

Exploring Early Childhood Factors as an Avenue to Address Chronic Peer Victimization

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Most youth experience peer victimization, and when chronic, it can lead to problems related to social-emotional development,¹ peer relationships,¹ and school engagement.² In their study, “Early Childhood Factors Associated With Peer Victimization Trajectories from 6 to 17 Years of Age,” Oncioiu et al³ investigate peer victimization over time, beginning with the first years of school. This study is one of the largest and most extensive studies ever conducted on this topic. The authors use a repeated-measure, person-centered approach that allows for the comparison of personal trajectories over time and for causal inferences to be drawn. Four developmental trajectories of peer victimization are uncovered. Approximately one-third of children are in the low-victimization trajectory. The remaining two-thirds of children are in either the high-chronic (11%) trajectory, in which victimization is persistently higher than peers; the childhood-limited (26%) trajectory, in which early childhood victimization decreases by adolescence; or the moderate-emerging (30%) trajectory, in which victimization levels are moderate, remaining relatively steady and above normative levels, compared with those in the low-victimization trajectory across childhood and adolescence.

Given that nearly two-thirds of school-aged youth in the current study report peer victimization during elementary

and/or middle school, this is an important period in which pediatricians can screen for victimization during well-child visits. Screening can be integrated into routine social history questions and can include prompts for peer friendships, social conflicts, and peer victimization and, as appropriate, the impact of these experiences in school and at home. Pediatricians should have referrals and resources available for patients, including services that are offered at their practice or institution or credible options in the community or online. Finally, pediatricians can provide valuable anticipatory guidance by defining peer bullying (eg, aggressive or mean behavior that happens repeatedly in the context of a power imbalance), forms of bullying (eg, physical behaviors such as pushing, hitting, or threatening; verbal behaviors such as insults; and/or relational behaviors such as using gossip and social exclusion to harm others in real time or through electronics and social media), and the impact of bullying on a child and family.

Another notable study finding is that boys and children with high levels of externalizing behaviors (eg, hitting, biting, kicking) at age 5 or younger are more likely to be in the high-chronic, childhood-limited, and moderate-emerging peer victimization trajectories. Given the comorbidity of externalizing behaviors and preschool expulsion,⁴ attention-

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deficit/hyperactivity disorder,⁵ and lower academic success⁶ among young children, it is not surprising that these children are also at high risk for later peer victimization. Pediatricians should therefore recognize externalizing behaviors as risk factors for adverse outcomes and assist families in accessing evidence-based interventions such as family behavioral counseling or parent training.⁷

Parental mental health (including paternal antisocial behaviors) is another issue that could warrant attention from pediatricians as it relates to peer victimization among their patients. Notably, children in the moderate-emerging and high-chronic peer victimization trajectories are more likely to have a father with a history of antisocial behavior during adolescence, and these findings hold true even when controlling for other family characteristics and children's behavior. In fact, paternal history of antisocial behavior has the highest odds ratio for predicting whether children are in the high-chronic victimization group. Multiple factors may drive the association between paternal history of antisocial behavior

and child peer victimization (eg, shared genetic traits, epigenetic modifications, parental psychopathology, parenting behaviors, and/or environmental factors), but early detection of these parental behaviors and subsequent intervention are important for pediatricians to conduct because they may help prevent transmission of these adult behaviors and childhood experiences to the next generation.

To interrupt a cycle of antisocial behaviors among boys in families, pediatricians could play a role in the detection of these behaviors and subsequent intervention during adolescence, before youth become parents. There may also be value in pediatricians being more attuned to indicators of parental psychopathology so that they can make recommendations to address the parents' mental health needs and better prepare parents to support their child's social-emotional development. If parenting practices are a driving factor in peer victimization among children, pediatricians can make referrals to well-known parenting programs such

as The Incredible Years,⁸ Triple P (Positive Parenting Program⁹), and Parent-Child Interaction Therapy.¹⁰ These programs are designed to enhance parents' skills, confidence, and opportunities to interact positively with their children, which encourages positive child development and prevents later social-emotional problems. Finally, pediatricians can recommend parental involvement in school-based prevention programming. For example, Walk away, Ignore, Talk it out, Seek help,¹¹ an evidence-based program for reducing relational and physical victimization, has a classroom-based curriculum that includes take-home learning sheets for parents that are designed to increase adult involvement in children's social-emotional learning and conflict-management skills.

CONCLUSIONS

In the current article, we highlight the important role that pediatricians play in detecting, treating, and referring youth who are victimized by their peers.

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