7), 882-889.

Ragatz, L.L., Anderson, R.J., Fremouw, W., et al. (2011). Criminal thinking patterns, aggression styles, and the psychopathic traits of late high school bullies and bullyvictims. *Aggressive Behavior*, 37, 145-160.

U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

(2009). *National Crime Victimization Survey School Crime Supplement, 2009 [Codebook]*. Ann Arbor, MI: Interuniversity Consortium for Political and Social Research.

Wang, J., Iannotti, R.J., & Nansel, T.R. (2009). School Bullying among US

Adolescents: Physical, Verbal, Relational, and Cyber. *Journal of Adolescent Health*, 45(4), 368-375.

Zwierzynska, K., Wolke, D. and Lereya, TS (2013). Peer victimization in childhood and internalizing problems in adolescence: a prospective longitudinal study. *Journal of Abnormal Child Psychology*, 41, 309-323.

#### References: Chapter five

Committee on Injury, Violence, and Poison Prevention. (2009). Role of the Pediatrician In Youth Violence Prevention. *Pediatrics*, 124, 393-402.

Eisenberg, M.E., & Aalsma, M.C. (2005). Bullying and peer victimization: Position paper of the society for adolescent medicine. *Journal of Adolescent Health*, 36(1), 88-91.

## Curriculum Vita

### Victoria R. Hensley, PhD, CPNP

---

#### EDUCATION

<u>Dates</u>	<u>Degree or Course</u>	<u>Institution</u>
01/2006 to 12/2015	Doctor of Philosophy in Nursing	University of Kentucky
08/2002 to 05/2005	Master of Science in Nursing	University of Kentucky
08/1995 to 05/2000	Bachelor of Science in Nursing	University of Kentucky

#### LICENSURE/CERTIFICATION

2005-Present	Pediatric Nurse Practitioner	3094783	Pediatric National Certification Board
2000-Present	Registered Nurse	1093667	Kentucky Board of Nursing

#### PROFESSIONAL EXPERIENCE AND ACADEMIC APPOINTMENTS

<u>Dates</u>	<u>Title</u>	<u>Institution</u>
08/2004- Present	Nursing Instructor	University of Kentucky
08/2006-05/2013	Pediatric Nurse Practitioner	Family Care Center
08/2000-08/2003	Community Health Nurse Educator	Good Samaritan Nursing Center, College of Nursing University of Kentucky
05/2000-12/2002	Staff Nurse	Children's Hospital University of Kentucky
08/2003-08/2005	Nursing Instructor	Midway College

#### RESEARCH/SCHOLARLY ACTIVITY

##### Grant Activity



2002 Development of interactive computer software to teach health education to elementary school children: *Gerbusters 1 and 2* CD-ROM and teacher manuals. Funded by Good Samaritan Foundation of Lexington, KY. (\$20,000)

### **Peer-Reviewed Publications**

2015 Hensley, V. (In Press) Development and Psychometric Evaluation of a Questionnaire to Evaluate Pediatric Healthcare Provider's Knowledge, Attitudes, Practices, and Self-confidence regarding Bullying Assessment. *Medical Research Archives*.

2013 Hensley, V. (2013). Childhood Bullying: A Review of the Literature and Implications for Healthcare Professionals. *Nursing clinics of North America*.

### **Media Publications**

2003 *Gerbusters II* CD-ROM and Teacher Manual: interactive computer software with additional teaching material for grades 4-5 that teaches children about rest, nutrition, and exercise.

2003 *Gerbusters* CD-ROM and Teacher Manual: interactive computer software with additional teaching material for grades 4-5 that teaches children healthy hygiene.

2002 *Brainzilla* CD-ROM and Teacher Manual: interactive computer software with additional teaching material for grades 4-5 that teaches children about their brain.

### **Presentations**

2001 School Health Conference Poster Presentation, Baltimore, Maryland **PROFESSIONAL ACTIVITIES**

### **Membership in Professional Societies**

2005-Present National Association of Pediatric Nurse Practitioners, Member

2004-Present Kentucky Nurse Coalition of Nurse Practitioners and Nurse Midwives, Member

1999-Present Sigma Theta Tau, Delta Phi (Nursing Honor Society), Member

2003-2004 Sigma Theta Tau, Delta Phi (Nursing Honor Society), Co-chair of Fundraising Committee

*12/1/15 CV revised*