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Running head: BULLYING SURVEY FOR HEALTHCARE PROFESSIONALS

Development and Psychometric Evaluation of a Questionnaire to Evaluate Pediatric Healthcare Provider's Knowledge, Attitudes, Practices, and Self-confidence regarding Bullying Assessment

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ABSTRACT

PURPOSE

The purpose of this research was to develop and evaluate the psychometric properties of Hensley's Healthcare Provider's Practices, Attitudes, Self-confidence, & Knowledge Regarding Bullying Questionnaire (HCP-PACK).

METHODS

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 re-test reliability and internal consistency for the questionnaire's subscales.

RESULTS

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.

CONCLUSION

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.

1. 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).

There are three different classifications of children who are involved in bullying behavior: 1) the bully, 2) the victim, and 3) the bully-victim. A bully is defined as the person engaged in bullying others, while the victim is the person who is being bullied, and the bully-victim is the child who is both a bully and a victim of bullying. Traditionally, bullying has been seen as overt physical behavior or verbal attacks. However, children use many ways to bully others such as social bullying and cyberbullying. Social bullying involves actions such as social exclusion, manipulation of friendship, lying, and spreading rumors about others. More recently, cyberbullying has become a common mechanism in which children can harm others (Smith, Mahdavi, Carvalho, Fisher, Russell, and Tippett, 2008). Cyberbullying involves using technology, such as cell phones, email, and chat room, to aggressively taunt or attack someone who cannot defend themselves.

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 1: Outcomes Associated with Bullying Behavior

Affected Persons	**Short and Long-term Adverse Effects**
Bullies	**Short Term** -Associated with vandalism, shoplifting, school absenteeism, school drop-out, fighting, and drug and alcohol use -Increased complaints of somatic symptoms, illnesses, and injury **Long Term** -Associated with violence, including criminal acts, alcohol and substance abuse, aggression, and antisocial behavior. -Criminal thinking, psychopathy, and criminal behavior; Intimate partner violence
Victims	**Short Term** -Symptoms of sadness, anxiety, stomach aches, and headaches -Depression, restrained eating, and body dissatisfaction -Feelings of being unsafe at school and sadness -Bedwetting, sleeping problems, feelings of tension or tiredness -May have homicidal or suicidal thoughts. **Long Term** -Shyness; Poor friendship quality and trust -More at risk of self-harm -Aggressive behaviors, such as hitting walls, intentionally breaking things, and pushing/shoving a partner

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.

2. METHODS

2.1 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

2.2 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.

3. RESULTS

3.1 INSTRUMENT VALIDITY

3.1.1 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 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

3.2 INSTRUMENT RELIABILITY

3.2.1 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.

3.2.2 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.

4. 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.

5. LIMITATION

The limitation to this study was study participants primarily worked in Kentucky; therefore, further psychometric testing of Hensley's HCP-PACK with a larger, more diverse sample is recommended.

6. CONCLUSION

Psychometric testing of Hensley's HCP-PACK questionnaire showed promising results regarding content validity, stability reliability, and internal consistency. Hensley's HCP-PACK is an appropriate instrument for evaluating healthcare providers' current practices, attitudes, self-confidence, and knowledge regarding bullying and assessing for bullying during well-child exams.

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.

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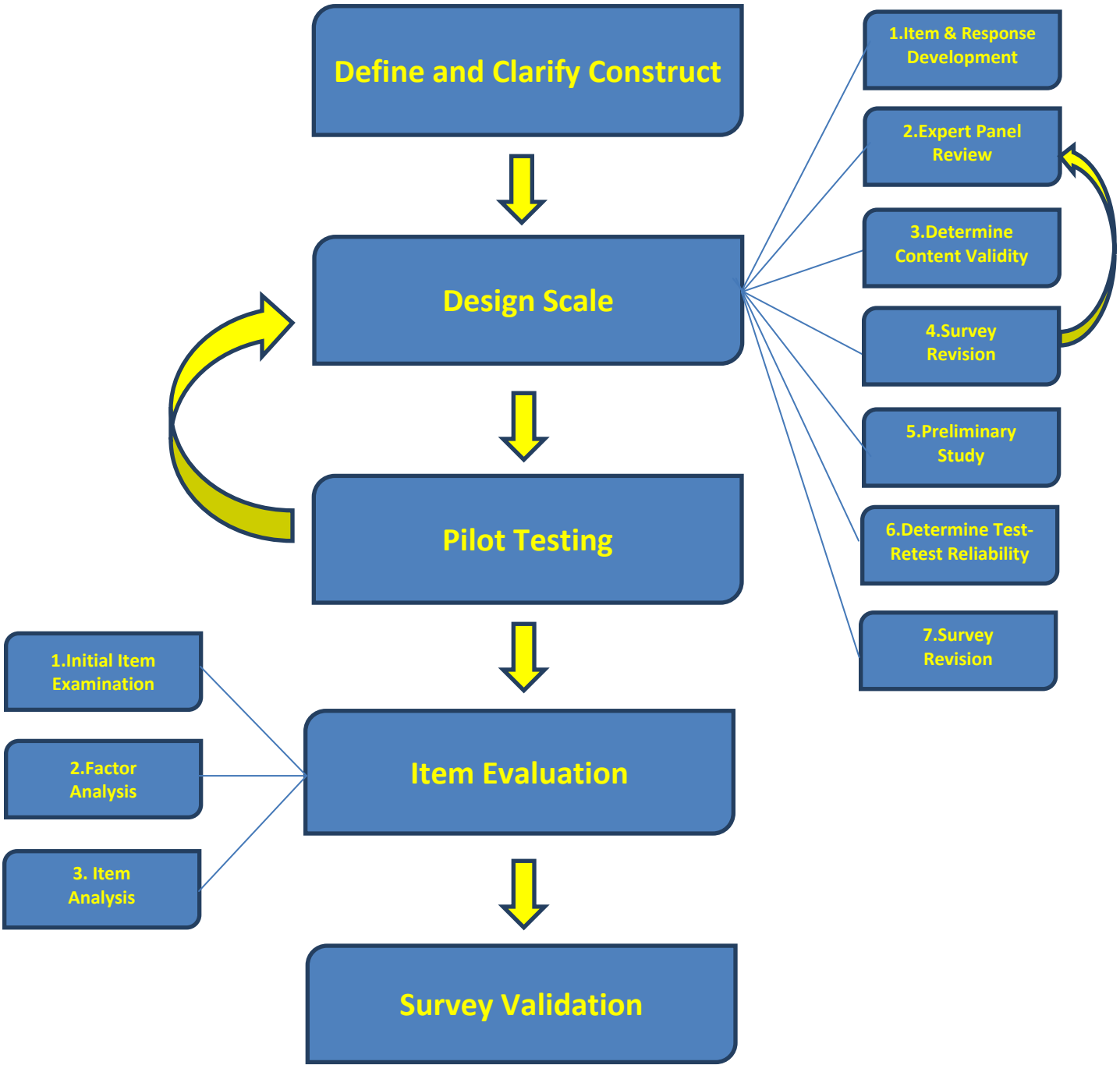
Figure 1. Steps to Development Survey



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? (where you spend most of your time)

- ❑ 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

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

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

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

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

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

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

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

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

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

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

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

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