Violence in the School Setting: A School Nurse Perspective

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Abstract

Violence in schools has become a significant public health risk and is not limited to violent acts committed in the school setting. Violence in homes, neighborhoods, and communities also affects the learning and behaviors of children while at school. School violence, such as shootings, weapons in schools, assaults, fights, bullying; other witnessed violence in non-school settings; and violence as a cultural norm of problem solving can all impact the ability of children to function in school. School nurses serve on the front-line of problem identification and intervene to diminish the effects of violence on both school children as individuals and on populations in schools and the community. This article describes ways in which school nurses deal with violence and concludes with discussion of potential responses to violence, including the school nurse response to violence and implications for other healthcare professionals.

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The Centers for Disease Control and Prevention (CDC, 2013) defines school violence as acts of violence committed during the school day, on school property, on the way to and from school or at school sponsored events, and as a "subset of youth violence, a broader public health problem (para. 1)" that typically occurs in children ages 10-24, although patterns can also be recognized in in early childhood. At first look, it seems as if the incidence of violent acts in the school setting is increasing. Certainly, the increase in social media and around-the-clock news coverage paints this picture. Schools and school nurses are seeing the effects of violence in many forms. Homicides among children, both during and outside of the school day, are the most obvious violence, followed by assaults and weapons brought to school. In 2010, homicide was the fourth leading cause of death for children ages 10-14 and the second leading cause of death for children ages 15-19. In 2011, among persons ages 10 to 24 years, the non-fatal assault-related injury rate for males was 1279.6 per 100,000 persons; the rate for females was 847.2 per 100,000 (CDC, 2013). While not all of these incidents occur within schools, with an estimated 50 million children aged 3 to 21 enrolled in school, pre-kindergarten through 12th grade (U.S. Department of Education, 2013), many of these assaults happen to school children.

Less visible statistically are the effects of witnessed violence and increased prevalence of violence as a coping mechanism in schools and the community. Children who witness violence, even as infants, have been shown to experience mental health distress. This can result in behavior and mental health issues during the school day. Violence in schools has become a significant health risk and is not limited to violent acts committed in the school setting but also how violence in homes, neighborhoods and communities affect the learning and behaviors of children at school (Selekman, Pelt, Garnier, & Baker, 2013)
The effects of violence on school performance and behavior typically fall into three categories: school violence as defined by the CDC, witnessed violence, and cultural norms of using violence as a problem solving mechanism (Selekman, Pelt, Garnier, & Baker, 2013; World Health Organization 2009). Each of these will be discussed related to their contribution to the escalating effects of violence in schools, including bullying, physical violence, weapons, school shootings, behavioral issues and psychological problems. School nurses serve on the front-line of problem identification and intervene to diminish the effects of violence on both school children as individuals and on populations in schools and the community. This article describes ways in which school nurses deal with violence and concludes with discussion of potential responses to violence, including the school nurse response to violence and implications for other healthcare professionals.

School Violence

School and youth violence has increased dramatically in the past decade. While it is often suggested that the media has sensationalized school violence, it is the perception of school administrators and teachers also that violence in schools has increased significantly in the past two decades (Wynne & Joo, 2011). Youth violence is defined as "the intentional use of physical force or power, threatened or actual, against another person or against a group or community that results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation" (Dahlberg & Krug, 2002, p 1084). Intent to harm is not a factor in this definition as there may be a disparity between actions and consequences when violent acts are committed by youth. Shootings, fights, possession of weapons, and bullying are common types of school related violence; statistics for each will be discussed briefly below.

School Shootings

The most horrific and publicized of these violent acts are school shootings. From July 1, 2010, through June 30, 2011, there were 31 school-associated violent deaths in elementary and secondary schools in the United States. Of the 31 student, staff, and nonstudent school-associated violent deaths occurring between July 1, 2010, and June 30, 2011, there were 25 homicides and 6 suicides. (U.S. Department of Education, 2013). In 2010, the CDC classified school homicide as rare, however, starting in 2012, mass school shootings killing three students at Chardon High School in Ohio, 26 students and staff at Sandy Hook Elementary School in Connecticut, a student and teacher at Sparks Middle School in Nevada, one student by a stabbing at Spring High School in Texas and a teacher killed at Danvers High School in Massachusetts added 32 homicides at schools. In many of these incidents, both teachers and students were the victims of shootings.

Fights

Fights at school are another type of violence. According to the CDC (2013), the leading cause of injury for children ages 4 to 19 was non-sexual assault, and 66.6% of injuries for ages 10 to 14 were caused by non-sexual assaults. The Youth Risk Behavioral Survey (YRBS) of 2011 stated about 33% of students in grades 9 to 12 reported they had been in a physical fight (anywhere) at least one time during the previous 12 months, and 12% said they had been in a fight on school property during this same timeframe (CDC, 2012). Generally, a higher percentage of students in 9th grade reported having been in fights than students in any other grade, both anywhere and on school property. Also, males reported more fights than females. Four percent of males said they had been in a fight anywhere twelve or more times, compared to 1% of females. One percent of males said they had been in a fight on school property twelve or more times, compared to less than half a percent of females (U.S. Department of Education, 2013). Fights and violence involving children, wherever they occur, spill into the school day either by continuation of the fight; talk, gossip and bravado about the fight; and/or planning for future retaliation.
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Possession of Weapons

Weapons brought to school, even if not used at school, are a type of violence. Seven percent of students in grades 9 to 12 in 2011 reported a threat or injury with a weapon, such as a gun, knife, or club, on school property. Specifically, 3% of students were threatened or injured with a weapon one time; 2% were threatened or injured with a weapon two or three times; 1% were threatened or injured with a weapon 4 to 11 times; and 1% were threatened or injured with a weapon 12 times or more (U.S. Department of Education, 2013). Nationwide, 16.6% of students had carried a weapon (gun, knife, or club) on at least one day during the 30 day period prior to completing the survey. The 2011 YRBS (CDC, 2012) indicated that 5.1% of students reported carrying a gun at school and 5.4% had carried a weapon on school property. When asked why weapons are brought to school, children gave a variety of reasons such as: protection; status/popularity; use for after school; and use for at school; and the ever popular, “I don’t know.”

The Penny Belief Scale (Penny, Walker, & Gudjonsson, 2012) is a 36 item tool developed to address a lack of tools to measure reasons people carry and use weapons. Using themes identified in a literature review and in consultation with forensic psychologists, research using this scale has demonstrated that violent cognitions predict beliefs about carrying and using weapons above and beyond sensation seeking and impulsivity. These findings suggested that violent cognitions are the single most powerful predictors of positive beliefs about carrying and using weapons (Penny et al., 2012). Decreasing parental responsiveness was also associated with 9th and 10th graders’ increased risk of fights and likelihood of bringing a weapon to school (Strawhacker, 2002). The combination of lack of parental interest with violent thoughts of students indicates a high risk for weapons violence. Metal detectors at school to deter weapons often give a false sense of security as weapons can be handed through unmonitored opened doors and windows (National School Safety and Security Services, 2014).

Bullying

Bullying in schools or by school children is another form of school violence. According to the YRBS (CDC, 2012), 20.1% of children reported being bullied on school property, 5.9% did not go to school because of safety concerns, and 16.2% reported being bullied electronically. Bullying statistics from 2010 (CDC, 2013) indicate that about one in seven students in grades kindergarten through 12th is either a bully or has been a victim of bullying. Sometimes a child who has been a victim of bullying becomes a bully in retaliation. Sixty-one percent of children believe that school shooters are victims of bullying either at school or at home. Many times children act out violently by bullying their peers because they are abused at home (CDC, 2013). Bullying, especially electronic bullying, is another form of violence that many times takes place outside of school, but greatly affects school climate, behaviors, and learning.

There is great controversy regarding who has responsibility for identifying and intervening in bullying that occurs outside of school but carries over to the school day. The media has highlighted recent cases of suicide allegedly caused by bullying. Parents, too, are coming forward in the media to call attention to perceived and real individual school and school district lack of attention to reported bullying. A review of the literature addressing bullying and suicide by Cooper, Clemens and Holt (2012) found a strong correlation between childhood bullying and suicidal behavior and possibly even bullying as an independent indicator of suicide.

Witnessed Violence

Annually, an estimated 10 million or more children are exposed to acts of domestic violence between adults in their homes (American Academy of Child and Adolescent Psychiatry, 2013). These children are at risk for abuse themselves as well as other immediate and long-term problems, especially if exposed to repeated episodes of domestic violence. Multiple behavioral manifestations, including anxiety, depression, and posttraumatic stress disorder, may be associated with violence exposure, and it is imperative that school nurses recognize these. Children who experience domestic violence in their families are more likely to exhibit aggressive and/or anti-social behavior, depression, and anxiety (Brown & Bzotek, 2003). Other researchers (Ramirez et al., 2013) have found higher levels of anger, hostility, oppositional behavior, and disobedience. Students who are absent from school on a frequent basis without an adequate explanation, such as a diagnosed illness, may be victims of domestic violence exposure. Ramirez et al. (2013) found that exposure to
violence correlated with absenteeism and suspension. The differences between children witnessing and experiencing violence are not well defined, however, both can have effects of psychological distress, desensitization to aggression, and changes in behaviors (Ramirez et al., 2013, McDonald et al., 2007). The prevalent belief that only children who have the cognitive ability to understand violence is being challenged and preliminary research shows that infants who witness violence are effected as well with a possible increase in symptoms in later years (McDonald et al., 2007).

Violence as a Cultural Norm of Problem Solving

Anecdotally, school nurses are seeing more violence as a learned problem solving method or coping mechanism. The increase in young children in primary grades who erupt in anger, shout expletives, and physically lash out in response to clear, calm directives is a demonstration of learned behavior. Parents come to schools to “fight” students who they perceive to have slighted their child. Parents, in front of their children, erupt in anger, using obscenities and threatening behavior towards school administrators and staff. Parental attitudes and behaviors have been linked with children’s violent behaviors. In children at age 10, favorable parental attitude toward violence was a good predictor of violent behavior in that child at age 18 (Strawhacker, 2002).

Gang violence falls into this category as well. The use of violence by gang members or students imitating gang behavior creates a culture of violence as a problem solving mechanism in the community and in schools. In a 2010 study, periods of active gang membership were associated with a 10 to 21% increase in the odds of involvement in violent incidents (Melde & Esbensen, 2013). WikiHow to do anything, an online resource often used by computer savvy youth, even has a “how to” page on using violence as a problem solver (How to solve problems using violence, 2013). Too often, students perceive that violence and retaliatory violence is the only way to address conflicts and consider other conflict resolution methods as ineffective, weak, and, in fact, inflammatory. While the constant exposure of images of violent responses to seemingly slight infractions by media and social media may sensationalize this behavior, the increasing stories of these behaviors as an attempt at problem solving cannot be ignored.

School Nurses Dealing with Violence

The Role of the School Nurse

School nurses have a key role in preventing and reducing violence in the school setting on several levels, as outlined in a position statement by the National Association of School Nurses (NASN; Tuck, Cagginello, & Rose, 2013). First, school nurses act to create safe school environments by collaborating with school personnel, parents, healthcare providers, and community members. They promote evidenced-based education and programs related to violence prevention. School nurses also intervene to prevent violence and decrease the effects of violence for individual students. As with many physical illnesses that may present with subtle symptoms or symptoms that appear unrelated to the untrained eye, the effects of violence present as multi-variant patterns which can be difficult to diagnose.

The school nurse is a non-disciplinary, non-academic staff member who, in this position, engenders trust and accountability to both students and staff. As such, a school nurse has a unique rapport with students, unlike any other in the school setting, that allows students to confide in and build trust with him or her. Students often tell the school nurse things about themselves, or about their friends, that enables the nurse to intervene to address actual or potential school violence. As a member of school-based interdisciplinary teams, the school nurse also frequently sees students with health issues, special education diagnoses, attendance problems, and discipline or behavior issues (Council on School Health, 2008). The school nurse office or clinic can serve as a safe haven for students with a variety of needs. Utilizing expertise in assessment, school nurses can identify behaviors that could be seen as malicious, such as angry outbursts, running away, bullying, or sleeping in class, as possible effects of violence. The nurse also identifies physical symptoms that may be caused by effects of violence, such as headaches, stomach aches, and injuries. With this knowledge, the nurse can intervene and make appropriate referrals.
The student who is perceived as a “frequent flyer,” i.e., one who visits the school nurse several times a week, may be a victim of violence. Unfortunately, several variables related to school nursing impact the ability for school nurses to intervene to decrease violence. For example, the number of school nurses; educational requirements to serve as a school nurse; legislative support for the presence of school nurses; and ratio of school nurses to students vary from state to state and, in many states, from school district to school district (Council on School Health, 2008). While school nurses are in the best position to address the effects of violence at school for individuals and aggregates, many schools are without a school nurse, or have very limited access to school nurses. In addition, many school administrators and personnel view the school nurse role as a provider of “band-aids and ice” rather than a key player in identifying and creating prevention and intervention strategies, thus missing the opportunity to utilize school nurse knowledge and expertise in this current crisis of violence (National Association of School Nurses, 2011).

**Stories from the Field**

Statistics and descriptions, such as those above, provide a numerical picture of the effects of violence in schools that school nurses must address in their professional role. However, it is the stories that can provide additional context to create a comprehensive picture of the challenges that both school nurses and our youth face in the current epidemic of violence. Here are a few anecdotal examples of actual encounters between students and school nurses that demonstrate the range of societal violence typical for some students:

- A first grade student with a fever of 100 degrees tells the school nurse that her daddy cannot pick her up from school. When the nurse asks who can take her home, she states matter-of-factly, with no emotion, "He's in jail. He killed his girlfriend's baby."
- A middle school boy consistently sleeps through class and is viewed by teachers as lazy. He is referred to the school nurse, who asks not only, "Why are you sleeping in class?" and "What time do you go sleep at night?" but also, "Where do you sleep?" and "Why?" His answer is, "I sleep on a sofa in the living room, 'cause we got broke into last week and I can’t see windows from my bedroom." This is a young teen who is protecting his family from further violence.
- A high school student, and known gang member, approaches the school nurse before summer break so he can measure her hand. Since she wouldn't be at school under his protection during the summer, he wanted to give her an appropriately sized gun for her to have at home. She expresses gratitude for his concern and politely declines.
- A star high school basketball player is shot and his friend is killed while they are stopped at streetlight in a car, asking for help with his gunshot wounds. He is treated at the local emergency department and released without supplies or knowledge of how to re-dress his bandages. He is then immediately moved to the police station. The school nurse ultimately provides supplies and education about caring for the wound. She acknowledges his stoic silence about the event and the perpetrator as self-protection, and encourages counseling to address his feelings, rather than focusing on the incident itself.
- A diminutive high school student is "choked out" (a World Wrestling Federation move) by a classmate and loses consciousness. He does not report the incident until an observer tells the school nurse about it. His mother’s first words to him at the school are (yelled), "Why didn't you fight back? You should have kicked their a***!" She does not voice any concern for his health or well-being.

These few anecdotes demonstrate the variety of incidents by age group (e.g., elementary, middle school, and high school students) and by location (e.g., both on and off school property). They also demonstrate the level of trust placed in the school nurse by the student and his/her ability to make an impact related to violence. In addition to the more serious examples listed above, school nurses must respond to more common exposure to violence, often on a daily basis, such as the frequent occurrences of students who come to the school nurse’s office to eat lunch every day, because they feel safer there than in the cafeteria. The next section describes potential responses to violence by both school nurses and other healthcare providers.

**Conclusion: Responses to Violence**

School nurses can and should take a leadership role to address the escalation of societal violence. Strawhacker (2002) recommends that school nurses re-examine traditional roles in school health programs and advocate for less traditional roles in the school setting. Interventions should include crisis management and school violence prevention utilizing a primary, secondary and
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School nurses, who often have post-baccalaureate education in health counseling, are trained in crisis response and are appropriate persons to serve on or lead crisis intervention teams (Tuck et al., 2013). School nurse crisis management interventions should include: training school staff to assist in medical response; assessing, planning and implementing programs for after crisis intervention both in initial and long term phases of treatment and recovery; coordinating the medical response disaster plan until emergency medical services arrive; providing nursing care for injured students; and applying crisis intervention strategies that help de-escalate a crisis situation and help resolve the conflict. As mentioned above, school nurses have unique rapport with students. They can provide a safe area away from other students and classrooms, which can be instrumental in preventing fights. Viewed as a safe and effective source for problem solving, the school nurse is often one of the first school staff members to learn about a student who has a weapon at school and should activate the school crisis plan in that event. School nursing involvement early in the planning process guarantees that important aspects of health and safety are included in the school violence plan.

School violence prevention also requires school nurse interventions. Utilizing a primary, secondary and tertiary intervention model from the public health perspective can help with organization and planning to address violence in each of these three domains (Skybo & Polivka, 2007; Strawhacker, 2002).

Primary prevention. Primary prevention efforts involve facilitating community and school partnerships; engaging parents in school activities that promote connections with their children; and supporting activities that create a climate that promote respect for others (Tuck et al., 2013). School nurses should develop and implement educational programs about conflict resolution and gun safety for parents and students (Selekman, Pelt, Garnier, & Baker, 2013). Creating a safe, bully free environment takes a multi-disciplinary and whole school effort; school nurses can initiate and coordinate that effort. Staff education and training is another intervention in primary prevention. School nurses must be involved in the creation of the violence prevention plan for the school or district in order to assure health concerns are addressed and to promote the school nurse leadership role.

Secondary prevention. Secondary prevention focuses on students at risk for behavior problems, such as students who have witnessed or experienced violence. All children should be screened for domestic violence exposure at regular intervals, and those who are at risk should have a more thorough health assessment. An adult observant presence in the hallways, at lunch, at recess, and on buses goes a long way toward limiting bullying behavior (Blosnich, & Bossarte, 2011). The school nurse can be a part of that presence as well as a provider of that safe place to come to report bullying. Children who have experienced violence or a crisis in the school setting must have safe place to express emotions and then return to a normal school routine (Skybo & Polivka, 2007). Alerting other adults (e.g., teachers, classroom aides) to potential victims and areas to monitor is another intervention that can be very helpful to address bullying.

Tertiary prevention. Tertiary prevention targets those students who already exhibit behavior problems and focuses on providing services to the student both within the school setting and in referrals to community services and agencies. Many children who have witnessed and/or experienced violence or are being bullied may present with repeated somatic complaints, school absences, or acting out behaviors. These students, as well as those who exhibit violent behavior, may need more intervention than the school can provide. By assessing and referring students who require in-depth counseling services, the school nurse not only prevents violence but also provides advocacy and support.
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repeated somatic complaints, school absences, or acting out behaviors.

Implications for Other Healthcare Professionals

Many healthcare professionals do not know the full scope of the role of the school nurse. School nurses are often viewed as nice ladies who give first aid, band aids, and ice, rather than highly expert professionals in caring for the health of school children. Communication and collaboration between community healthcare providers and school nurses enhances healthcare for school children. Several implications for community healthcare professionals to promote collaboration that can address violence in schools and/or an overall healthy school environment includes:

- Asking parents to sign release of information documents. This is the first step to allow communication between healthcare providers in the community and schools. Information filtered through a third party often loses much in translation; direct access to these documents can facilitate appropriate interventions at the school level.
- Communicating potential concerns for safety and violence to the school in order to provide the best care for students.
- Assisting the efforts of school nurses by learning about and then communicating to others the value of the school nurse’s expertise about evidence-based methods, schedules, and techniques to provide healthcare in the school setting.
- Serving on district and individual school level School Health Advisory Committees to provide valuable input that can facilitate school and community collaboration.

The effects of violence in schools can only be prevented and addressed with the combined efforts of schools and communities. Promoting peace over violence in the school environment requires an intentional, detailed effort over time and education of the community (Kaya, Bilgin, & Singer, 2012). It is important for school nurses to recognize and include the roles of individual students and school personnel, family members, and society as a whole in the collaborative effort to work toward nonviolent conflict resolution in the school setting.

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Kate King received a Bachelor of Science in Nursing from the University of Akron and a Master of Science with a major in nursing from The Ohio State University with a specialty in Community Health and Baccalaureate Education. She has worked in community health since 1988 in many capacities: public health clinic manager; Assistant Professor of Community Health Nursing at Mount Carmel College of Nursing in Columbus, Ohio; and school nurse for Columbus City Schools in Columbus, Ohio. She is currently the Supervisor of Health, Family and Community Services, overseeing 101 school nurses as well as the occupational health clinic and wellness initiatives for the district. Kate is the current president of the Ohio Association of School Nurses (OASN). She has been a board member of the OASN for five years as a Representative at Large, President-elect, and President. She has served as the President of the Central Ohio Association of School Nurses. Kate also holds an Adjunct Faculty position at the Ohio State University in Columbus, OH, teaching in the School Nurse Licensure Program. Her passion and commitment to assuring the health of children in her district and across the state is evident in her work with Columbus City Schools, the Ohio Association of School Nurses and the Ohio State University.

References


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