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RESEARCH

Implementation of the PPC-17 survey to identify children aged 8–17 years at risk of suffering from school bullying: a quantitative, descriptive, cross-sectional study in French primary care

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Abstract

Background: School bullying (SB) is an important public health issue with profound mental and physical health consequences. In France, data are lacking regarding the prevalence and detection of SB among children seen in primary care settings.

Aim: To assess the prevalence of children aged 8–17 years at risk of SB consulting GPs, using the PPC-17 (persécution par les camarades; persecution by colleagues) screening tool.

Design & setting: A quantitative, descriptive, cross-sectional study in 13 general practices in France.

Method: Between January and May 2023, children consulting their GP (accompanied by a parent) completed the 17-item self-administered PPC-17 questionnaire. A positive risk screening was defined as at least one 'often' response. GPs recorded the initial consultation reason. Data were analysed using univariate and bivariate statistics.

Results: Of 248 responders, 52.8% (n = 131) were girls and 34.7% (n = 86) were identified at risk of SB. Boys scored higher for physical violence (mean 4.3, standard deviation [SD] 4.2) while girls had higher scores for psychological violence (mean 7.4, SD 6.1); older girls (aged 13–17 years) had the highest psychological violence scores; boys aged 8–12 years the highest physical violence scores. Psychiatric symptoms were rarely given as the reason for consulting (17th most common reason out of 23). Children at higher risk were younger on average (mean age 11.7 years versus 12.8 years, P<0.003).

Conclusion: More than one-third of children consulting GPs were at risk of SB. The PPC-17 enables effective screening during routine consultations and reveals distinct gender and age patterns. Systematic integration of SB screening in primary care could enhance early identification and support.

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How this fits in

Primary care data are lacking regarding the prevalence and detection of school bullying (SB) among children seen by GPs. The 17-item self-administered PPC-17 questionnaire allows GPs during routine

consultation to identify and support children at risk of SB. Our study revealed that more than one-third of children consulting GPs were at risk. The screening revealed distinct gender and age patterns among the children aged 8–17 years.

Introduction

The prevalence of SB ranges from 9% to 30%.[1–3] In the context of education, students are considered to be victims of bullying when they are repeatedly and over an extended period of time exposed to negative actions by ≥1 students.[4]

According to French legal terminology, SB occurs when a student's aggressive comments or behaviour are repeatedly directed at another student.[5] Several factors have been identified as contributing to bullying, including disability, social disadvantage, physical appearance, sexual orientation, ethnic and cultural differences, domestic violence, and social and gender norms.[6]

SB can have immediate and long-term consequences for both the victims and the harassers. The psychological and physical effects of this period can sometimes persist into adulthood. The psychological impact is significant, with a higher prevalence of anxiety and depressive disorders, post-traumatic stress, and suicidal risk.[7–13] Somatic effects include general symptoms such as abdominal pain, back pain, headaches, sleep disorders, dizziness, and asthenia. Schooling is disrupted, and this may be reflected in lower school results and increased absenteeism.[10] A study of adult students reveals a higher incidence of economic insecurity among those who have experienced harassment.[11,12]

There are several other indirect signs that should be considered. There have been numerous reports of students failing to maintain their equipment, missing class, and failing to attend physical education and sports classes. Some students have also been known to isolate themselves in the cafeteria. Other indications of mental health concerns may be more apparent in the home environment, including irritable moods, eating disorders, excessive use of video games, and social isolation.[14]

SB is defined as any form of harassment, intimidation, or bullying that occurs within the school environment, including on the way to and from school. In some cases, the problem persists beyond school hours, manifesting in various forms such as cyberbullying, social media interactions, and in-person social interactions after school hours. These interactions may involve sports, music, or other communities associated with after-school activities. Bullying that occurs outside of school hours can persist 24/7. The present study focuses on bullying that occurs in person at school, excluding cyberbullying and bullying that occurs outside of school. This focus is owing to the nature of the screening tool that was used in this study for this specific context.

GPs could identify SB at an early stage by asking targeted questions and listening attentively to young people and their families as they express their concerns.[15] The authors hypothesise that the prevalence of bullied pupils is higher in general practice than in the general population. If this is the case, this additional argument would motivate GPs to become more involved. The primary objective of this study was to estimate the prevalence of SB among pupils aged 8–17 years who consulted a general practice in the Nord-Pas-de-Calais region. We also evaluated the students' sociodemographic profile and the initial reason provided by the student for seeking consultation with the GP.

Method

The full protocol has been published elsewhere.[16] From January to May 2023, a quantitative, descriptive, cross-sectional study was conducted using a self-administered questionnaire. The PPC-17 (persécution par les camarades; persecution by colleagues) screening tool was carried out in 13 general practices in the Nord-Pas-de-Calais region. Doctors were asked to include any schoolchild aged between 8 and 17 years. The child had to be accompanied by at least one parent. Before inclusion, the investigator was provided with training at: https://kitpatient.fr/ressources/harcelometre.

The anonymous questionnaire contained 17 items that were answered using a Likert scale (see Supplementary Information S1). Individuals who indicated that they had been subjected to harassment at least once (at least one 'often' response) were considered probable victims.

The questionnaire and informational letters were then distributed to the children in the waiting room. The completed questionnaire was then submitted to the GP, who added the initial reason for the consultation. The GP confirmed that there was no indication of risk related to suicide. If this was

not the case, the GP contacted their usual contacts for immediate action. The GP also provided the child, who may have been a victim of bullying, with a helpline number.

The data were stored in a secure space on the F2RSM Psy (Fédération Régionale de Recherche en Psychiatrie et Santé Mentale) Next Cloud platform. The paper questionnaires were stored at the F2RSM Psy location for the required legal period.

Statistical analysis

The statistical analyses were carried out by the third author, who is a member of the F2RSM Psy des Hauts-de-France research team. The process was executed in two stages.

First, univariate analyses were performed to describe all quantitative variables using means and standard deviations (SDs) and all qualitative variables using numbers and percentages.

Second, bivariate analyses were conducted. The proportions were compared using a parametric χ^2 test or a non-parametric Fisher's exact test (when the theoretical numbers were 5). The means were compared using a parametric Student test (when the groups were ≥30 individuals per group, their distribution followed a normal distribution, and the variances were equal) or using a non-parametric Wilcoxon test (when the conditions for using a Student test were not met). The results were deemed to be statistically significant when the *P*-value was <0.05. Analyses were performed using Microsoft Excel, RStudio, and R (version 4.2.1).

Results

A total of 248 validated questionnaires were analysed. Of these, 34.7% (*n* = 86) of the students selected the 'often' box at least once to identify themselves as at risk of SB (see Supplementary Information S1). Of the responders, 52.8% (*n* = 131) identified as female. The sociodemographic data are summarised in ***Table 1***.

Overall, 34.7% (*n* = 86) of children with a high suspicion of bullying consulted a doctor. The main reasons for consulting a doctor among children with a high suspicion of bullying were as follows: ear, nose, and throat infection (32.7%, *n* = 81), osteoarticular pain (9.3%), abdominal symptoms (8.1%), and psychiatry (1.2%) (***Table 2***).

The average total PPC-17 score was 10.6/51, with no significant differences observed by age or gender and a median score of 9.0/51. The mean and median scores for physical violence were 3.5/21 and 2.0/21, respectively, and for psychological violence, 7.1/30 and 6.0/30, respectively. The PPC-17 score was higher in boys than in girls for physical violence (4.3, SD 4.2 versus 2.8, SD 3.4). The average score for psychological violence was higher for girls than for boys (7.4, SD 6.1 versus 6.7, SD 5.4). As shown in ***Table 3***, the highest score for psychological violence was found among girls aged 13–17 years (8.4, SD 7.1) and the highest score for physical violence was found among boys aged 8–12 years (4.7, SD 4.7). Children at higher risk were younger on average (mean age 11.7 years versus 12.8 years, *P*<0.003). As shown in ***Table 4***, the PPC-17 score was notably higher among children with a strong suspicion of SB, including those in the youngest age groups. A statistically significant difference was found between the average age of pupils with a high suspicion of bullying and those with a low suspicion of bullying (11.7 years [SD 2.9] versus 12.8 years [SD 3.0]; *P* = 0.003).

Table 5 shows the proportion of children who answered 'often' to the question, by age and gender.

Discussion

Summary

Bullying can have significant psychological and physical consequences, and primary care physicians can play a key role in detecting it. Our objective was to assess the prevalence of this phenomenon in general practices. A statistically significant difference was found between the average age of pupils with a high suspicion of bullying and those with a low suspicion of bullying (11.7 years [SD 2.9] versus 12.8 years [SD 3.0]; *P* = 0.003). The prevalence of bullying in general practices found in the present study was higher than that found in the general population in national surveys. However, national studies with larger samples are needed to give context to these results.

Table 1 Sociodemographic data of the study population (*N* = 248)

Characteristic	*n* (%)
Gender	
Boy	117 (47.2)
Girl	131 (52.8)
Age, years, mean (SD)[a]	12.4 (3.0)
Age group, years	
8–12	131 (52.8)
13–17	117 (47.2)
Establishment	
Primary (elementary school)	83 (33.5)
College (middle school)	93 (37.5)
Lycée (high school)	67 (27.0)
CAP	2 (0.8)
IME	2 (0.8)
ULIS	1 (0.4)
Class/level	
CE1	15 (6.0)
CE2	16 (6.5)
CM1	37 (14.9)
CM2	16 (6.5)
6ème	31 (12.5)
5ème	20 (8.1)
4ème	21 (8.5)
3ème	20 (8.1)
2nde	23 (9.3)
1ère	18 (7.3)
Tle	25 (10.1)
1ière professionnelle	1 (0.4)
CAP	2 (0.8)
IME	2 (0.8)
ULIS	1 (0.4)

[a]Range = 8–17; median = 12. 1ère = 10th year or grade of high school. 1ière professionnelle = 1st professional school. 2nde = 9th year or grade of high school. 3ème = 8th year or grade of middle school. 4ème = 7th year or grade of middle school. 5ème = 6th year or grade of middle school. 6ème = 5th year or grade of elementary school. CAP = certificate of professional competence. CE1 = 1st year or grade of elementary school. CE2 = 2nd year or grade of elementary school. CM1 = 3rd year or grade of elementary school. CM2 = 4th year or grade of elementary school. IME = Medical Education Institute (special education). SD = standard deviation. Tle = 11th year or grade of high school. ULIS = Local Units of Inclusive Education.

Strengths and limitations

A strength of this study is the implementation of a screening tool for SB in a real-world primary care setting. The PPC-17 questionnaire is a reproducible, reliable, and ergonomic screening tool that can be easily integrated into a general medical consultation for any reason. The questions are worded in an accessible manner and can be posed in the presence or absence of a parent to initiate a dialogue about SB.

Table 2 Reasons for consulting a GP (*N* = 248)

Reason for consultation	*n* (%)
ENT infection	81 (32.7)
Gastrologic	30 (12.1)
Vaccination	20 (8.1)
Orthopaedics	19 (7.7)
Prevention	18 (7.3)
Dermatology	15 (6.0)
Certificates	14 (5.6)
Cardiology	6 (2.4)
Pneumology	5 (2.0)
Traumatology	5 (2.0)
ENT non-infection	5 (2.0)
Neurology	4 (1.6)
Rheumatology	4 (1.6)
Gynaecology	4 (1.6)
Urology	3 (1.2)
Renewal of a treatment	3 (1.2)
Psychiatry	3 (1.2)
Haematology	3 (1.2)
Ophthalmology	2 (0.8)
Endocrinology	1 (0.4)
Infectious	1 (0.4)
Nutrition	1 (0.4)
Stomatology	1 (0.4)

ENT = ear, nose, and throat.

The reason for consultation was not a discriminating factor in our study. A systematic approach to identifying bullying in young people as victims, witnesses, or perpetrators seems appropriate. However, the question remains: how can this practice be integrated into the consultation process?

When it comes to identifying children at risk, GPs should be attentive to all children aged between 6 and 18 years, and systematically take advantage of every consultation. During consultations scheduled for vaccinations and sports aptitude certificates, it would be advisable for them to enquire about the subjects that were only mentioned in third and seventh positions in our study.

With respect to profiles of children at risk, GPs should be aware that the characteristics of at-risk populations tend to differ between boys and girls.

The presence of the parents and the GP may have induced a reporting bias in the child responder. We have restricted our screening to in-person SB, and as a result, we are unable to consider data related to cyberbullying.

Comparison with existing literature

Recent statistics indicate that between 4% and 6% of students in French schools outside of universities are affected by bullying. In the same schools, between 5% and 19% of pupils are at risk of SB.[17] There are two aspects to the GP's role. The first is the care to be given to those identified as victims of bullying. This is merely the proverbial tip of the iceberg, and it is essential to not lose sight of the larger issue, which includes young people at school who are at risk of bullying. In such cases, the GP's expertise in prevention becomes paramount. They have the advantage of knowing both the young person and the family and can address the issue directly or by looking for indirect signs. This knowledge is further reinforced by their understanding of the young person's ecological environment. The doctor is a local figure, which often leads them to discuss the atmosphere in the various schools attended by those who come for a consultation. In the event of bullying in the schools surrounding the GP's practice, they will be interested in the victims as well as the witnesses and the perpetrators. Research has demonstrated that both witnesses and harassers experience adverse outcomes.[18,19]

The male participants in our study were more likely to experience SB at an earlier age, around 8 years, compared with their female counterparts. Additionally, male participants expressed greater concern over physical violence, while female participants demonstrated a higher risk of experiencing psychological violence. Cosma *et al* observed significant cross-national variations in gender differences in bullying.[20] According to the study's findings, boys exhibited a higher propensity to engage in traditional and cyberbullying, as well as victimisation by traditional bullying, compared with girls. Greater gender inequality at the national level was associated with heightened gender differences in traditional bullying. Conversely, lower levels of gender inequality were found to be associated with more pronounced gender differences in cases of cyber victimisation. Societal gender inequality

Table 3 The total PPC-17 score by age and gender

Category	Total	All children (aged 8–12 years)	All teenagers (aged 13–17 years)	All boys	Girls (aged 8–12 years)	Boys (aged 8–12 years)	Girls (aged 13–17 years)	Boys (aged 13–17 years)	All girls
Total, *n*	248	131	117	117	67	64	64	53	131
Physical violence /21, avg (SD)	3.5 (3.8)	3.7 (4.0)	3.2 (3.6)	4.3 (4.2)	2.8 (2.9)	4.7 (4.7)	2.7 (3.8)	3.9 (3.4)	2.8 (3.4)
Psychological violence /30, avg (SD)	7.1 (5.8)	6.5 (5.1)	7.8 (6.4)	6.7 (5.4)	6.4 (5.0)	6.5 (5.2)	8.4 (7.1)	7.0 (5.6)	7.4 (6.1)
Isolation from other children	2.5 (2.5)	2.7 (2.6)	2.2 (2.4)	2.4 (2.5)	2.7 (2.5)	2.7 (2.8)	2.4 (2.6)	2.1 (2.2)	2.5 (2.5)
Insults and mockery	4.6 (3.9)	3.8 (3.2)	5.5 (4.4)	4.3 (3.6)	3.7 (3.2)	3.8 (3.2)	6.0 (4.8)	5.0 (3.9)	4.8 (4.2)
Total score, avg (SD)	10.6 (8.6)	10.2 (8.1)	10.9 (9.1)	11.1 (8.8)	9.2 (6.8)	11.4 (9.2)	11.0 (9.8)	10.8 (8.2)	10.1 (8.4)

avg = average. PPC-17 = persécution par les camarades; persecution by colleagues. SD = standard deviation.

Table 4 Comparison of children with a suspicion of harassment considered high with children with a suspicion of harassment considered low, according to the average score on the PPC-17 scale

Category	Children with strong suspicion of bullying,[a] *n* = 86	Children with low suspicion of bullying, *n* = 162	*P* value
Total PPC-17 score, avg (SD)	18.1 (8.4)	6.6 (5.4)	<0.001[b]
Gender, *n* (%)			0.412
Girl	49 (57.0)	82 (50.6)	
Boy	37 (43.0)	80 (49.4)	
Age, years, avg (SD)	11.7 (2.9)	12.8 (3.0)	0.003[b]

[a]Answered 'often' to at least one question on the PPC-17 scale. [b]Significant result. avg = average. PPC-17 = persécution par les camarades; persecution by colleagues. SD = standard deviation.

Table 5 Proportion of children who answered 'often' to the question, by age and gender

Question	Total, *n* = 248	Girls (aged 8–12 years), *n* = 67	Boys (aged 8–12 years), *n* = 64	Girls (aged 13–17 years), *n* = 64	Boys (aged 13–17 years), *n* = 53
1. Has another pupil ever told others that they should no longer talk to you?	18 (7.3)	5 (7.5)	8 (12.5)	5 (7.8)	0 (0.0)
2. Has another pupil ever told others that they should no longer be friends with you?	25 (10.1)	7 (10.4)	7 (10.9)	10 (15.6)	1 (1.9)
3. Has another pupil ever said that you must not sit next to him or her?	6 (2.4)	1 (1.5)	3 (4.7)	0 (0.0)	2 (3.8)
4. Has another pupil ever insulted you?	30 (12.1)	5 (7.5)	8 (12.5)	11 (17.2)	6 (11.3)
5. Has another pupil ever made fun of you in a nasty way?	24 (9.7)	5 (7.5)	6 (9.4)	10 (15.6)	3 (5.7)
6. Has another pupil ever made fun of you because of your height or weight?	18 (7.3)	6 (9.0)	3 (4.7)	9 (14.1)	0 (0.0)
7. Has another pupil ever made fun of you because of your hairstyle or clothes?	9 (3.6)	2 (3.0)	1 (1.6)	4 (6.3)	2 (3.8)
8. Has another pupil ever said that you must no longer play with the others?	5 (2.0)	2 (3.0)	2 (3.1)	0 (0.0)	1 (1.9)
9. Has another pupil ever played nasty tricks on you?	17 (6.9)	1 (1.5)	7 (10.9)	7 (10.9)	2 (3.8)
10. Has another pupil ever said bad things about you to others?	26 (10.5)	3 (4.5)	5 (7.8)	15 (23.4)	3 (5.7)
11. Has another pupil ever hidden your things to upset you?	14 (5.6)	4 (6.0)	5 (7.8)	1 (1.6)	4 (7.5)
12. Has another pupil ever forced you to give him or her something by threatening you?	6 (2.4)	1 (1.5)	4 (6.3)	1 (1.6)	0 (0.0)
13. Has another pupil ever threatened to hit you?	13 (5.2)	1 (1.5)	5 (7.8)	6 (9.4)	1 (1.9)
14. Has another pupil ever kicked you?	11 (4.4)	3 (4.5)	6 (9.4)	1 (1.6)	1 (1.9)
15. Has another pupil ever bitten or scratched you?	1 (0.4)	0 (0.0)	1 (1.6)	0 (0.0)	0 (0.0)
16. Has another pupil ever hit you?	11 (4.4)	2 (3.0)	7 (10.9)	2 (3.1)	0 (0.0)
17. Has another pupil ever pushed you, shoved you, or tripped you up?	14 (5.6)	2 (3.0)	7 (10.9)	5 (7.8)	0 (0.0)

relates to adolescents' involvement in bullying and gendered patterns in bullying. It is imperative to consider societal factors at the earliest stages of development, as they play a pivotal role in shaping children's and adolescents' behaviours.

Implications for research and practice

Our study population revealed that more than one-third of children are at risk of being bullied, which justifies focusing more GP research on SB and exploring the practice implications of this issue.

Completion of the PPC-17 questionnaire by the GP at the surgery can help identify children at risk of SB. The present study showed boys are more likely to be affected by SB, both in terms of frequency and intensity. In girls, SB occurs later and more often because of psychological violence.

These gender-related characteristics can guide GPs in their prevention, screening, and accompaniment practices. Integrating the PPC-17 into the child's health record and into GPs' professional software could foster closer follow-up of children at risk for SB. The French government has issued informational materials for GPs to utilise in their offices to initiate conversations with children. The national prevention programme pHARe ('lighthouse' in French) is a comprehensive plan developed to combat harassment in schools. It has been in place since 2021, was extended to all schools and colleges at the start of the 2022 academic year, and has been extended to upper-level secondary schools (lycées) since the start of the 2023 academic year. The programme is currently implemented in all other schools and establishments, except for elementary schools.[21] However, in France, the prevalence of SB has increased among the youngest children in recent years, including kindergarten and preschool-aged children.[22]

SB is likely to begin at a very early age among children. Research on the youngest victims and aggressors is still limited, but it is growing.[23–25] Further studies could concentrate on SB among the youngest, from 4–7 years of age, to identify a threshold for the onset of SB.

To facilitate comprehension for younger children, the PPC-17 questionnaire could be supplemented by illustrative images depicting the scenarios to be evaluated.

The reason for consultation was not a discriminating factor in our study. A systematic approach to identifying bullying in young people as victims, witnesses, or perpetrators seems appropriate. However, the question remains: how can this practice be integrated into the consultation process?

When it comes to identifying children at risk, GPs should be attentive to all children aged between 6 and 18 years, and systematically take advantage of every consultation. During consultations scheduled for vaccinations and sports aptitude certificates, it would be advisable for them to enquire about the subjects that were only mentioned in third and seventh positions in our study.

With respect to profiles of children at risk, GPs should be aware that the characteristics of at-risk populations tend to differ between boys and girls.

To conclude, systematic screening for SB using brief, self-administered questionnaires, such as the PPC-17, in primary care reveals a high prevalence of risk and uncovers important gender and age patterns that can direct GPs' preventive and therapeutic actions. Integrating structured SB risk assessment into routine general practice could substantially improve case identification and enable earlier, more effective multidisciplinary intervention for affected children.

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Ethical approval

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Provenance

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Data

The dataset relied on in this article is available from the corresponding author on reasonable request.

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