

ambitious goal not only in children and young adults but also in the aging population.

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Guest editorial

The impact of food allergy and bullying

Food allergy is a common childhood illness, affecting approximately 3.9% of the US population.¹ To add to the psychological stress of the potential morbidity² and even mortality associated with this illness, in this issue of the *Annals*, Lieberman et al³ highlight the fact that 24% of children who participated in a questionnaire survey reported having been teased, harassed, or bullied as a result of their food allergy. Furthermore, 57% of those who reported harassment described acts of physical provocation, such as being touched by the food allergen or having it waved at them or put into their food. Even more disconcerting

was the fact that teachers or school staff were reported as the perpetrators of the harassment in 21% of cases.

This article is informative and thought provoking to the allergist caring for food-allergic children. Furthermore, it should prompt new research that extends beyond the limitations of this sentinel work. These limitations include the fact that the surveys were completed by a subset of food-allergic families attending a Food Allergy & Anaphylaxis Network meeting and may not be representative of the larger population of food-allergic children. Most questionnaires were completed not by the allergy sufferers but by parents or caregivers of the food-allergic children. New research should encompass a more diverse patient population and include reports from parents, children, and, perhaps, other observers to confirm or correct the startling statistics presented in this article.

Disclosures: Authors have nothing to disclose.

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doi:10.1016/j.annai.2010.10.003

The problem of bullying lies in the perceived imbalance of power that can be the result of age, strength, or size, with the more powerful child attacking the physically or psychologically vulnerable victim.⁴ Bullying can be direct or indirect and can be perpetrated through physical, verbal, or other means.⁴ Although the results of the study by Lieberman et al³ seem to suggest an unusually high rate of bullying of children with food allergies, bullying in general is alarmingly common. In a large-scale report⁵ on the occurrence of bullying among 6th to 10th graders across the United States, 17% reported being bullied "sometimes" or more frequently. A direct comparison of these national data with the results of the study by Lieberman et al³ is not possible because the latter study inquired about food allergy-related bullying only. However, future studies may include an assessment of food-related and non-food-related bullying, with a comparison of the incidence of the latter between food-allergic and nonallergic children.

It is unlikely that a child will present to the allergist with the complaint of being bullied. It is, thus, our job to identify children who are possibly being bullied, to assess potential psychiatric sequela, and to advocate bullying prevention programs at school when necessary. Although no classic phenotype of a bullied child exists, good students and children who are obese or physically disabled are more likely to be bullied.⁶ This study adds concern that food allergy sufferers may need to be included in the list. What then should we, as allergists, look for as a sign of a child being bullied? Indicators of concern include recent poor school performance and frequent absences, psychosomatic or behavioral problems, and initiation of tobacco, drug, or alcohol use.⁷

A particularly troubling finding from the study by Lieberman et al³ is that school faculty members were the perpetrators of bullying in more than 20% of cases. Although surprising, one cannot help but wonder if this is a reaction from school staff to parental pressure to conform to demands that the school environment be adapted to the food-allergic child's needs.

A solution specifically for the problem of the bullying of food-allergic children by peers and adults has not been introduced, likely owing to a general lack of awareness of the problem, thus reinforcing the need for further research.

In the meantime, in an attempt to move forward regarding this issue, we suggest that the following steps be considered: (1) better education regarding food allergies would help adults and children appreciate the special challenges faced by the food-allergic child and, perhaps, help counter the perception that such atopic problems are not serious; (2) school personnel should be informed about the possibility of food allergy-related bullying to increase awareness and prompt counter measures; and (3) parents of food-allergic children may need help recognizing that adopting an adversarial approach to requesting food-safe areas may generate resentment. In the end, careful education and tactful solicitation of support is a better approach than is assertion of entitlement.

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