A Peer Education Program to Promote the Use of Conflict Resolution Skills Among At-Risk School Age Males

JOSEPH D. GIULIANO, RN, BA, BSN

Mr. Giuliano is a Clinical Nurse in the Division of Radiation Oncology at the Johns Hopkins Oncology Center, Baltimore, MD. He was formerly a student in the School of Nursing, Catholic University of America, Washington, DC.

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Tearsheet requests to Mr. Giuliano, 1707 E. Baltimore St., Baltimore, MD 21231; tel. 410-276-0829.

Synopsis

Violence is devastating the lives of children in America's major cities. The problem of violence is particularly acute among disadvantaged young urban males. This program focuses on violence prevention in school-age boys using creative educational techniques and community partnership. The goal of this school-based program is to decrease the incidence of violent episodes in the school by teaching conflict resolution skills.

Conflict resolution skills are taught in the health education component of the school health program. Skills are taught using a peer education model supervised by the school health nurse and planned in partnership with a Violence Prevention Advisory Board. Peer education teams consisting of fifth and sixth grade boys are trained and serve as peer educators for the boys in grades K-4.

The violence prevention peer education program stresses primary prevention and targets at-risk school age males. The proposal uses a model that promotes the development of student leadership skills and self esteem. The proposal suggests ways to promote school and community involvement using an advisory board made up of student, community, and school leaders. The peer education program is cost effective and demonstrates how existing resources can be used creatively within the school setting.

VIOLENCE IS DEVASTATING the lives of children in America's major cities. The following all-too-familiar litany is overwhelming.

- The leading cause of death for both black and white teenage boys in America is gunshot wounds.
- Between 1986 and 1991, the violent crime arrest rate for youth ages 10-17 rose 48 percent.
- In 1991, 130,000 youth were arrested for rape, robbery, homicide, and aggravated assault.
- Juvenile violent crime rose in 44 States between 1986 and 1991.
- Male juveniles were seven times more likely to be arrested for a violent crime than females (*1*).

Health care professionals and organizations such as the American Medical Association acknowledge that violence in the United States constitutes a public health emergency that must be addressed (*2*). It is estimated that significant health costs can be attributed to the consequences of violence.

Violence can be prevented, however. One way is with community-based youth violence prevention programs that address the complex issues fostering violence in society (*2*). These programs should target the disadvantaged young urban males who are most at risk. Creative peer education and violence programs can best be implemented in the elementary school with the supervision and guidance of the school health nurse.

Several barriers exist in planning and implementing a program in an elementary school. Cultural values and beliefs related to male roles and behaviors must be assessed and considered. Financial constraints

have limited the resources available to elementary schools, especially those in urban areas. In addition, there is limited time in the school day, and adding extracurricular programs to the already strained schedule will not impress administrators and faculty.

Literature Summary

The problem of violence is very complex. Many sociological, developmental, psychological, and neurophysiologic factors are related to violence (*3*). There are no easy answers. Any solution to the problem of violence facing young people must be multifaceted, based in the community, and emphasize prevention (*2*).

One certainty is that disadvantaged urban youth, who live in families where violence and adult discord are common, are at greatest risk (*1*). These children are victimized and grow up witnessing and participating in acts of violence. Ropp and colleagues report a staggering 50-percent increase in all-cause mortality in the urban pediatric population between 1980 and 1988 compared with no change in the rate for suburban and national pediatric populations (*4*). Most of the increase was in the African American urban population where homicides rose a dramatic 252 percent (*4*). The ubiquity of violence in our cities is leading to the death of an entire generation of youth.

Of these disadvantaged youths, males are especially at risk.

Males tend to have a higher rate of delinquency, adult criminality, and history of violent criminal behavior than females (*5*). Boys are socialized differently than girls. Boys are told from a very early age to be aggressive, controlling, and dominant. As a result, boys tend to engage in more risk-taking behaviors that predispose them to more injuries. The socialization of aggressive behavior has been suggested as a predisposing factor for violent behavior (*6*). Realizing that aggressive behavior predisposes males to violence, it would make sense to target this population. Therefore, primary prevention should be directed at the high-risk school age male aggregate.

Violence prevention focusing on the school age male must start early. Research supports the "cycle of violence" hypothesis (*5*). For this cycle to be broken, efforts must be directed to primary prevention in the form of early childhood interventions. These interventions must stress nonviolent problem solving and conflict resolution skills (*7*).

Conflict resolution skills, a type of nonviolent problem solving, can be taught through the health education component of the school health program. Traditionally, didactic teaching techniques have been used in the cognitive domain of student learning. Innovative instructional methods are needed to address a target population that does not do well in the traditional teaching-learning situation. New techniques that are creative and based in cooperative learning help the students develop interpersonal skills. Comprehensive programs must use a variety of teaching methods with special attention given to student-centered learning and involvement.

Sheffrin suggests the use of more cross-age and peer teaching with special concern for the affective domain in building self-esteem and promoting self-efficacy (*8*). Finn provides a number of reasons why peer education should be used in health education programs (*9*). One very important advantage is that it promotes ongoing and informal educational opportunities. Urban youth at risk for violence would benefit most from the use of such strategies that promote self-esteem and impart valuable life skills. The youths who participate as peer educators are given additional responsibility within the school and are identified as leaders. The school community recognizes these young people as belonging to a group that impacts positively on the school. This approval and sense of belonging builds the self-esteem of the at-risk urban youth.

Program Objectives

The overall goal of a school-based violence prevention peer education program is to decrease the incidence of violent episodes such as fighting in the school. This is accomplished through the following techniques:

- a partnership with the community, parents, teachers, students, and school administrators through the formation of a Violence Prevention Advisory Board,
- increased school commitment to reducing violent episodes through the development of peer leaders and educational teams that model and teach nonviolent conflict resolution,
- increased student knowledge in the use of conflict resolution skills through peer education.

Methodology

The following four-phase implementation process provides school nurses with a general framework for introducing conflict resolution skills.

Phase One includes a violence assessment that focuses on objective data relating to violence in the child's environment, such as community crime statistics, and in the school setting, the number of fights during school hours, for example. The assessment identifies social factors such as cultural beliefs and values that relate specifically to violence.

The school nurse enters into partnership with members of the school community by forming a Violence Prevention Advisory Board (VPAB). The VPAB involves parents, community members, students, teachers, and administrators in several important tasks. One is the formulation of a violence prevention policy for the school. In addition, the board plays a key role in increasing awareness of episodes of violence and attitudes surrounding violence within the school community. This is necessary to make people aware of the need for violence prevention in the school. The VPAB also provides a broad base of support and allows for a variety of input into violence prevention strategies (*10*).

Phase Two involves student recruitment and formation of peer education groups from among the older boys in the fifth and sixth grades. Each group should contain no more than six members. The school health nurse uses his or her rapport with students, knowledge of student needs, and advice from teachers in recruiting members for peer education teams (PETs). After students agree to participate, parental permission will be sought. Then these students will be involved in all phases of planning in order to promote a feeling of ownership for the program.

Program evaluation is identified during this planning phase. A violence reporting system is developed in partnership with the VPAB and school administrators. Under the reporting system, coordinated by the administration and the school nurse, acts of physical aggression that occur on school property, the time of day, and the number of people involved are documented.

In Phase Three of program implementation, the PETs are trained by the school nurse in the following areas:

- communication skills (that is, listening, responding, and teaching);
- identification of feelings;
- problem solving skills;
- refusal skills (that is, learning how to say no);
- methods of safe early intervention prior to fight escalation; and
- how to recognize the warning signs of violence
- patterns of altercations, risky situations, "dissing," peer pressure used against younger children, and playground scenarios.

The school nurse writes learning objectives for each skill area and determines the number of training sessions based on the PETs' mastery of the learning objectives. Finally, the nurse provides the PETs with time to practice presentation skills using role play situations. This allows the students time and opportunities to develop confidence in their abilities.

In Phase Four, the peer education module is implemented in the lower grades. The school nurse develops learning objectives for each grade level. The objectives are used to plan instruction and evaluate learning. Individual class times are arranged with teachers, the male students in each grade, and the peer leaders. The school nurse and PET prepare the lesson plan and learning activities (for example, role play, games, talks, and so forth) for each class. To maintain interest and involvement, class will be limited to 25-45 minutes, depending on the age group, and a variety of activities will be used during that time.

Significance of the Project

The following elements of the violence prevention peer education program are significant: (*a*) the project demonstrates how an important public health problem can be addressed using existing resources in the school setting in a cost effective way; (*b*) innovative esteem-building activities are used to teach prevention skills. This model can be used to teach children about other health topics.

Ways In Which the Project Is Innovative

The project

- stresses primary prevention and targets at-risk school age males,
- uses an innovative teaching-learning technique that addresses educational needs on a variety of levels,
- promotes the development of conflict resolution skills, leadership skills, and self-esteem among the older youngsters while providing the younger boys with knowledge and skills related to conflict resolution, and
- promotes overall school and community involvement with the problem of violence by using the VPAB in planning and modeling constructive ways to intervene.

Summary of Evaluation

Data from the violence reporting system are used to determine program effectiveness and the need for modification. Fights that occur on school property are reported and monitored through the school health office. Each class taught by the PETs is evaluated using a student pre- and post-test based on the learning objectives. This testing evaluates the mastery of conflict resolution skills among the boys in grades K-4. All evaluation data (fight reporting and instructional testing) are compiled by the school nurse, presented to the VPAB, and analyzed in an end of the year review. Modifications are made in the program based on the evaluative assessment.

Budget Estimate

In times of cost containment and cut-backs, a program with minimal cost is refreshing. The following budget is proposed for an elementary school of 600-700 students with the target population being 300-350 male students:

Learning materials for 30 peer leaders....	$300
Flyers, posters, promotional aids.....	150
Supplies for VPAB administration and meetings.....	100
Total.....	$550

Teaching conflict resolution skills using a peer education program is cost effective. It would cost about $1.83 per male student and $0.92 for each child in the school to implement this program. Certainly, the benefits of a safer learning environment and a more hopeful future for our children outweigh the cost.

References

1. Kids count data book: State profiles of child well-being. Center for the Study of Social Policy, Washing ton, DC, 1993.
2. Rosenberg, M. L., O'Carroll, P. W., and Powell, K. E.: Let's be clear: violence is a public health problem. JAMA 267: 3071-3072, June 10, 1992.
3. Roberts, C., and Quillian, J.: Preventing violence through primary care intervention. Nurse Pract 17: 62-70 (1992).
4. Ropp, L., Visintainer, P., Uman, J., and Treloar, D.: Death in the city: an American childhood tragedy. JAMA 267: 2905-2910, June 3, 1992.
5. Widom, C. S.: The cycle of violence. Science 244: 160-166, Apr. 14, 1989.
6. Herzog, E. A.: Care of men. *In* Nursing in the community, edited by M. J. Clark. Appleton and Lange, Norwalk, CT, 1992, pp. 522-543.
7. Interventions in early childhood. *In* Forum on Youth Violence in Minority Communities: Setting the Agenda for Prevention. Public Health Rep 106: 258-263, May-June 1991.
8. Seffrin, J. R.: The comprehensive school health curriculum: closing the gap between state-of-the-art and state-of-the-practice. J Sch Health 60: 151-155 (1990).
9. Finn, P.: Institutionalizing peer education in the health education classroom. J Sch Health 51: 91-95 (1981).
10. Stone, E. J.: ACCESS: Keystones for school health promotion. J Sch Health 60: 298-300 (1990).