8-1-1998

The Effect Of An Educational Intervention On Adolescents' Knowledge And Attitudes About Violence

Jean E. Szorady
Mississippi University for Women

Follow this and additional works at: https://athenacommons.muw.edu/msn-projects

Part of the Nursing Commons

Recommended Citation
https://athenacommons.muw.edu/msn-projects/272

This Thesis is brought to you for free and open access by the MSN Research at ATHENA COMMONS. It has been accepted for inclusion in MSN Research Projects by an authorized administrator of ATHENA COMMONS. For more information, please contact acpowers@muw.edu.
THE EFFECT OF AN EDUCATIONAL INTERVENTION ON ADOLESCENTS' KNOWLEDGE AND ATTITUDES ABOUT VIOLENCE

by

JEAN E. SZORADY

A Thesis
Submitted in Partial Fulfillment of the Requirements for the Degree of Master of Science in Nursing in the Division of Nursing Mississippi University for Women

COLUMBUS, MISSISSIPPI

August 1998
The Effect of an Educational Intervention on Adolescents’ Knowledge and Attitudes About Violence

by

Jean E. Szorady

Instructor of Nursing
Director of Thesis

Professor of Nursing
Member of Committee

Professor of Nursing
Member of Committee

Director of the Graduate School
Abstract

Violent injury is among the leading causes of death in adolescents. Adolescents' immaturity and underdeveloped impulse control put them at risk of acting rashly, thus at higher risk for violent injury. This significant public health problem is a preventive objective of Healthy People 2000. The purpose of this study was to examine the effects of an educational intervention on adolescents' knowledge and attitudes about violence. The nurse practitioner in a school or family clinic is in a unique position to intervene with adolescent clients using an educational intervention. Orem's Self-Care Deficit Theory served as the theoretical framework for the research. Two research questions were utilized, the first concerning adolescent knowledge about violence pre- and post-intervention and the second concerning adolescent attitudes about violence pre- and post-intervention. The null hypothesis stated there will be no significant difference in pretest and posttest knowledge scores for adolescents who attend an
educational intervention about violence. A pre-
experimental, pretest-posttest, one-group design was used.
The setting for the research was in a middle school in a
small, rural, economically-disadvantaged town in the
Southeastern United States. The 77 subjects' ages ranged
from 12 to 15 years. Data analysis revealed that students' 
knowledge increased slightly after the intervention, but
that increase was not statistically significant.
Therefore, the null hypothesis was accepted. Changes in
attitudes, as well as significant additional findings,
revealed that students who already had violent tendencies
were unaffected or negatively affected by the
intervention. Younger students generally had a more
positive response than older ones.
Dedication

I dedicate this thesis with love and gratitude to my husband

Brian

who has been a tower of strength and support during a difficult year,

and to our daughter

Meagan

who sacrificed "Mommy time" so I could complete this thesis.

They are my Light and my Life.

To our Lord Jesus Christ, through Whom all things are possible,

I give thanks.
Acknowledgments

To Dr. Mary Pat Curtis, without whose loving support and gentle nudging I would not have completed this thesis,

To Lorraine Hamm, who was my chairperson, my mentor, and my good friend, who believed in the value of this work as much as I did, and who taught me at a hands-on level the value and the fun of research,

To Dr. Linda Sullivan, who challenged me to prove that research on violence prevention was a valid subject for a nurse practitioner in a clinic setting. Researching it and proving it to her focused and strengthened my study.

To Melinda Rush, who encouraged me to write clearly, concisely, and according to APA standards, and who was able to see the missing pieces in my writing when I got lost,

To Sherry Franks, who was always willing to listen, who shared her telephone, paper, stapler, other office supplies, and her advice during this busy year,
And to Phyllis McCorkle, who took my bits of cutup and taped together paper and turned them into this book, I give my heartfelt gratitude.

I could not have made it without all of you. God bless you.

A special thanks to the Marshall County Superintendent of Schools, to the principal and school counselor of Henry Middle School, to the librarian, and to the four seventh-grade teachers who allowed me free run of their school, their classes, their library, and their time during my research I am truly grateful.

Last, but certainly not least, my heartfelt thanks go to the young men and young women of the seventh grade who answered all my questions, who did everything I asked of them, and without whose cooperation this study would never have succeeded.
# Table of Contents

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstract</td>
<td>iii</td>
</tr>
<tr>
<td>Dedication</td>
<td>v</td>
</tr>
<tr>
<td>Acknowledgments</td>
<td>vi</td>
</tr>
<tr>
<td>List of Tables</td>
<td>x</td>
</tr>
<tr>
<td>List of Figures</td>
<td>xi</td>
</tr>
</tbody>
</table>

### Chapter I. The Research Problem

- Establishment of the Problem | 2
- Statement of the Problem | 6
- Significance to Nursing | 7
- Theoretical Framework | 9
- Research Questions | 11
- Hypothesis | 11
- Definition of Terms | 11
- Assumptions | 13
- Summary | 14

### Chapter II. Review of the Literature

<table>
<thead>
<tr>
<th></th>
<th>15</th>
</tr>
</thead>
</table>

### Chapter III. The Method

- Design of the Study | 53
- Variables | 54
- Setting, Population, and Sample | 54
- Method of Data Collection | 55
  - Techniques and instrumentation | 55
    - Procedures | 57
- Methods of Data Analysis | 59
- Summary | 59
IV. The Findings ................................................. 60

Description of the Sample ................................. 60
Demographic Data ............................................. 61
  Correlations Among Demographic Variables ........... 63
  Knowledge ................................................. 64
  Attitudes ................................................. 67
Additional Findings ......................................... 72
Summary .................................................... 74

V. The Outcomes ................................................. 75

Summary and Discussion of Findings ..................... 76
Conclusions .................................................. 85
Implications for Nursing ................................... 86
  Practice .................................................. 86
  Education ............................................... 87
  Research ................................................... 88
Limitations .................................................... 89
Recommendations for Future Research ..................... 90

References .................................................... 92

Appendix

A. Szorady Adolescent Attitudes Toward Violence Assessment Questionnaire .......... 95

B. Approval of the Committee on Use of Human Subjects in Experimentation of Mississippi University for Women ............... 103

C. Educational Intervention Tool ................................ 105

D. Consent Form of Superintendent .......................... 107

E. Consent Form of Principal .................................. 111

F. Consent Form of Student ...................................... 115

G. Consent Form of Parent/Guardian ............................ 117
# List of Tables

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Demographic Characteristics of the Sample by Frequency and Percentage</td>
<td>62</td>
</tr>
<tr>
<td>2. Significant Relationships Between Age and Violent Behaviors</td>
<td>64</td>
</tr>
<tr>
<td>3. Knowledge Change by Variable Including Pretest and Posttest Scores</td>
<td>65</td>
</tr>
<tr>
<td>4. Significant Relationships Between Gang Membership and Attitudes About Violence</td>
<td>69</td>
</tr>
<tr>
<td>5. Significant Relationships Between Keeping a Found Gun and Demographic Variables</td>
<td>70</td>
</tr>
<tr>
<td>6. Significant Relationships Between Desirable Non-Violent Attitudes and Non-Gang Membership</td>
<td>71</td>
</tr>
<tr>
<td>7. Significant Relationships Between Desirable Nonviolent Attitudes and Age</td>
<td>72</td>
</tr>
<tr>
<td>8. Significant Relationships Between Defeatist Attitudes and Demographic Variables</td>
<td>73</td>
</tr>
</tbody>
</table>
# List of Figures

<table>
<thead>
<tr>
<th>Figure</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Attitudes of adolescents regarding violence by question and pretest/posttest responses</td>
<td>68</td>
</tr>
</tbody>
</table>
Chapter I

The Research Problem

Adolescent violence is an important health problem which is escalating yearly. From 1986 to 1992, the death rate from injuries due to violence in children younger than 15 years increased by 25%. In contrast, deaths from motor vehicle accidents decreased by 24% in the same time period (Li et al., 1996). In 1992, death from firearm related injuries was the fifth leading cause of death in children under 15 years and was the second leading cause of death in African-American children (Li et al., 1996).

An estimated 4,000 children are seen in emergency departments each year, and fully half of those are hospitalized for violently inflicted injuries. The mean hospital cost for each admission due to a violent injury is $13,794 (Li et al., 1996).

In 1990 the United States Department of Health and Human Services (DHHS) developed a list of health promotion and disease prevention objectives for the year 2000. This list is known as Healthy People 2000. Objective 7 on the
list is entitled Violent and Abusive Behavior Objectives ("Designing Health Promotion," 1993). Objective 7.9 concerns decreasing physical fighting by adolescents in school by the year 2000. Objective 7.16 states by the year 2000, 50% of all primary and secondary schools in the United States should offer courses in nonviolent, conflict-resolution skills. Objective 7.17 speaks to the availability of coordinated, violence prevention programs within communities nationwide by the year 2000 (DHHS, 1993). The inclusion of objectives to decrease adolescent violence as part of health promotion and disease prevention for the nation underscores its importance as a research problem. The purpose of this study was to assess the effectiveness of an educational intervention on violence before and after an educational intervention.

Establishment of the Problem

Adolescence is the stage of development at which mastering the skills necessary to resolve conflicts is an important milestone. This skill is not innate, but is learned, usually within primary social groups, such as the family, school, and peer groups (Durant et al., 1996). Adolescents, in particular, are at risk for violent injuries due to their levels of emotional immaturity and...
underdeveloped impulse control. More and more often, adolescents are resorting to violence in response to pressure and because of a lack of learned alternative methods through which to cope with everyday frustrations. Peer pressure is very powerful at this stage. Adolescents tend to become more easily embarrassed and susceptible to peer pressure and may overreact to perceived insults. If adolescents are in situations where peers expect them to fight, it is especially difficult for them to resist that sort of peer pressure (Roberts & Quillian, 1992).

Societal attitudes toward violence have also been shown to influence adolescents' attitudes toward violence. Television, movies, and popular music tend to make heroes of those who solve problems through the use of violence. Many teen idols are characterized as being tough and no-nonsense types of people who resort to violence when crossed (Roberts & Quillian, 1992).

The news media has given teens who kill their parents and peers a type of popular notoriety and has portrayed such youth as victims. Adolescents who are already at risk because of a history of abuse are getting the message that the slaying of their abusers is righteous.
Despite pervasive societal attitudes that adolescent violence is an out-of-control situation, American health care providers are taking a stand. In the objectives of Healthy People 2000, established in 1990 and updated yearly by the National Center for Health Statistics in Washington, violence and abuse are powerfully addressed. Statistics drawn from 1987 to 1990 are listed in the document along with desired minimal level improvement in statistics projected for the year 2000. Among these statistical objectives are the following:

Reduce assault injuries among people aged 12 and older from 11.1 per 1,000 to 8.7 per 1,000.

Reduce physical fighting among adolescents 14 to 17 years old from 137 incidents per 100 students per month to 110 incidents per 100 students per month. A reduction of 20%.

Reduce weapon carrying by adolescents 14 to 17 years old from 107 incidents per 100 students per month to 86 incidents per 100 students per month. A reduction of 20%.

Increase at least 50% the proportion of elementary and secondary schools that teach nonviolent conflict resolution skills, preferably as part of quality school health education. (There were no statistics available on whether schools were teaching conflict resolution in 1990).

Extend coordinated, comprehensive, violence prevention programs to at least 80% of local jurisdictions with populations of 100,000 or more. (DHHS, 1990, p. 51)
In the United States the second most common cause of death for people ages 15 to 24 years is homicide. For every death there are 100 nonfatal assaults. Violence is pervasive throughout society and is especially heinous when it involves youth. Violence prevention is a health care issue and, therefore, mandates further research (Landis & Brykczynski, 1997).

Conflicts play a particularly important role for adolescents, because conflict resolution skills are developed during adolescence (Durant et al., 1996). Learning appropriate resolution of conflicts offers an adolescent opportunities to clarify personal identity and values, increase social status, promote personal growth, and generate interpersonal insight (Johnson, Johnson, Dudley, Mitchell, & Fredrickson, 1997). The skills involved in learning conflict resolution are learned within the home, at school, and within the peer group. Learning to control anger and manage conflict is one of the important developmental tasks of adolescence. Appropriate conflict management skills do not develop naturally; they must be taught and practiced. Many adolescents, however, live in environments of social and familial disorganization and/or in high levels of poverty,
unemployment, and social immobility (Durant et al., 1996). Violence, which is a learned response to stress, is a daily reality in their lives. Youth, in this environment, do not experience nonviolent conflict resolution. They are not taught by family or the community to avoid the use of violence nor are they given the skills of anger management and conflict resolution with which to handle stressors (Durant et al., 1996). In this multicultural, interdependent world, learning to cooperate, to see another perspective, to actively listen, and to effectively communicate are vital skills (Horowitz & Boardman, 1994).

Statement of the Problem

A number of research studies have been conducted on the impact of conflict resolution programs on adolescent students within the school setting (Durant et al., 1996; Eggert, Thompson, Herting, & Nicholas, 1994; Johnson et al., 1997). Anticipatory guidance and prevention are the main foci of such programs. Primary prevention of violence is based on averting the behaviors which place adolescents at risk (Roberts & Quillian, 1992). Since adolescence is the developmental time when conflict resolution skills are mastered (Durant et al., 1996), nonviolent conflict
resolution skills should be taught in early adolescence to 12- to 13-year-olds, who are beginning their developmental work (Roberts & Quillian, 1992). Health education by a primary health care provider, such as a nurse practitioner, may be the only opportunity adolescents have to be exposed to primary prevention interventions. Providers of primary care have an obligation to address the issue of violence, as part of anticipatory guidance during adolescent client visits, so that clients will recognize it as a valid health care concern (Roberts & Quillian, 1992).

Based on the longevity of the problem of adolescent violence and the vital role nurse practitioners fill as health care providers for these adolescents, the research problem for this study emerged. In this study, the problem under investigation concerned the impact of an educational intervention on adolescents’ knowledge and attitudes about violence.

Significance to Nursing

Violence is seen as a health care issue by the DHHS (1993). Nurse practitioners, as primary care providers, emphasize health promotion and disease prevention in providing nursing and medical services to individuals,
families, and groups. Teaching and counseling individuals, families, and groups are a major part of nurse practitioners’ activities (American Academy of Nurse Practitioners, 1993).

Conflict resolution programs might feasibly be utilized by nurse practitioners in primary care with adolescent clients in need of anger management and nonviolent conflict resolution. Nurse practitioners also can work with schools or school boards to develop and implement conflict resolution programs as part of the school curriculum (Roberts & Quillian, 1992). Further, brief educational programs might be presented by nurse practitioners in community and consultant situations.

Nursing interventions are based on nursing research. Data from this researcher’s study adds to the existing body of nursing knowledge about violence among adolescents and the success or failure of certain interventions in preventing such violence. This study also has significance as conclusion can increase the limited data existing on the knowledge and attitudes of adolescents concerning violence in rural settings. The particular type of educational intervention was studied to determine if a program, which could be taught in one 50-minute classroom
setting or in one or two clinic visits, would be an effective strategy among young adolescents who are just beginning the work of learning anger management skills. The effectiveness of this strategy in changing knowledge and attitudes toward violence in young adolescents could or may potentially be a useful adjunct to nurse practitioners' primary prevention programs.

This study also has significance for nursing education. Findings from this study might contribute to the development of a nursing curriculum that includes a focus on violence prevention. The addition of this subject matter is of particular importance in family and pediatric nurse practitioner programs of study.

Theoretical Framework

Orem's Self-Care Deficit Theory was the theoretical framework upon which this research was based. Orem, in 1971, portrayed the individual as an integrated whole, composed of an internal physical, psychological, and social nature, with varying degrees of self-care ability (Chinn & Kramer, 1995). Orem's theory involves three constructs: self-care, self-care deficits, and nursing systems. Self-care indicates that the person (agent) regulates his or her own needs from learned behaviors. The
effectiveness of the agent is contingent upon individuals being capable of managing themselves, in their environments, under stable and changing conditions. There are three types of self-care requisites: universal, developmental, and health deviation. Universal requisites are basic requisites to maintain human functioning, such as air, water, food, elimination, balance between activity and rest, balance between solitude and socializing, hazard prevention, and promotion of normalcy. Developmental requisites are needs which arise from changes in growth and development which come with maturation. Health deviation self-care requisites are needs which arise when people are ill, injured, have defects or disabilities, or are undergoing diagnosis or treatment (Hartweg, 1991).

This author's research was based on the concept that adolescents, due to pubescence, are experiencing a time of emotional and physical turmoil developmentally. They potentially have universal deficits in harm prevention, and their developmental requisites occupy much of their time (Orem, 1995).

Adolescents can learn and want to be responsible for their personal health-related care. They also want and need guidance from a responsible adult, though they will resist this guidance at times. Sustained interest of the nurse can greatly contribute toward the adolescent
becoming an effective self-care agent. (Orem, 1995, p. 31)

A supportive-educative nursing system, in which the client performs the action while the nurse guides and teaches, provides a positive developmental environment, for the adolescent (Hartweg, 1991).

Research Questions

For the purposes of this study, students’ knowledge and attitudes were studied separately; therefore, two research questions were used to guide this study:

1. What is adolescents’ level of knowledge before and after an educational intervention about violence?
2. What are adolescents’ attitudes about violence before and after an educational intervention?

Hypothesis

The null hypothesis was: There will be no significant difference in adolescents’ knowledge about violence before and after attending an educational intervention about violence.

Definition of Terms

For the purposes of this study, the following terms were defined theoretically and operationally:
Adolescents: Theoretical: Persons who are in the period of life from puberty to maturity, officially ending at age of majority and who are in a time of preparation for adulthood. Operational: the age range was 12 to 15 years and included students who attended seventh-grade classes in a public middle school.

Level of knowledge about violence: Theoretical: an understanding reflecting an individual’s past experience and exposure to different kinds of information about issues related to violence. Operational: a specific score derived from the knowledge section of the Szorady Violence Assessment Questionnaire.

Attitudes about violence: Theoretical: an individual’s general perception or overall feeling of favorableness or unfavorableness toward his or her own performance of violent behaviors, i.e., rough or injurious physical force. Operational: a specific score derived from the attitudes section of the Szorady Violence Assessment Questionnaire.

Educational intervention: Theoretical: a program relating information to students about the consequences of violence and alternatives for conflict resolution for the purpose of assisting them in developing knowledge or
skills. Operational: a classroom session consisting of a 20-minute video, entitled Understanding and Resolving Conflicts, and a 30-minute class lecture/discussion about violence and methods of conflict resolution.

Assumptions

For this study, the following assumptions were made:

1. An individual’s abilities to engage in self-care are conditioned by age, developmental state, life experience, sociocultural orientation, health, and available resources.

2. Nurses determine the current and changing values of patients’ abilities to meet their self-care requisites, select valid and reliable processes for meeting these requisites, and formulate the course of action necessary to meet identified self-care requisites.

3. Adolescents’ knowledge and attitudes about violence are concepts which can be empirically measured.

4. Conflict resolution skills are not naturally occurring, but need to be taught and practiced, just as in learning any other skill (Durant et al., 1996).
Summary

Adolescent violence is an important health problem which is escalating yearly. Despite a number of research studies on the effectiveness of conflict resolution programs in positively changing adolescents' knowledge and attitudes about violence, conflict resolution programs are not a standard part of public school curricula. Primary health care providers have an obligation to assess their adolescent clients for problems in managing conflicts and to intervene preventively to avert problems.

In this chapter, the establishment of the problem, significance to nursing, hypothesis, definition of terms, and assumptions were presented. The theoretical framework which guided this study was Orem's Self-Care Deficit Theory.

With little research data available on the knowledge and attitudes of adolescents toward violence and with no data available on the potential effectiveness of a conflict resolution program, which could be used in both a school and clinic setting, the necessity for this study emerged.
A review of literature was conducted to determine the status of current research regarding knowledge and attitudes about violence among adolescents. Seven research articles were reviewed for this study. Li et al. (1996) measured the scope of the problem of adolescent injury due to violence. Kann et al. (1995) measured six risky behaviors of adolescents, violence being one of the behaviors. Public Health Reports ("Designing Health Promotion," 1993) measured knowledge of and attitudes toward risky behaviors by high-risk adolescents and by parents of high-risk adolescents. Gielen, McDonald, Forrest, Harvilchuck, and Wissow (1997) measured the effectiveness of injury prevention counseling within the clinic setting. Eggert et al. (1994), in reporting on 10 years of studies involving high school students, had developed a method to predict which students would be high-risk. The Eggert et al. group had also developed a school-based prevention program and had been studying the
program's effectiveness over an 8-year period. The last two articles by Durant et al. (1996) and Johnson et al. (1997) measured the effectiveness of several school-based interventions in influencing adolescents' knowledge and attitudes about violence.

Li et al. (1996) gave statistical evidence of the scope of the problem of adolescent injury due to violence. Using a nonexperimental, ex post facto design, the researchers sought to examine the demographic and circumstantial factors associated with the intent of childhood firearm-related injury using comparative analysis of patients 14 years of age or younger.

Unintentional injury was compared to assaultive injury, documenting patterns of injury and clinical outcomes. One set of dependent variables was demographic factors and circumstantial factors surrounding the injuries. These factors were associated with the independent variables of the intent of unintentional injury (UI) versus the intent of assaultive injury (AI). The other set of dependent variables was the injury patterns and clinical outcomes associated with UI versus AI.

At the National Pediatric Trauma Registry, from which the study data were collected, the term "intent of injury"
was coded as accident, assault, self-destruction, or other. Unintentional injury was defined as all accidental injuries. Assaultive injury included all injuries inflicted by another person with the intent to harm, including stray bullets or crossfire injuries. The only data used for this research, under intent of injury, were the injuries coded "accident" and "assaultive." Criteria used to predict intent were the victim's age, sex, time and day of injury, and scene of injury. There were three categories of scenes: "'Home'--all private, non-institutional places of residence, including yards, gardens, driveways and garages; 'road'--any road commonly used for travel; and 'other public place,' a non-road, public area, i.e., school, park or sports field" (Li et al., 1996, p. 1161).

The National Pediatric Trauma Registry (NPTR), from which the data were collected, was a database to which 68 trauma centers and pediatric hospitals reported on the effects of acute-care management on functional outcomes of pediatric trauma patients. The sample (N = 649) obtained was from a data base on patients collected from January 1, 1990, to December 31, 1994. Children under 20 years old who had been diagnosed with either an assaultive or
accidental firearm related injury and were admitted to one of the 68 trauma centers, which reported to NPTR during this period, were selected to be in the research. Measurements used in evaluating data were frequency distributions of firearm related injuries relationships to intent and circumstances of injury, odds ratios on whether the injuries were AI or UI, injury severity scores (ISS), and in-hospital mortality rates.

Statistical testing used to measure differences between patients were chi-square tests and t tests. Differences in intent with the victim's demographics and injury circumstances were further measured by multivariate unconditional logistic regression. There were marked differences in time, age group, sex of victims, and circumstances between assaultive and unintentional firearm related injuries. Victims of UI were usually male, at home, and unsupervised. The time of day stretched from 6:00 a.m. to 6:00 p.m., peaking from 12:00 noon to 5:00 p.m. (usually on a weekend), Friday through Sunday. Victims of AI were either less than 5 years old or 10 to 14 years old and the majority (72%) were female. The time of day of the injury usually rose from 12:00 noon to a peak at 9:00 p.m., then fell during the late night, early
morning hours. The day was usually Monday through Thursday, and the shooting usually occurred in a public place. Statistical data on the second set of dependent variables, the injury patterns and clinical outcomes associated with UI versus AI, showed little statistical difference in outcomes.

The researchers concluded that many unintentional injuries probably occurred when children were at home, unsupervised, and playing with a gun. Assaultive injuries, on the other hand, probably were part of drug or gang-related activity. Li et al. (1996) recommended the development of school- and community-based extracurricular activities, access to social services, and limit of children's access to guns as part of intervention in this problem.

The Li et al. (1996) research provided insight as one measurement of the scope of the problem of adolescent violence. Further, the study offered information regarding which adolescents might be at special risk, depending on the environment in which they lived. This information could be of value to the family clinician in educating client-families on injury prevention as part of child-care teaching as well as educating the community, as a whole,
on the need for preventive programs for young adolescents. This concept was directly linked to research involving the effectiveness of an educational intervention regarding knowledge about adolescent violence, which this researcher undertook.

In another study which underscored the enormity of the violence problem, Kann et al. (1995) sought to measure health risk behaviors which were established in youth and which contributed to leading causes of mortality and morbidity among youth and adults. Leading causes of mortality among youth 5 to 24 years old were motor vehicle accidents (30%), other unintentional injuries (12%), homicide (19%), and suicide (11%). A majority of deaths for adults 25 years of age and older were from heart disease (35%), cancer (25%), and stroke (7%). The researchers developed the Youth Risk behavior Surveillance System (YRBSS) to monitor six risky behaviors, which contributed to the leading causes of mortality and morbidity for the nation. The six risky behaviors, the independent variables for the study, were as follows: behaviors which contributed to intentional and unintentional injuries, tobacco use, alcohol and other drug use, sexual behaviors that contributed to unintended
pregnancy, and STDs including HIV infection, unhealthy dietary behaviors, and physical inactivity (Kann et al., 1995).

The research method used was a nonexperimental, national, school-based survey. Subjects were obtained using a three-stage cluster sample design to produce a nationally, racially/ethnically, representative sample of ninth- and 12th-grade students for the YRBSS study. The three racial-ethnic classes represented were black/non-Hispanic, white/non-Hispanic, and Hispanic. A weighting factor was applied to each student record to adjust for non-response and for the oversampling of Hispanic and black students.

The independent variables measured were the behaviors in which the students engaged, which were considered to contribute to the dependent variables. Behaviors which were considered to contribute to unintentional injuries were lack of safety belt use, motorcycle helmet use, bicycle helmet use, and riding with a driver who had been drinking alcohol (Kann et al., 1995). Independent variables, which were considered to contribute to intentional injuries, were carrying a weapon, engaging in a physical fight, school-related violence, and suicidal
ideation and attempts (Kann et al., 1995). Tobacco use behaviors measured were use of cigarettes and smokeless tobacco (Kann et al., 1995). Alcohol and other drug use behaviors measured were use of alcohol, marijuana, cocaine, steroids, injected drugs, and a separate measurement of tobacco, alcohol, and other drug use on school property (Kann et al., 1995). Sexual behaviors measured were sexual intercourse, condom use, and birth control pill use (Kann et al., 1995). Dietary behaviors measured were perceived overweight, attempted weight loss, servings of fruits and vegetables eaten daily, and servings of foods high in fat eaten daily. Physical activity behaviors measured were the amounts of vigorous physical activity, stretching exercises, strengthening exercises, and participation in physical education classes by the study subjects in the week preceding the study date (Kann et al., 1995).

Questionnaires, which consisted of 84 multiple-choice questions, were completed during a regular class period using scantron-type answer sheets. A total of 16,296 questionnaires were completed in 155 schools across the country. Students were represented evenly across grades and between gender (Kann et al., 1995).
For the purposes of this review of literature, only the results of behaviors which could lead to violence are discussed. Results of behaviors that could contribute to intentional injuries were as follows:

1. Carrying a weapon: Twenty-two and one-tenth percent of students nationwide had carried a weapon, gun, knife, or club to school in the 30 days prior to the survey. Of the weapon-carrying group of students, over one third used guns as their weapon, and 92 weapon-carrying incidents occurred monthly per 100 students. Across all subgroups, male students were significantly more likely than female students to have carried a weapon and for that weapon to have been a gun. Among female students, 18.9% of black female students had carried weapons as compared to 11.5% of Hispanic female students, and 6.9% of white female students. Black male and female students were significantly more likely to have carried a gun than white male and female students (Kann et al., 1995).

2. Engaging in a physical fight: In the 12 months preceding the survey, 41.8% of the students surveyed had been in a physical fight, and 4.0% had been treated by a health care provider for injuries sustained in a physical fight. Approximately 137 physical fighting incidents
occurred per 100 students per year. Across all subgroups, male students were significantly more likely than female students to have been in a physical fight. Among females, black female students were significantly more likely to have been involved in a physical fight than white female students. Among grade levels, ninth-grade students were involved in physical fighting more than 10th-, 11th-, or 12th-grade students. Regarding injuries, black male students were significantly more likely to be injured in a physical fight than black female students or white male students (Kann et al., 1995).

3. School-related violence: Nationally, 4.4% of students had missed at least one day of school during the 30 days preceding the survey because they felt unsafe at school or traveling to and from school. Both Hispanic and black male and female students were significantly more likely than white male or female students to miss school because they felt unsafe, and ninth-grade female students were significantly more likely than 12th-grade female students to miss school for the same reason (Kann et al., 1995).

Nationally, the prevalence of weapon carrying on school property was 11.8% in the 30 days preceding the
survey. Across all subgroups, male students were significantly more likely than female students to carry a weapon onto school property, and black female students were significantly more likely than Hispanic female students or white female students to have done so.

Nationally, during the 12 months preceding the survey, 7.3% of students admitted to having been threatened or injured with a weapon on school property, and 16.2% of students had been in a physical fight on school property. Across all subgroups, male students were significantly more likely to have been in a fight on school property than female students, and black students were significantly more likely than white students to have been in a fight on school property. However, white male students and black female students were significantly more likely than white female students to have been threatened or injured with a weapon on school property. Male and female students in the ninth grade were significantly more likely than male and female students in Grades 11 or 12 to be in a physical fight on school property. Male students in Grades 10, 11, and 12 were significantly more likely than female students in Grades 10, 11, and 12 to be threatened or injured on school property.
Another behavior measured as part of school-related violence was theft or destruction of students' property on school grounds. In the 12 months preceding the survey, 32.7% of students nationwide had property such as car, clothing, or books stolen or deliberately damaged. Across racial and grade subgroups, male students (except Hispanics) were significantly more likely than female students to have property stolen or damaged (Kann et al., 1995). Ninth-grade male and female students were significantly more likely than 12th-grade male and female students to have property stolen or damaged (Kann et al., 1995).

4. Suicide ideation or attempts: Nationally, 24.1% of students had seriously considered attempting suicide in the 12 months preceding the survey. Nineteen percent of students reported making a specific suicide plan. Eight and six-tenths percent of students actually attempted suicide resulting in 2.7% of students needing health-care intervention for an injury, poisoning, or overdose. Across all subgroups, female students were significantly more likely than male students to have had suicide ideation and attempts. Racially/ethnically, Hispanics were
significantly more likely than blacks or whites to have suicide ideation and attempts (Kann et al., 1995).

The YRBSS produced valuable data which have been used nationwide by health and education officials to create school policies, and programs designed to reduce health-risk behavior by students. The YRBSS data also have been used to measure progress toward achieving 26 national health objectives as listed in the Healthy People 2000 report (Kann et al., 1995). This researcher also used the YRBSS data to support the significance of implementing the current study of adolescents' knowledge and attitudes about violence.

In the third research study reviewed ("Designing Health Promotion," 1993), the researchers completed self-reported data from high-risk youth on the youth's understanding and concerns involving risk-taking behavior and on what the youth believed would help them change their risk-taking behavior. The research, supported by Public Health Service (PHS) agencies and the Department of Education, Justice and Transportation ("Designing Health Promotion," 1993) was part of a larger project directed by the PHS Office of Disease Prevention and Health Promotion with oversight by a Federal Advisory Panel. The purpose of
the research was to obtain information toward planning programs for youth in high-risk situations to meet objectives for the adolescent population set in Healthy People 2000. The specific research questions were the following:

1. To what extent is health a priority among high-risk youth? How does it compete with other needs and concerns?

2. What do they (high-risk youth) know and how do they feel about smoking, HIV-AIDS, sexual activity, pregnancy, alcohol and other drugs, and violence? Do knowledge and attitudes differ by age, race/ethnicity or sex?

3. What factors inhibit or promote the adoption of positive health practices?

4. What opportunities are there for programs to address the problems that threaten the health prospects of this population? ("Designing Health Promotion," 1993, p. 70)

Variables measured in the research were the youth’s attitudes, perceptions, and beliefs (dependent variables) contributing to the youth’s health behaviors and practices (independent variables). Focus group methodology was the design used and a quota system was used to gather subjects for the study. The quota system consisted of community leaders who knew area youth recruiting youth engaged in high-risk health practices, who were also school drop-in/dropouts or were in alternative schools, were in the
juvenile court system, were runaways, or were in alcohol or other drug treatment programs. Most of the youth and their families received some sort of government welfare assistance. Between 40% and 50% of the youth were involved in gangs and lived with a female, single head of the house. Greater than half of the youth had close family members who abused alcohol and other drugs, were involved in gangs, and/or were in jail.

The subjects were divided into four ethnic groups, including African American, White, Hispanic, and Native American. Age divisions were 10-12 years, 13-15 years, and 16-18 years. Subjects were divided by gender. A total of 160 youth were in the Public Health Service focus group study, divided into 24 groups. They came from one of four large cities or one rural area in the United States.

The community leaders who had recruited the subjects were trained to be the focus group facilitators, guiding the semi-structured, group discussions using specific research questions. Sessions were audiotaped. Confidentiality was protected for subjects and everyone involved in the research, since many of the self-reporting discussions involved discussing illegal activities. Moderators prepared reports on the focus group
discussions, which were used with the audiotapes by project analysts to write a comprehensive report. The report included ranking of the top 12 life priorities by race/ethnicity and by gender of the group. The second part listed the six risk behaviors (smoking, violence, drugs/alcohol use, sexual activity, pregnancy, and AIDS) with levels of knowledge, acceptance, and concern regarding these behaviors by the group.

The youth focus groups were conducted in 1990 and 1991. Eight focus groups for parents and grandparents of at-risk youth (not the same youth) were conducted in 1992. Adult responses to the adolescents’ attitudes, perceptions, and beliefs were assessed. Focus group discussion also concerned the importance of parental involvement in youth programs. The adult groups were separated by race/ethnicity. Groups were conducted in three large urban areas and one rural area.

Common findings for the youth group were that the high-risk youth shared similar life priorities with their less high-risk adolescent peers. The 12 life priorities (in no particular order) were:

- being close to God,
- having a family,
- having someplace to call home,
- being loved,
- having enough to eat,
- being healthy,
- looking good,
- feeling safe,
- having money,
- being loved,
having enough to eat, being healthy, looking good, feeling safe, having money, learning something, getting along with others and feeling important. ("Designing Health Promotion," 1993, p. 69)

These youth engaged in high-risk activities in spite of expressed life priorities and a generally high knowledge of the health consequences because living within their often dysfunctional environments produced a fatalistic view of their own future. Another finding of the Public Health Service focus group study was that multiple, risk-taking behavior, i.e., drinking alcohol and/or taking other drugs before engaging in sex or violence, was the norm. Areas of most misinformation with this group seemed to concern how to avoid getting pregnant and avoiding exposure to HIV/AIDS.

The daily lives of the youths in this study seemed to be unstructured and unsupervised by adults. None of the youth were involved in any sanctioned, supervised, after-school activities.

In the adult focus group, parents verbalized awareness that the older youth did not have enough supervision or structured activities. They mentioned economic and transportation difficulties as part of the problem and placed blame on lack of involvement by
communities, schools, and parents themselves. Parents were involved more with younger children, jobs, and family chores; and older youth were left to their own devices.

In discussions involving how to or whether to change their risk-taking behavior, the concept of "risk-taking behavior" itself seemed to cause a conflict. Neither parents nor youth saw all risk-taking behaviors as bad. Even if adults did not consider some behaviors acceptable, they were considered inevitable or as part of youth having a good time. In the youth group, smoking cigarettes was the least acceptable behavior, while fighting and sexual activity were most accepted. Becoming HIV positive was the most feared result of their activities; however, lack of knowledge concerning how to prevent exposure to HIV/AIDS showed in their acceptance of other risk-taking behavior ("Designing Health Promotion," 1993).

In discussing what would help them change risk-taking behavior, both youth and adults mentioned family support as being important. Youth also mentioned having someone they could talk to whose information they could trust, who would be straight with them, and who would not judge them, as important to changing behavior. Accurate knowledge concerning HIV transmission and pregnancy prevention was vital for this group, along with having skills taught and
programs designed to help them break away from their harmful environment.

The "Designing Health Promotion" (1993) study by the Public Health Service was germane to this researcher's study on adolescents' knowledge and attitudes about violence because conclusions suggested that appropriate, timely intervention could potentially change an adolescent's at-risk behavior. More research was recommended to support the findings and to determine what types of interventions would be most effective. This current researcher endeavored to answer that recommendation with an educational approach.

In a study which focused directly on health care providers' violence prevention activities, Gielen et al. (1997) conducted research on injury prevention counseling by pediatric resident physicians in an urban pediatric clinic. The purpose of the study was to determine whether, how much, and what type of injury prevention counseling was being delivered to clients with preschool aged children, since children 5 years of age and younger had high injury rates. Most injuries occurred at home. Injury prevention in children merited inclusion as an objective of Healthy People 2000.
The independent variable was the well-child clinic visit. Dependent variables were the amount and types of injury prevention counseling given, the amount of time used, and the communication method(s) used. Terms defined were eliciting information, giving information, asking for feedback, obtaining a commitment, and reinforcing intentions or efforts.

Gielen et al. (1997) used a descriptive design in the research, using audiotapes from a previous study, which examined interviewing and communicating styles of pediatric residents. The setting for the study was an urban, hospital-based primary care clinic. Residents involved in the study were second- and third-year residents of a 3-year pediatric residency program. Residents were followed from February 1990 through January 1991. There were 52 residents involved in the study, 15 residents in their third year, and 37 residents in their second year. Additionally, 178 client-families were involved. The clients were children, ages 6 months to under 5 years old, who were seen during clinic visits, which included a well-child component, and were accompanied by their mother or their legal female guardian. Permission was gathered from all participants,
who were told they were being audiotaped to study communication styles. Confidentiality was assured.

The sampling design of the original study was a convenience sample of all children 14 years and younger, who saw the 52 residents on a well-child visit or on a visit with a well-child component to it. Of the 232 original clients, a subset of 178 preschool aged children was selected for the Gielen et al. (1997) study because anticipatory guidance was typically provided during well-child visits for preschool aged children.

Gielen et al. developed a special coding system for three areas which included injury topics, prevention strategies, and communication methods. One of the researchers trained two coders on how to identify injury prevention information on the tapes. The investigator who trained the coders and the coders themselves rechecked one another, in listening to the tapes, until all three agreed 100% on the information they gathered regarding the presence or absence of injury counseling. Another coding system was developed to measure the content of injury prevention counseling and the communication method used. To ensure coding reliability and investigator reliability, the coding system was revised several times and tested.
The investigators assessed each other's reliability several different ways. "Interrater reliability was 1.0 for injury topics, 0.89 for prevention strategies, and 0.89 for communication methods. Based on these results, the coding manual, operational definitions and coding form were finalized" (Gielen et al., 1997).

The coders listening to the audiotapes picked up 11 injury topics and from 1 to 12 prevention strategies per topic were isolated. For each prevention strategy, the researchers coded whether the resident made a specific recommendation. The duration of time spent discussing injury prevention also was measured per visit. To measure methods of communication, the researchers classified each injury topic discussion into one of three mutually exclusive categories: eliciting information, giving information, and eliciting and giving information.

Results of analyzing the audiotapes revealed that 13 residents (5 third-year and 8 second-year) offered no injury prevention counseling in 38 visits. For the remaining 39 residents, 10 had one taped visit, 16 had two taped visits, 11 had three visits, and 2 had four visits taped with injury prevention counseling on them. Of the total of audiotaped visits with preschool aged children,
47% had injury prevention counseling on them. In the 83 visits, which had injury prevention counseling, topics discussed ranged from ingestion of toxic substances, aspirations, and suffocation (36%), to falls (20%) and pedestrian injuries (12%). One hundred sixty-three injury topics were covered during these 83 visits and 222 prevention strategies were mentioned. Of these, the pediatric residents specifically recommended 77 prevention strategies. Injury prevention discussion averaged 1.08 minutes per visit. In assessing effectiveness of methods of communication, it was found that parents interacted with the physician more often when the physician actively sought information from them than when he or she only gave information to them.

Gielen et al. (1997) concluded that pediatric residents spent little time discussing injury prevention during well-child visits, and topics of importance to the clients in that inner-city area, i.e., smoke detectors and firearm safety, were never mentioned. The researchers recommended that health care providers prioritize their injury prevention counseling so that the most important topics and prevention strategies be covered in the limited time available and that communication skills be
emphasized. Implications for advanced practice included injury prevention counseling as a basic part of primary prevention care. Prioritizing, counseling, and enhancing communication to improve outcomes within the limits of time constraints are important skills for all health care providers.

The reviewed study linked directly to this researcher's study as Gielen et al. (1997) recommended that injury prevention strategies be developed. The current research focused on an intervention in a school health setting to impact knowledge and attitudes about violence. If injury prevention education and the counseling which emerge from such a program could modify at-risk behavior, then such counseling should receive high priority in well-child visits and in school health clinics and other educational programs.

The study by Eggert et al. (1994) added the dimension of the school setting. These researchers focused on some of society's most profound problems: adolescent drug involvement, school failure, risky behaviors, including violence and suicide behaviors. Suicide behavior measurements included measurements of related risky behaviors involving anger and violence/victimization.
Three sets of studies were used to address program goals. The first set of studies tested theory-driven preventive interventions which focused on the multiple causes for adolescent drug involvement and suicide potential. The second set of studies targeted potential school dropouts from a distinctly underserved population; and the third set of studies researched whether preventive interventions could be integrated into school-based programs utilizing a multidisciplinary team of clinicians and researchers (Eggert et al., 1994).

The three sets of studies were part of a 10-year research program (1984 to 1994) entitled Reconnecting At-Risk Youth (RAY). The research program was a collaborative effort by a team of psychosocial, PhD/RNs, educators, and professionals from related fields to "prevent deviant or adverse adolescent development by intervening when maladaptation occurred and/or when support from the social environment failed" (Eggert et al., 1994, p. 108). A major assumption which guided the RAY program was that adolescents' risky behaviors (e.g., drug use, violence, and school dropouts) were not caused by adolescents alone, but were caused within adolescents' social systems. For an intervention program to work, it must work as a social
network support system within the adolescent’s natural school environment.

The first pilot studies were ethnographic in methodology. The researchers were looking for identifiable measurable risk factors which could predict which students in a high school population would be at risk for deviant outcomes. The first groups of students, whom the researchers sought to understand, were “skippers,” youths who frequently skipped class, which placed them at risk for school failure. The sample subjects included 45 skippers, 107 non-skippers, 71 parents, and 60 high school teachers, and a verification sample of 96 skippers. The researchers sought to understand the skippers’ culture, norms, and communication in order to find implications for interventional preventive programs. Field work included surveys, interviews, and focus group discussions (Eggert et al., 1994).

The ethnography of skippers showed measurable factors which could identify high-risk youth within the school population. The five main criteria were as follows: (a) below average credits for grade level, (b) in the top 25th percentile for absenteeism, (c) low school performance, (d) prior dropout status, and (e) referrals from school
personnel as a youth at-risk for dropping out (Eggert et al., 1994). In a follow-up study, researchers used causal methodology to validate the ethnographic findings. Using self-reporting survey data, a sample group of 337 high-risk youth were compared to 204 "typical" high school students. The high-risk group reported significantly higher levels of risk factors including more emotional distress, more family distress, greater involvement with drug-using peers, lower levels of personal resources, less social and familial support, and less school bonding. The evidence obtained from these pilot studies indicated that youth's social environments (e.g., school, family, and specially, peers) actively determined whether a student would have problems with school deviance, drug use, depression, and, in some cases, violence/victimization and suicidal ideation (Eggert et al., 1994).

Over the next 2 years, Eggert et al. (1994) carried out three more causal model studies to further define the independent variables (emotional and familial distress, associations with drug-using peers, low levels of personal resources, less social support, and less school bonding) within the high-risk youth's social environments which influenced the dependent variables of risky behaviors,
school deviance, drug use, depression, and suicide ideation. From their findings, the researchers developed a school-based prevention program, implemented it, and began the studies to determine its effectiveness.

Five recommendations were made for the original prevention program. High-risk students needed: (a) life skills training, (b) social support resources, (c) peer interventions, (d) family interventions, and (e) fit with school structure. These recommendations were hypothesized to influence the desired outcomes of reduced risky behaviors, school deviance, drug involvement, and depression, which might decrease suicide ideation.

Eggert et al.'s next set of pilot studies were quasi-experimental. There was an experimental group of 73 high-risk youth, and a control group of 73 high-risk youth. Dependent variables were risky behaviors, including violence, school deviance, drug involvement, depression, and suicidal ideation. Independent variables were the life-skills training, social support resources, peer interventions, and family interventions of the school-based prevention program. The prevention program was carried out over 5 months of the school year. The first pilot study and the subsequent experimental studies over
the next 3 years in which Eggert et al. (1994) studied high-risk students from five different high schools showed a significant decrease in truancy and other deviant behavior, and drug involvement and an increase in school achievement by the experimental group. The control group showed no change, or an increase in truancy, other deviant behavior, and drug involvement, and a decline in school achievement (Eggert et al., 1994).

In the third year of the prevention program, a Personal Control Skills training unit was added which included anger management skills training. The experimental youth group showed a significant improvement in stress management and appropriate conflict resolution, while the control group showed no improvement in these skills.

The implications for psychosocial nursing practice were as follows:

1. Prevention was essential for high-risk youth.
2. Co-occurrence of problem behaviors was common.
3. Adults were important to high-risk teens.
4. The youth peer group's influence was powerful.
5. High-risk youth were vulnerable.
6. Teens needed basic life skills, including anger management and conflict resolution skills.

7. Teens needed alternatives.

8. Teens needed a voice in the community.

The research of Eggert et al. (1994) provided direction and background data for this current research. Both studies sought to add conflict resolution to educational programs on violence. Further, both studies addressed prevention as essential for high-risk youth.

In a study most similar to the current study, Durant et al. (1996) used a quasi-experimental design to compare the effectiveness of two violence prevention curricula for middle-school adolescents living in or around public housing. Subjects included a sample (N = 225) of adolescents representing 20% of the student population in two middle schools in Augusta, Georgia. Students were in the sixth, seventh, or eighth grade. Grade distribution was not significantly different between the schools. Eighty-nine percent of students were African American, 10% were white, and 1% were Native American, which reflected the student population of both schools. Forty percent of students lived in public housing, and 60% of students lived in neighborhoods adjacent to public housing. Student
anonymity was protected during the study and data gathering.

The two curricula were Violence Prevention Curriculum for Adolescents by Prothrow-Stith and Conflict Resolution: A Curriculum for Youth Providers by The Community Board Program, Inc. Violence prevention curriculum for adolescents used information and role-playing to help students become more aware of homicide, positive ways to handle anger and arguments, how fights begin and escalate, and choices, other than violence, that were available to adolescents in conflict situations. Conflict Resolution: A Curriculum for Youth Providers was designed to define and review major types of conflict, reviewed three styles of resolving conflicts and their effectiveness, reviewed factors which influence the communication process, reviewed skill building in basic communication behavior, and practiced an informal, collaborative, conflict resolution process (Durant et al., 1996).

The 225 students were given a pretest questionnaire, and then each school was randomly assigned a curriculum. Each curriculum was administered during ten 50-minute sessions held twice a week over a 5-week period. One week
later, the 209 students who had completed the entire 10 sessions took the same test as a post-questionnaire.

The results were as follows: At pretest, the students, who were subsequently given the conflict resolution curriculum, had significantly higher scores on the scale measuring use of violence in hypothetical situations than the students who were given the violence prevention curriculum. Both groups showed significant reductions, on posttest, in their use of violence in hypothetical situations, following the interventions. The conflict resolution group, however, continued to have higher scores than the violence prevention group. At both pretest and posttest, females showed more appropriate avoidance of violence responses than males, and neither intervention significantly affected this scale. Students in the conflict resolution group reported engaging in more physical fights, in the 30 days prior to the pretest, than the violence prevention group. After the interventions, both groups showed a significant drop in physical fighting, but the conflict resolution group showed a greater drop in physical fighting which resulted in injury than the violence prevention group (Durant et al., 1996).
Both curricula had positive influences on self-reported use of violence by young adolescents living in and around public housing. The curricula taught both facts and skills in avoidance, confrontation, problem solving, and conflict resolution.

The success of the study by Durant et al. (1996) lends credence to the conduction of this author’s study on adolescents’ knowledge and attitudes about violence and the effects of a conflict resolution program on that knowledge and attitudes. The current study is also based on a preestablished violence curriculum similar to those in Durant et al. (1996).

In the final study reviewed, Johnson et al. (1997) researched the effectiveness of a conflict resolution and peer mediation training program in a midwestern middle school on 176 students in Grades 6 through 9. A pretest-posttest control group, experimental design was used. There were 116 students in the experimental group (57 boys and 59 girls) with 36 sixth-graders, 30 seventh-graders, 27 eighth-graders, and 23 ninth-graders. The control group consisted of 60 students (27 boys and 33 girls) with 19 sixth-graders, 13 seventh-graders, 15 eighth-graders, and 13 ninth-graders. All the students were white, from
middle-class backgrounds, and had similar ranges of academic achievement in each group, from gifted to special needs level.

Dependent variables measured were the students’ answers to the pretest-posttest questionnaire. There were two dependent measures. The first was the "How I Manage Conflicts" measure, and the second measure involved two case studies with an unresolved conflict at the end. All the students answered the dependent measure questions in essay form. The independent variable was the training in conflict resolution and peer mediation versus no training. The experimental group of students received training during a 25-minute homeroom period 3 days per week until they had received 14 hours of training. The control group received no training. They spent their homeroom time as a study hall. The training time took 3 months, and one week after training was completed, all students took the posttest (Johnson et al., 1997).

To control for possible differences in teaching, four graduate students and a professor, the program creator, conducted the training. All five had previously conducted the training. The regular teachers and aides assisted the trainers. Halfway through the program, the trainers were
randomly reassigned to another class and stayed with that class until the end of the program. The trainers and principal investigator met daily to critique each other and to practice training to ensure that the same materials were being taught in the same manner (Johnson et al., 1997).

The program consisted of integrative negotiation, which focused on disputants finding a mutually satisfying solution to the problem and the perspective reversal procedure which focused on viewing the conflict from both points of view. Teaching methods included role-playing, drill and review exercises, and small group exercises. Teaching focused on (a) the nature of conflict, (b) how to engage in integrative negotiations, and (c) how to mediate schoolmates’ conflicts (Johnson et al., 1997).

The study had been previously conducted to determine if middle-school students could learn the procedures necessary to constructively resolve conflicts and could apply these procedures to actual conflict situations. Before training, in the experimental group and in the control group, 2% of the students listed three or more steps of the negotiating process in describing how they would solve a conflict. After training, 88% of the
experimental group were able to list three or more negotiating steps to resolving conflicts, while only 1% of the control group could list the steps. There were no significant differences in grade level responses or in gender responses. Johnson et al. (1997) concluded that students in the sixth to ninth grades, when given training in conflict resolution and peer mediation, could learn the steps involved and could see themselves handling conflicts in this manner (Johnson et al., 1997). The study was especially pertinent to the current study as an educational intervention among a similar age group (very young adolescents) was utilized. The current study expanded the concepts to include attitudes as well as knowledge about violence and conflict resolution.

To summarize, the first three researchers ("Designing Health Promotion," 1993; Kann et al., 1995; Li et al., 1996) supported the concept that adolescent injury due to violence was real and that the need for early, primary intervention was valid. Gielen et al. (1997) discovered that time constraints in a primary care clinic were a serious barrier and must be considered in planning a primary preventive intervention.
All of the researchers in the last three articles reviewed (Durant et al., 1996; Eggert et al., 1949; Johnson et al., 1997), in studying the effects of different intervention programs on adolescents, concluded that preventive educational conflict resolution programs do make a positive change in adolescents' conflict resolution skills.

Like the research which this author undertook, many of the interventions discussed above were school-based programs. Each of those interventions was carried out over several weeks to months, in contrast to this author's research, in which one day was devoted to the pretest and intervention. In each of the interventions discussed in this review, the posttest were given within one week after the intervention program. This author gave the posttests one month after the intervention program in order to evaluate a slightly longer longitudinal effect. The socioeconomic and racial/ethnic backgrounds of the subjects in this author's study were similar to the backgrounds of the subjects in the studies of Durant et al. (1996) and Eggert et al. (1994), with a large proportion of at-risk youth in the subject group. Findings in the literature indicated that if one-day prevention
programs could make a significant difference in adolescents' knowledge and attitudes about violence, it would be useful in a family clinic setting as well as in a school setting. The purpose of the current study was to evaluate the effectiveness of such a program in a school-based setting among youth in early adolescence.
The purpose of this study was to ascertain the knowledge and attitudes of adolescents about violence both before and after attending an educational intervention about violence. In this chapter, methods used to study the variables of interest are identified. The research design, setting, population, and sample are described. The instrument utilized for measurement is discussed as well as the procedure for data collection. Finally, the methods of data analysis are identified.

Design of the Study

A pre-experimental, one-group design was undertaken for this study. The design was appropriate because the study involved the manipulation of an independent variable but lacked two of the other properties that characterize true experiments, which are randomization and a control group (Polit & Hungler, 1995).
Variables

The dependent variables for the study were attitudes and knowledge. The independent variable was the educational intervention. Controlled variables were the geographical location and age of the students. Intervening variables may have included student honesty in answering the questions, understanding the questions, the size of the groups who received the intervention, the environment in which the pretest and posttest were taken, and the environment in which the intervention was performed. Extraneous variables assessed by the Demographic Data Sheet were subjects' previous exposure to anger management or conflict resolution courses, and whether a subject had ever belonged to a gang, carried a weapon, or had been arrested.

Setting, Population, and Sample

The setting for this study was a middle school in a small, economically disadvantaged town in rural northern Mississippi. Three large manufacturing plants, which surround the town, supply most of the employment for the town. Because of this, unemployment has been fairly low, but because most of the jobs are of the unskilled or blue-collar type, wages also are fairly low. Ethnically, the
town is composed of approximately 70% Caucasians (whites), 30% African Americans (blacks), and a small Latino population. In the public middle school, however, there is a higher proportion of African Americans to Caucasians. There is a small but growing gang presence in the town. Even the elementary school-age children verbalized familiarity with gang insignia. Crime is relatively low, but crimes such as auto theft and break-ins, which police attributed to gang activity, and which had been perpetrated by both black and white gang members, has been on the rise (Police Chief Sanderford, personal communication, January 22, 1998). The weekly newspaper, The Pigeon Roost News, reported that police were trying to stop this crime increase before it got worse.

The target population for the study sample included 90 seventh-grade adolescents, aged 12 to 15 years, who attended the public middle school. The study sample (N = 90) was drawn from all seventh-grade students, male and female, who agreed to participate and who had parental consent to participate.

Methods of Data Collection

Techniques and instrumentation. The instrument utilized for measuring the variables of this study and for
collecting the data was the Szorady Violence Assessment Questionnaire, a 46-item questionnaire (see Appendix A). The researcher-developed questionnaire contained 10 demographic questions, 8 questions which measured knowledge about violence, and 28 questions which measured attitudes about violence. The demographic questions were used to gather data concerning gender, age, race/ethnicity, living arrangement, and number and ages of siblings. Additionally, participants were asked if they belonged to a gang, if they had ever been arrested, or if they had ever participated in a conflict resolution program.

A total knowledge score was obtained by totaling correct responses to the knowledge section about violence. Answer options for knowledge questions were true, false, and “don’t know.” Questions answered “don’t know” were counted as wrong answers and were given a score of zero. Correct answers were given a score of 1; therefore, the range of possible scores was 0 to 8 for the knowledge section.

There were seven potential conflict situations on the attitude section of the Szorady questionnaire. Each situation had four attitude responses, and student
agreement with each of those responses was scored on a 4-point Likert-scale ranging from 1 (strongly disagree) to 4 (strongly agree). Each response item was scored individually, and no total attitude score was assessed.

Procedures. Approval to conduct the study was first obtained from the Mississippi University for Women Committee on Use of Human Subjects in Experimentation (see Appendix B). The researcher appeared in person before the superintendent of schools for the county where the study was conducted to explain and describe the study. The video entitled Understanding and Resolving Conflicts, which was used as a part of the intervention and which was obtained from the Bureau for At Risk Youth (see Appendix C) was viewed and approved by the principal and the school counselor, whereupon the superintendent and principal then granted their permission to conduct the study (see Appendices D and E).

As the next step, the researcher contacted the four seventh-grade teachers at the middle school in order to arrange a meeting with their students, inform the students about the study, and distribute the student and parental consent forms (see Appendices F and G). The consent forms described the study and described measures which would be
taken to protect confidentiality. The consent forms were distributed one week prior to the scheduled pretest. The four teachers were instrumental in getting students to return the signed forms to class. Student and parental consent forms were collected prior to giving the pretest. Only those students who wished to participate and who had parental consent were given the pretest. The researcher explained the written instructions to the students and answered questions. A box was provided in each classroom for the students to place their questionnaires, face down, after completion. The researcher was the only person other than the students who handled the questionnaires. Each questionnaire was numbered to correspond to a numbered list of names, so each student’s pretest and posttest scores could be analyzed. The researcher was the only person who saw the list, and after posttest questionnaires were distributed, the list was destroyed.

One day after the pretest was given, the researcher presented a 50-minute teaching session. The school library was made available for the intervention program. Two classes of participating seventh-graders came per session; therefore, the researcher presented the program twice. Forty-five students attended each session.
One month later, the posttest, which was identical to the pretest, was given to the students who had taken the pretest and attended the intervention program. After all the questionnaires had been sorted and incomplete questionnaires discarded, the final sample size was 77.

Methods of Data Analysis

Descriptive statistics, such as frequency distributions and percentages, were utilized to identify the characteristics of the students in the study. Means and standard deviations were used to answer the research questions. The dependent t test was utilized to test the research hypothesis and assess whether a significant change in knowledge existed between the pretest and posttest questionnaires. Pearson procedures were used to glean additional findings.

Summary

In this chapter, the design of the current study was discussed. The variables, limitations, setting, population, and instrumentation were presented as well as the methods of data collection. Finally, the methods of data analysis were identified in order to establish the empiricalization of the current study.
The purpose of this study was to assess the knowledge and attitudes of adolescents regarding violence before and after an educational intervention. The design was a pre-experimental, pretest/posttest one-group design with two research questions and a null hypothesis. In this chapter, a description of the sample and analysis of the data in relation to the research questions and hypothesis are presented. Additional findings also are included.

Description of the Sample

Convenience sampling was utilized to collect the statistical data from adolescent middle-school students. The participants attended a middle school in a small, economically disadvantaged town in North Mississippi. The school counselor chose the four seventh-grade classes, according to convenience and appropriateness, which comprised the population from which the sample was obtained. Ninety-five students took the pretest.
Eighty-six students attended the educational intervention, and 78 students took the posttest. The final sample consisted of the 77 students who turned in their parental and student consent forms, completed the pretest, attended the education intervention, and completed the posttest.

Demographic Data

Demographic data were collected for all participants regarding gender, age, race, parent or guardian lived with, number of siblings, previous conflict resolution education, gang member, weapon carrier, or arrest record. The students, all enrolled in Grade 7, ranged in age from 12 to 15 years. The mean age was 13.3 years. The remainder of the data regarding demography of the sample may be seen in Table 1.
Table 1

Demographic Characteristics of the Sample by Frequency and Percentage

<table>
<thead>
<tr>
<th>Variable</th>
<th>f</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)(^a)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>11</td>
<td>14.5</td>
</tr>
<tr>
<td>13</td>
<td>37</td>
<td>48.7</td>
</tr>
<tr>
<td>14</td>
<td>16</td>
<td>21.1</td>
</tr>
<tr>
<td>15</td>
<td>12</td>
<td>15.8</td>
</tr>
<tr>
<td>Ethnic origin(^b)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>48</td>
<td>61.8</td>
</tr>
<tr>
<td>Caucasian</td>
<td>28</td>
<td>36.8</td>
</tr>
<tr>
<td>Hispanic</td>
<td>1</td>
<td>1.3</td>
</tr>
<tr>
<td>Gender(^c)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>35</td>
<td>44.7</td>
</tr>
<tr>
<td>Female</td>
<td>42</td>
<td>55.3</td>
</tr>
<tr>
<td>Living arrangements(^d)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Both parents</td>
<td>35</td>
<td>45.5</td>
</tr>
<tr>
<td>Have siblings(^e)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td>3.9</td>
</tr>
<tr>
<td>Yes</td>
<td>73</td>
<td>96.1</td>
</tr>
<tr>
<td>Previous conflict(^f) resolution education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>72</td>
<td>94.7</td>
</tr>
<tr>
<td>Yes</td>
<td>4</td>
<td>5.3</td>
</tr>
<tr>
<td>Member of gang(^g)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>72</td>
<td>96.1</td>
</tr>
<tr>
<td>Yes</td>
<td>3</td>
<td>3.9</td>
</tr>
</tbody>
</table>

(table continues)
### TABLE 1 (continued)

<table>
<thead>
<tr>
<th>Variable</th>
<th>f</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carry weapon to school&lt;sup&gt;h&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>53</td>
<td>71.6</td>
</tr>
<tr>
<td>Yes</td>
<td>21</td>
<td>28.4</td>
</tr>
<tr>
<td>History of being arrested&lt;sup&gt;i&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>72</td>
<td>90.5</td>
</tr>
<tr>
<td>Yes</td>
<td>5</td>
<td>9.5</td>
</tr>
</tbody>
</table>

Note. Not all participants answered all items.

<sup>a</sup>n = 76.  <sup>b</sup>n = 77.  <sup>c</sup>n = 76.  <sup>d</sup>n = 76.  <sup>e</sup>n = 76.  <sup>f</sup>n = 76.  <sup>g</sup>n = 75.  <sup>h</sup>n = 74.  <sup>i</sup>n = 75.

**Correlations Among Demographic Variables**

To further explicate sample demographics, Pearson product-moment correlations were conducted. Only those relationships which emerged as statistically significant are presented. In Table 2, the relationships between age of the students and violent behavior are elucidated. These significant correlations indicate that the older the student, the more likely the student was to have joined a gang, to have been arrested, or to carry a weapon.
Table 2

Significant Relationships Between Age and Violent Behaviors

<table>
<thead>
<tr>
<th>Behavior</th>
<th>r</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gang member</td>
<td>0.210*</td>
<td>&lt; .05</td>
</tr>
<tr>
<td>Been arrested</td>
<td>0.195*</td>
<td>&lt; .05</td>
</tr>
<tr>
<td>Carry a weapon</td>
<td>0.358**</td>
<td>&lt; .01</td>
</tr>
</tbody>
</table>

*p < .05. **p < .01.

Knowledge

In this study, knowledge and attitudes were evaluated separately. Two research questions and one hypothesis were used to guide the study. The first research question was the following: What is adolescents’ level of knowledge before and after an educational intervention about violence? The mean knowledge score on the pretest was 4.99 (SD = 1.27). After the intervention, the mean posttest score was 5.09 (absolute range: Low = 0, High = 8). This finding demonstrates a slight increase in adolescents’ knowledge about violence after the educational intervention.

The null hypothesis was: There will be no significant difference in adolescents’ knowledge about violence before
and after attending an educational intervention about violence. The knowledge increase was not statistically significant, $t(74) = .409, p > .05$; therefore, the researcher retained the null hypothesis.

Data regarding knowledge scores were compared among selected demographic variables. Information regarding changes in knowledge scores among violence related demographic variables as well as gender and race can be seen in Table 3.

Table 3

<table>
<thead>
<tr>
<th>Variable</th>
<th>Pretest</th>
<th>Posttest</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-gang members</td>
<td>4.94</td>
<td>5.14</td>
<td>+0.194</td>
</tr>
<tr>
<td>Gang members</td>
<td>6.00</td>
<td>3.67</td>
<td>-2.333</td>
</tr>
<tr>
<td>Non-weapon carrying</td>
<td>4.91</td>
<td>5.26</td>
<td>+0.359</td>
</tr>
<tr>
<td>Weapon carrying</td>
<td>5.10</td>
<td>4.62</td>
<td>-0.476</td>
</tr>
<tr>
<td>Non-arrest record</td>
<td>4.89</td>
<td>5.13</td>
<td>+0.246</td>
</tr>
<tr>
<td>Arrest record</td>
<td>5.31</td>
<td>4.85</td>
<td>-0.462</td>
</tr>
<tr>
<td>Previous conflict education</td>
<td>4.75</td>
<td>5.25</td>
<td>+0.500</td>
</tr>
</tbody>
</table>

(table continues)
<table>
<thead>
<tr>
<th>Variable</th>
<th>Pretest</th>
<th>Posttest</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>No previous conflict education</td>
<td>5.00</td>
<td>5.08</td>
<td>+0.080</td>
</tr>
<tr>
<td>Female</td>
<td>4.93</td>
<td>5.21</td>
<td>+0.286</td>
</tr>
<tr>
<td>Male</td>
<td>5.06</td>
<td>4.94</td>
<td>-0.118</td>
</tr>
<tr>
<td>African American</td>
<td>5.09</td>
<td>5.19</td>
<td>+0.196</td>
</tr>
<tr>
<td>Caucasian</td>
<td>4.93</td>
<td>4.89</td>
<td>-0.040</td>
</tr>
<tr>
<td>Hispanic</td>
<td>5.00</td>
<td>6.00</td>
<td>+1.000</td>
</tr>
</tbody>
</table>

These findings reflect an overall drop in knowledge scores among gang members, weapon carriers, students with arrest records, males, and Caucasians. The researcher further subjected these scores to dependent t test analysis. Only one finding, the drop in gang members’ knowledge, was statistically significant, $t(2) = 5.71$, $p < .05$. This result indicates that gang members’ knowledge about violence actually dropped after the intervention.

Although no separate pretest and posttest scores were assessed among age groups, the Pearson $r$ statistic revealed a significant inverse relationship between posttest knowledge scores and age of the student, $r =$
Younger students, therefore, had significantly greater increases in knowledge than older students.

Attitudes

The second research question was: What are adolescents’ attitudes about violence before and after an educational intervention? Attitudes about violence were assessed and analyzed.

There were 28 attitude questions. No total attitude scores were assessed as each question was independent. Possible answers ranged on a Likert scale from Strongly agree (equal to 4 points) to Strongly disagree (equal to 1 point).

Figure 1 illustrates the mean group responses to each attitude question. Pretest mean scores are represented as diamond shapes on the figure. Posttest mean scores will be represented as star shapes. A lightly shaded area represents the measurements on the Likert scale in which an appropriate, nonviolent conflict resolution would be reflected. Darker shaded areas represent measurements in which inappropriate, aggressive, or violent responses would be reflected.
### Attitudes of Adolescents Regarding Violence by Question and Pretest/Posttest Responses

<table>
<thead>
<tr>
<th>Question</th>
<th>Pretest</th>
<th>Posttest</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Bring a weapon</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Protect self</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Weapon to protect friends/family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Never bring a weapon to school</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. 5-8 is all right to hit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. If I'm hit first</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. If I'm insulted behind my back</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. If someone hurts my friends/family</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Scenarios

**Scenario A**
- A boy pushes cousin
  - Hit the boy
  - Verbalize: I do not like it. Stop.
  - Call a teacher for help.
  - Walk away

**Scenario B**
- Cousins find a gun on the way home.
  - Keep it.
  - Leave it and go home.
  - Leave it and tell a trusted adult.
  - Call the police.

**Scenario C**
- Boy crashes into student, knocking books down, boy keeps running.
  - Mutter under breath, pick up books.
  - Chase boy & knock him into wall.
  - Did you know you knocked my books?
  - Joke: You must be late for track.

**Scenario D**
- Friend tells student another friend wrote on his/her locker.
  - How could you?
  - Ask "Who wrote this on my locker?"
  - "How do you know who did this?"
  - Shake head & clean off locker.

**Scenario E**
- Student sees significant other holding hands with someone else.
  - Plan to beat up new person.
  - Angrily yell at significant other.
  - Meet the new person. Find out situation.
  - Student assumes she/he has lost significant other and walks away.

#### Figure 1
Attitudes of adolescents regarding violence by question and pretest/posttest responses.
Data regarding attitude scores were subjected to further statistical analysis in order to assess which demographic variables were correlated with violent attitudes. In Table 4, gang members’ attitudes about violence which were statistically significant are presented.

Table 4

Significant Relationships Between Gang Membership and Attitudes About Violence

<table>
<thead>
<tr>
<th>Attitude</th>
<th>r</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Okay to take a weapon on campus</td>
<td>.265*</td>
<td>&lt; .05</td>
</tr>
<tr>
<td>Hit someone if they insult me</td>
<td>.357**</td>
<td>&lt; .01</td>
</tr>
<tr>
<td>Hit someone if they threaten a significant other</td>
<td>.234*</td>
<td>&lt; .05</td>
</tr>
</tbody>
</table>

*p < .05. **p < .01.

These findings indicate that gang members held attitudes that violence was acceptable in certain situations. Reasons for carrying a weapon were specifically identified as “to protect self,” “to protect friends and family,” and “to be admired.” Non-gang members
also agreed that hitting another person was an acceptable way to protect self, family, or friends, $r = .391$, $p < .01$.

In the scenario which described finding a gun on the ground, keeping the gun was significantly correlated with several demographic variables. Those correlations can be seen in Table 5.

Table 5

Significant Relationships Between Keeping a Found Gun and Demographic Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>$r$</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weapon carrier</td>
<td>.274*</td>
<td>&lt; .05</td>
</tr>
<tr>
<td>Older student</td>
<td>.306**</td>
<td>&lt; .01</td>
</tr>
<tr>
<td>Male</td>
<td>.223*</td>
<td>&lt; .05</td>
</tr>
<tr>
<td>History of arrest</td>
<td>.192*</td>
<td>&lt; .05</td>
</tr>
</tbody>
</table>

*p < .05. **p < .01.

These findings indicate that older seventh graders, males, students who carry weapons, and students who have a history of being arrested are more likely to hold the attitude that they would keep a gun they found on the
ground rather than turning the gun over to authorities or other trusted adults.

Non-violent attitudes among non-gang members which were significant also were extrapolated and are presented in Table 6. These attitudes were both nonviolent and are considered desirable attitudes for an adolescent to possess.

Table 6

<table>
<thead>
<tr>
<th>Variable</th>
<th>r</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never bring a weapon to school</td>
<td>.243*</td>
<td>&lt; .05</td>
</tr>
<tr>
<td>Never hit another</td>
<td>.233*</td>
<td>&lt; .05</td>
</tr>
<tr>
<td>Tell trusted adult when gun found</td>
<td>.197*</td>
<td>&lt; .05</td>
</tr>
</tbody>
</table>

*p < .05.

The variable of age also emerged as being significantly correlated with nonviolent attitudes in a number of circumstances. Specific nonviolent attitudes which were associated with ages of students may be seen in Table 7.
Table 7

Significant Relationships Between Desirable Nonviolent Attitudes and Age

<table>
<thead>
<tr>
<th>Attitude</th>
<th>r</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use an &quot;I&quot; statement to confront an aggressor</td>
<td>-.320**</td>
<td>&lt; .01</td>
</tr>
<tr>
<td>Tell trusted adult when gun was found</td>
<td>-.419**</td>
<td>&lt; .01</td>
</tr>
<tr>
<td>Call police when gun found</td>
<td>-.202*</td>
<td>&lt; .05</td>
</tr>
<tr>
<td>Accept that best friend has other friends</td>
<td>-.309**</td>
<td>&lt; .01</td>
</tr>
</tbody>
</table>

*p < .05. **p < .01.

These inverse correlations reflect that the younger the student, the more likely the student is to hold attitudes which reflect peaceful conflict resolution skills.

Additional Findings

Two of the attitude items on the research instrument contained response options which reflected attitudes that were nonviolent, but which are not desirable in an adolescent. The response options are undesirable because they reflect a defeatist attitude toward being insulted or
assaulted. Significant relationships between defeatist attitudes and demographic variables are presented in Table 8.

Table 8

<table>
<thead>
<tr>
<th>Variable</th>
<th>r</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Females</td>
<td>.281**</td>
<td>&lt; .01</td>
</tr>
<tr>
<td>Non-weapon carrier</td>
<td>-.390**</td>
<td>&lt; .01</td>
</tr>
<tr>
<td>Non-arrest history</td>
<td>-.202*</td>
<td>&lt; .05</td>
</tr>
<tr>
<td>Non-gang member</td>
<td>-.263*</td>
<td>&lt; .05</td>
</tr>
</tbody>
</table>

*p < .05. **p < .01.

These findings mean that there was a direct correlation between being female and having defeatist attitudes. There were inverse correlations between defeatist attitudes and being a weapon carrier, belonging to a gang, or having an arrest history. Therefore, female students and students with no histories of violent behaviors are more likely to hold defeatist, nonviolent attitudes about being assaulted or insulted.
Summary

The sample, as well as the data collection and analysis for the study, have been presented. Statistical findings revealed no significant change in mean knowledge scores from pretest to posttest; however, there were several attitudes which changed, as well as a number of attitudes on the posttest which were significantly correlated with a variety of demographic variables. In Chapter V, outcomes of the findings will be presented including discussion, conclusions, implications, and recommendations for nursing science.
Chapter V

The Outcomes

Violent injury is among the leading causes of death in adolescents. Adolescents’ immaturity and underdeveloped impulse control put them at risk of acting rashly, thus at higher risk for violent injury. This significant public health problem is a preventive objective of Healthy People 2000. The purpose of this study was to examine the effects of an educational intervention on adolescents’ knowledge and attitudes about violence. The nurse practitioner in a school or family clinic is in an unique position to intervene with adolescent clients using an educational intervention. Orem’s Self-Care Deficit Theory was the theoretical framework for the study. Orem (1995) asserted that people learn methods of action which either promote or adversely affect their functioning and through appropriate educational intervention can return to healthful self-care.

The researcher utilized two research questions, the first concerning adolescent knowledge about violence pre-
and post-intervention, and the second concerning adolescent attitudes about violence pre- and post-intervention. The null hypothesis stated there would be no significant difference in pretest and posttest knowledge scores for adolescents who attend an educational intervention about violence. A preexperimental, pretest-posttest, one-group design was used.

The setting for the research was a middle school in a small, rural, economically-disadvantaged town in the Southeastern United States. The 77 subjects’ ages ranged from 12 to 15 years.

In this chapter, the findings will be discussed and conclusions, implications for nursing science, and recommendations for future research will be set forth.

Summary and Discussion of Findings

Findings from this study, regarding knowledge of adolescents both before and after an educational intervention, showed no significant change in mean knowledge scores from pretest to posttest. However, in correlating knowledge change scores with demographic data, some interesting results were obtained. Gang members’ knowledge scores fell significantly. Knowledge change scores also dropped significantly for weapon carrying
students. This finding means that there was an apparent decline in knowledge scores among these students after the intervention. The statistical significance of this decline means that it is unlikely to have occurred by chance. One explanation is that these students became sensitized by the pretest and developed a reactive effect to the sensitive material. This researcher suspects that students who are gang members, weapon carriers, and have a positive arrest history, in order to maintain their "tough guy" image, may have deliberately given violent responses posttest after having been sensitized to the kinds of answers the researcher sought.

Although no specific data regarding incidents of violence in the middle school were gathered for the study, the researcher learned from the county superintendent of schools that students from the middle school had been involved in several on-campus incidents of physical violence in the last few years. No incidents of gun violence were reported (D. Ash, personal communication, March 31, 1998). The finding that 21 (28.4%) of the subjects in the study group were weapon carriers leads to the assumption that the threat of violence in the middle school is very real. Recent history in the United States
has borne out the fact that some middle-school students, given access to guns, will use them to kill (Roberts & Quillian, 1992). Current findings were consistent with the findings of a study conducted by Kann et al. (1995), who found that student weapon-carrying and school violence were connected. Nationally, 22% of students admitted to carrying a weapon prior to that study, and 16.2% of students had been in a physical fight on school property (Kann et al., 1995). In the Kann et al. study, weapon-carrying was associated with older students, and physical fighting was associated with younger students. Similarly, older students in the current study were significantly more likely to hold the attitude that weapon-carrying on campus is to be admired and that carrying a weapon to protect family and friends was acceptable.

A majority of the students (90%) in this study validated their awareness that students caught weapon-carrying on campus would be suspended. In the attitude section of the questionnaire, approximately 25% to 30% of students indicated they would bring weapons on campus in certain situations. Knowledge of consequences did not correlate with attitudes. Holding the attitude that guns were sometimes necessary was significantly correlated with
gang membership ($p < .05$), which supported the findings of a study by Public Health Service agencies in 1993. In that study, youth engaged in high-risk activities in spite of expressed knowledge of health consequences, because living within their often dysfunctional environments produced a fatalistic view of their own future ("Designing Health Promotion," 1993). These findings are pertinent to NP practice as are the findings of Gielen et al. (1997). The findings of Gielen et al. underscored the importance of prioritizing injury prevention counseling as part of primary prevention in the clinic setting.

As previously discussed, gang members, weapon carriers, and positive arrest history were strongly associated with low knowledge attainment. Students in gangs who had been arrested and carried guns also held attitudes that were associated with violence ($p < .05$). Older students were significantly more likely to belong to gangs ($p < .05$) as were males ($p < .05$). Being an older gang member was also correlated with bringing a weapon on campus to be admired ($p < .05$) and hitting someone in response to an insult ($p < .05$). These data support the Eggert et al. (1994) findings that high-risk youth can be identified by five criteria: (a) youth who have below
average credits for their grade level, (b) have low school performance, (c) are in the top 25% for absenteeism, (d) have prior dropout status, and (e) who are targeted by school personnel as being at risk for dropping out. No specific data were gathered regarding student absenteeism or dropout history, but the fact that older students were 14 and 15 years of age and still in the seventh grade as well as being gang members is evidence that these older students could be high-risk youth. Unfortunately, this educational intervention had no significant positive effect on these youth.

According to findings by Public Health Reports, high-risk youth identified having someone to talk to, whose information they could trust, who would not judge them, and who would be straight with them as being important to changing their high-risk behavior (“Designing Health Promotion,” 1993). The first step a nurse practitioner could take in helping these high-risk youth would be to identify them as part of primary prevention during routine clinic visits. More importantly, nurse practitioners must develop attitudes that reflect trust, honesty, and nonjudgment in order to be effective with these youth.
The Szorady Adolescent Knowledge and Attitude Toward Violence Questionnaire measured students' attitudes toward hitting an aggressor. Data analysis of mean scores indicated a majority of students consider hitting to be an appropriate response in some situations. The response that stated it was all right to hit someone if he or she hit first was the only violent response with which non-gang members consistently agreed (p < .05). This finding supported the conclusion of "Designing Health Promotion" (1993) that some risk-taking behaviors are not considered bad or are considered an inevitable part of youth behavior by some members of society, and especially by parents. Those who venture to intervene with violent youth need to consider the power of these parental messages when attempting to teach conflict resolution. The compilation of the current findings and the findings in "Designing Health Promotion" (1993) lend credence to the proposition of developing conflict resolution programs for parents of high-risk youth.

Except for the violent response discussed above, non-gang members were significantly more likely to give nonviolent responses to potential conflict situations. Others likely to give nonviolent responses were females.
younger students, students with no arrests, and non-weapon carriers. Posttest knowledge levels significantly increased in younger students (p < .01). Additional knowledge increases also were correlated with appropriate nonviolent responses. For example, in one scenario, an aggressor pushed a person’s cousin. Younger students were significantly more likely to use an “I” message to communicate with the aggressor (p < .05). The use of an “I” message to communicate with someone in a conflict situation was taught to the students during the educational intervention video (see Appendix E). There also was a significant overall knowledge increase (p < .05) associated with choosing the “I” message, suggesting that the educational intervention video information about “I” messages may have had a positive effect on some students.

The younger the students, the more likely they appeared to trust in adult authority as was evidenced by nonviolent responses to the scenarios about finding the gun. Younger students were significantly more likely to tell a trusted adult (p < .01) or to call the police (p < .05) upon finding a gun lying on the sidewalk. While there were no corresponding data in the literature, this finding
may indicate that younger students would be more receptive to educational interventions taught by a respected adult, such as a nurse practitioner, and should be taught separately from older, high-risk students.

Scenario E in the Szorady questionnaire was especially meaningful for this group of subjects because a seventh-grade teacher related anecdotally that the students most often physically fought over another student "stealing" a boyfriend or girlfriend (A. Richmond, personal communication, March 27, 1998). Li et al. (1996) noted that 72% of victims injured by assaults were females between the ages of 10 and 14 years, and the most common assault times were 12 noon to 9:00 p.m., Monday through Thursday, in a public place. Based on Li et al. and the personal communication, this researcher focused on the subject of "ownership" of another person as part of the educational intervention lecture. The majority of student responses to the attitude options in Scenario E were in disagreement (> 72%) with the two violent attitude options on both pretest and posttest. Students who were in agreement with a response which involved yelling or threatening another was correlated with gang membership.
(p < .05). Contrarily, 70% chose a nonviolent reply which involved respecting the other's right to make new friends. Additional correlations with a positive response included younger age (p < .01) and an increase in knowledge (p < .01). Though some of the students appeared skeptical when the subject of other's freedom to choose new friends was introduced during the educational intervention lecture, apparently some students were influenced by the new idea.

It is important to discuss the responses considered to be nonviolent but defeatist. Defeatist responses were strongly associated with female gender, non-gang members, no weapon-carrying, and no history of arrests (p < .05). It is commendable that this group of students was not inclined to react violently. On the other hand, this group seemed willing to allow themselves to be "pushed around." These students were not necessarily at risk for instigating violence. However, they may be more at risk for being victims of violence and in need of interventions directed at teaching assertive, but nonaggressive, conflict resolution. This finding goes beyond the parameters of this study, but it will be an area of interest of future research.
Conclusions

Based on the findings of this study, the following conclusions were drawn:

1. Overall knowledge about violence was not significantly improved after the educational intervention.

2. Older males and students who were gang members, weapon carriers, and had a history of being arrested were negatively impacted by the intervention.

3. After the intervention, subjects still held the attitude that using a weapon or a fist to protect oneself and one’s friends and family was acceptable, but the attitude of using a weapon or fist against an insult, or to elicit admiration was less acceptable.

4. Gang members were more likely to bring a weapon to school to protect friends and family, to protect themselves, and to be admired.

5. Gang members were more likely to hit someone if they were insulted and to threaten their significant other if that person became friendly with someone else.

6. Students who admitted to weapon-carrying, gang membership, and/or having been arrested tended to be older male subjects. These students tended to be higher risk
adolescents who may need intensive, nonjudgmental intervention to change high-risk behavior.

7. The younger the subject, the greater the knowledge increase, the more trust is evident in adult authority.

8. Adolescents who are not members of gangs selected more nonviolent conflict resolution responses.

9. Nonviolent defeatist attitudes were significantly more common among females with no history of violent activities.

Implications for Nursing

A number of implications for nursing science were derived from the study. Implications for nursing practice, nursing education, and nursing research are addressed.

Practice. Findings indicate that more time and effort need to be channeled into violence interventions. In order to change knowledge or attitudes, adolescents need to be repeatedly reminded about the consequences of violence. Among adolescents who already have violent tendencies, role-modeling of effective nonviolent conflict resolution is important. Since a classroom type educational intervention was not particularly effective in this study, other interventions, such as behavioral rehearsal for potentially violent situations, might also be implemented.
Nurse practitioners are becoming more recognized as professional health care resources and can capitalize on this recognition in the clinical setting. Nurse practitioners can provide primary prevention by consistently assessing adolescent clients’ knowledge of and attitudes toward violence and by introducing nonviolent conflict resolution alternatives.

Nurse practitioners are provided with a chance to teach, role model, and reinforce conflict resolution skills with every clinic visit. School and community-based nurse practitioners also can teach conflict resolution skills in schools. Since more than one fourth of students aged 12 to 15 years already take weapons to school, interventions must be targeted toward even younger students. Younger students also evidence more trust in adult authority, thus may be more receptive to educational interventions.

Education. Schools of nursing, at the baccalaureate and graduate levels, need to include education on violence and conflict resolution in their curricula and to emphasize the importance of violence as a health care issue. Because nurses will be working with all kinds of people, it is important that they explore, early in the
educational process, their own knowledge and attitudes about violence and the potentially violent client. Student nurses, graduate nurses, and even experienced nurses need educational opportunities to stay abreast of current issues about violence among young people and to rehearse personal conflict resolution methods when faced with potentially violent persons.

Research. Findings from this study, compiled with conclusions from previous studies, indicate that extensive additional research needs to be conducted to determine which conflict resolution interventions do and do not work in the young adolescent population. Apparently, a presentation type intervention with low interaction is not effective enough to significantly affect level of knowledge about violence. Attitudes, however, reflected more dramatic changes in the teaching environment utilized for this study. More studies are needed to determine whether knowledge and attitude changes remain stable over time, and whether a more interactive setting would have a significant impact on either knowledge or attitudes. This researcher also recommends opportunities for adolescents to engage in behavioral rehearsal regarding conflict resolution, followed by empirical studies to assess the
significance of such opportunities on knowledge and attitudes about violence.

Limitations

The design of the study and the experimental treatment imposed a number of threats to the external and internal validity of the current study. The highly publicized occurrences of violence in the United States middle schools between the pre-intervention data collection time and the post-intervention data collection time may have confounded the effect of the intervention.

The content of the pretest also may have affected the students to answer the posttest in a less than honest fashion. The sensitive and personal nature of research, such as that undertaken in this study, often produces an emotional reaction in the subject which can affect responses. Despite the researcher’s explanation and assurances, the students may have felt threatened by some of the questions, thus altering the validity of self-report.

One additional variable, that of the timing of the posttest and the classroom atmosphere during the posttest, is believed to have significantly impacted the internal validity of the current study. The pretest and
intervention were conducted during the spring semester. Students were excited about taking a break from schoolwork to be a part of the study which may have positively affected their motivation. The posttest was conducted one month later, 3 days before school ended. Students were eager for school to end, and their motivation had ebbed considerably.

The sample consisted of 77 seventh-grade students from one public middle school in a small economically disadvantaged town in a rural area of North Mississippi, which may limit generalization to nonrural or urban schools or to other grade levels. The sample was one of convenience, which contributed to a weaker design than if a random sample had been used. A researcher-developed questionnaire was utilized which may have resulted in a questionable degree of reliability and validity.

Recommendations for Future Research

Based on the findings from this study, the researcher makes the following recommendations for future research:

1. Replication of the study with multiple posttest data collection times to verify the gain or decline of knowledge over time.
2. Replication of the study using a more concise instrument to assess attitudes.

3. Conduction of an experimental study in which a similar intervention is presented in small group settings, in group settings which allow for feedback, peer interaction, and behavioral rehearsal, and in one-on-one settings such as would be used in a primary care clinic.

4. Qualitative research exploring attitudes in depth.

5. Studies regarding demographic variables of students and how those variables affect students’ abilities or motivation to change attitudes about violence.
REFERENCES
References


APPENDIX A

SZORADY ADOLESCENT ATTITUDES TOWARD VIOLENCE ASSESSMENT QUESTIONNAIRE
Instructions

1. DO NOT write your name on the questionnaire. The answers you give will be kept private and confidential.

2. Completing the questionnaire is voluntary. Your grade in this class will not be affected by whether or not you complete the questionnaire. There is no pass or fail.

3. Please answer ALL the questions on the form.

4. In the Knowledge section of the questionnaire, please do not guess at an answer. If you do not know the answer, please mark “I don’t know.”

5. In the Attitude section, read each situation and each answer.
   a. If the answer is something you definitely really would do in that situation, mark SA (Strongly Agree)
   b. If the answer is something you might do or probably would do, mark A (Agree).
   c. If the answer is something you might not do or probably would not do, mark D (Disagree)
   d. If the answer is something you absolutely really would not do in that situation, mark SD (Strongly Disagree).

5. Remember, the Attitude section is not measuring right or wrong. This section is measuring what real students would do in situations.

6. When you finish, please place the questionnaire face down in the box provided.
Szorady Violence Assessment Questionnaire

Knowledge Section

The following questions will measure your level of knowledge about violence. If you do not know if a question is true or false, please mark "Don't know."

1. Gun murders in the United States hardly ever occur between family members or acquaintances.
   True      False      Don't know

2. In a recent study, "fear of bullies" was one of the most common concerns listed by middle-school youngsters.
   True      False      Don't know

3. Gun violence is the third leading cause of death for middle-school youngsters.
   True      False      Don't know

4. There are no problems with gang violence in Byhalia, Mississippi.
   True      False      Don't know

5. Firearms kill more people between the ages of 15 and 24 years than all other natural causes combined.
   True      False      Don't know

6. If 100 eighth graders were asked, in a study, if they had been threatened with a weapon at school, at least 20 of them would answer "yes."
   True      False      Don't know

7. According to Henry Middle School Policy, a student found with a weapon (gun, knife) at school will be suspended.
   True      False      Don't know

8. It is common, in large public schools, for over one third of the males and one sixth of the females to report carrying a weapon (gun, knife) to school.
   True      False      Don't know
Attitude Section

The following questions will assess your attitudes about violence. Please answer them as you really believe you would react. The answer scale can be read as follows:

SA = Strongly Agree
A = Agree
D = Disagree
SD = Strongly Disagree

1. I might have to bring a weapon to school
   - To protect myself.
     SA   A   D   SD

2. I might have to bring a weapon to school
   - To protect my friends.
     SA   A   D   SD

3. I might have to bring a weapon to school
   - To be admired at school
     SA   A   D   SD

4. I should never bring a weapon to school
     SA   A   D   SD

5. It is all right to hit someone
   - Who hits me first.
     SA   A   D   SD

6. It is all right to hit someone
   - Who insults me behind my back.
     SA   A   D   SD

7. It is all right to hit someone
   - Who hurts my family/friends.
     SA   A   D   SD

8. It is not all right to hit someone.
     SA   A   D   SD
Attitude section (continued)

The following questions come from five different situations which are made up, but which could be real. Please answer each question as you might react to the situation.

A. I am on the playground at school with my cousin. A boy comes over and pushes my cousin for no reason. I will
1. hit or push the boy for pushing my cousin.  
   SA A D SD 
2. tell the boy, "I do not like it when my cousin is pushed. Please, stop!"  
   SA A D SD 
3. call a teacher to help us.  
   SA A D SD 
4. walk away with my cousin.  
   SA A D SD 

B. On the way home from school, I, and my brother find a gun on the ground. We will
1. pick it up and keep it. Wow! A free gun!  
   SA A D SD 
2. leave it there and go on home.  
   SA A D SD 
3. leave it there and tell a trusted grown-up.  
   SA A D SD 
4. call the police.  
   SA A D SD 

C. I am on my way to class when a boy, running down the hall, crashes into me, knocking my books on the floor. The boy keeps going down the hall. I will
1. mutter under my breath, pick up my books, and continue on to class.  
   SA A D SD 
2. chase down the boy and knock him into a locker.  
   SA A D SD 
3. call, "Did you realize you knocked all my stuff on the floor?"  
   SA A D SD 
4. joke, "You must be late for track team tryouts."  
   SA A D SD
D. My girlfriend, Darla, tells me, “Did you know Tamika wrote something nasty about you on your locker? I thought you two were friends.” I rush over to my locker to find Tamika, along with several other students, staring at it.
I will
1. **grab Tamika’s arm and shout, “So it’s true, you trash! How could you?”**
   SA     A     D     SD
2. **ask, “Does anyone know who wrote this on my locker?”**
   SA     A     D     SD
3. **turn to Darla and ask how she knows Tamika did this.**
   SA     A     D     SD
4. **shake my head in disgust and begin to clean off my locker.**
   SA     A     D     SD

E. I see my girlfriend/boyfriend walking down the hall with someone else. As they walk outside together, they hold hands. I will
1. **... be really angry! That’s my girlfriend/boyfriend! I start planning how I will get some of my friends together and beat up this other person who’s trying to take my friend.**
   SA     A     D     SD
2. **race after them, pull their hands apart and face my friend angrily yelling or threatening to hit him/her.**
   SA     A     D     SD
3. **walk over to meet my friend and his/her new friend. Maybe this is a cousin or old friend and we can be friends too. Or maybe my friend has found someone else. That would be hard to deal with, but my friend and I both have the right to meet and like new people.**
   SA     A     D     SD
4. **look at the two of them walking hand in hand, and shrug, “Well, I guess I’ve been dumped. I wonder when he/she was going to tell me?” Turn and walk sadly away.**
   SA     A     D     SD

This is the end of the questionnaire. Remember, do not put your name on this paper. Please take it to the teacher’s desk and place it face down in the box provided. Thank you for your participation in this study.
1. Gender
   — Male
   — Female

2. Age: ____________

3. Race
   — White
   — African American
   — Asian American
   — Hispanic/Latino
   — Southeast Asian (Cambodian, Vietnamese)
   — Native American
   — Other (please specify): __________________

4. Grade: ____________

5. Who do you live with?
   — Father and mother
   — Father
   — Mother
   — Grandparent(s)
   — Other family member(s)
   — Guardian

6. Do you have any brothers or sisters?
   — Yes
   — No
   If so, please list their ages:
   Brothers: ____________  Sisters: ____________

7. Have you attended any educational programs about violence, anger management, or conflict resolution?
   — Yes
   — No
8. Are you a member of a gang?
   _____ Yes
   _____ No

9. Do you own a gun or a knife?
   _____ Yes
   _____ No

10. Have you ever been arrested?
    _____ Yes
        _____ No
APPENDIX B

APPROVAL OF THE COMMITTEE ON USE OF
HUMAN SUBJECTS IN EXPERIMENTATION OF
MISSISSIPPI UNIVERSITY FOR WOMEN
February 21, 1998

Ms. Jean E. Szorady  
c/o Graduate Program in Nursing  
Campus  

Dear Ms. Szorady:  

I am pleased to inform you that the members of the Committee on Human Subjects in Experimentation have approved your proposed research with the requirement that questions (1) and (2) be changed from the first person to the third person.  

I wish you much success in your research.  

Sincerely,  

Susan Kupisch, Ph.D.  
Vice President  
for Academic Affairs  

SK:wr  

cc: Mr. Jim Davidson  
Dr. Mary Pat Curtis
APPENDIX C

EDUCATIONAL INTERVENTION TOOL
Video from the Bureau for At Risk Youth
135 DuPont Street
P. O. Box 760
Plainview, NY 11803-0760

Video Title: "Understanding and Resolving Conflicts for Grades 5 through 8"

Through incidents with which students could identify and clear step by step demonstrations, viewers learned how collaboration between feuding parties could be a real win-win way to settle conflicts. Skill building communication techniques and tips were offered so that misinterpretation was minimized during disputes. Mutual respect, active listening, and sending I-messages were encouraged as ways to improve communication. Students learned that it is how conflicts are handled that makes them a destructive episode or a positive experience. Included a 20-minute video and Teacher's guide. The video was followed by a 30-minute lecture by the researcher on misinterpreted communications, on respecting each other's rights, and on the importance of stopping to think of consequences before reacting violently to a conflict situation.
APPENDIX D

CONSENT FORM OF SUPERINTENDENT
March 30, 1998

Donnal Ash, Superintendent
Marshal County School System
P. O. Box 38
Holly Springs, MS 38654

Dear Sir,

My name is Jean E. Szorady. I am a registered nurse and a graduate nursing student at Mississippi University for Women in Columbus, Mississippi. I am conducting a research study concerning the effects of an educational intervention on the knowledge and attitudes of middle school students regarding violence.

The questionnaire, teaching plan, and consent forms, for the research study, have been reviewed and accepted by the Committee on Use of Human Subjects in Experimentation at the Mississippi University for Women. The study participants will be involved in a 50-minute educational intervention consisting of a lecture and a 20-minute video entitled “Understanding and Resolving Conflicts.” The video’s comprehension level is for children in Grades 5 through 8. Through incidents with which students can identify, students are shown how collaboration between feuding parties can be a win-win way to settle conflicts. Skill building, communication techniques are offered and mutual respect, active listening, and sending I-messages are encouraged as ways to improve communication. Students are taught it is how conflicts are handled that makes them a destructive episode or a positive experience.

The participants will voluntarily complete a questionnaire prior to and one month after the 50-minute teaching program. They will be informed of their rights as research subjects and will be assured of confidentiality and anonymity. Subject’s consent, as well as parental consent, will be obtained prior to completing the questionnaire. I have included the questionnaire, consent forms, and a description of the educational intervention for your examination.
If you have any questions or concerns, please call me at my home telephone number, (901) 373-9593, or my cellular telephone (901) 340-9593. If I am not available, please leave a message at either number, and I will return your call promptly.

Thank you for your time and consideration in this matter.

Sincerely,

Jean E. Szorady
Consent of Superintendent

I understand that Jean E. Szorady, a registered nurse and a graduate nursing student at Mississippi University for Women in Columbus, Mississippi, will be conducting a research study in Henry Middle School. I understand that the participants (middle-school students) will complete a questionnaire just prior to and one month after a teaching program assessing their knowledge and attitudes concerning risks of violent behavior. The teaching program will be an educational intervention which consists of a 20-minute video entitled "Understanding and Resolving Conflicts" and a 30-minute lecture. I understand that the participants will be informed that participation in the study is voluntary and their confidentiality will be assured. Participants will also be informed that their participation or nonparticipation will have no effect on their grades or status at school. I understand also that participation in the study will require parental consent for each student as well as consent from each student.

I understand the above information and give my consent to Jean E. Szorady to conduct the described study in Henry Middle School.

Superintendent's Signature: ______________________________

School System: ______________________________

Date: ______________________________
APPENDIX E

CONSENT FORM OF PRINCIPAL
March 30, 1998

Mr. Alva Gipson, Principal
Henry Middle School
P. O. Box 429
Byhalia, MS 38611

Dear Sir,

My name is Jean E. Szorady. I am a registered nurse and a graduate nursing student at Mississippi University for Women in Columbus, Mississippi. I am conducting a research study concerning the effects of an educational intervention on the knowledge and attitudes of middle school students regarding violence.

The questionnaire, teaching plan, and consent forms, for the research study, have been reviewed and accepted by the Committee on Use of Human Subjects in Experimentation at the Mississippi University for Women. The study participants will be involved in a 50-minute educational intervention consisting of a lecture and a 20-minute video entitled "Understanding and Resolving Conflicts." The video's comprehension level is for children in Grades 5 through 8. Through incidents with which students can identify, students are shown how collaboration between feuding parties can be a win-win way to settle conflicts. Skill building, communication techniques are offered and mutual respect, active listening, and sending I-messages are encouraged as ways to improve communication. Students are taught it is how conflicts are handled that makes them a destructive episode or a positive experience.

The participants will voluntarily complete a questionnaire prior to and one month after the 50-minute teaching program. They will be informed of their rights as research subjects and will be assured of confidentiality and anonymity. Subject's consent, as well as parental consent, will be obtained prior to completing the questionnaire. I have included the questionnaire, consent forms, and a description of the educational intervention for your examination.
If you have any questions or concerns, please call me at my home telephone number, (901) 373-9593, or my cellular telephone (901) 340-9593. If I am not available, please leave a message at either number, and I will return your call promptly.

Thank you for your time and consideration in this matter.

Sincerely,

Jean E. Szorady
Consent of Principal

I understand that Jean E. Szorady, a registered nurse and a graduate nursing student at Mississippi University for Women in Columbus, Mississippi, will be conducting a research study in Henry Middle School. I understand that the participants (middle-school students) will complete a questionnaire just prior to and one month after a teaching program assessing their knowledge and attitudes concerning risks of violent behavior. The teaching program will be an educational intervention which consists of a 20-minute video entitled "Understanding and Resolving Conflicts" and a 30-minute lecture. I understand that the participants will be informed that participation in the study is voluntary and their confidentiality will be assured. Participants will also be informed that their participation or nonparticipation will have no effect on their grades or status at school. I understand also that participation in the study will require parental consent for each student as well as consent from each student.

I understand the above information and give my consent to Jean E. Szorady to conduct the described study in my school system.

Principal’s Signature: ____________________________

School System: ________________________________

Date: ____________________________
APPENDIX F

CONSENT FORM OF STUDENT
Consent Form

(Student)

My name is Jean E. Szorady. I am a registered nurse and a graduate nursing student at Mississippi University for Women in Columbus, Mississippi. I am conducting a research study on the knowledge and attitudes of middle-school students about violent behavior. I would like to ask you to participate in my study. The study will require completing a list of questions, called a questionnaire, just before listening to a 50-minute teaching program. One month later you will answer another questionnaire. All the answers on everyone’s questionnaires will be grouped together into general answers so no one person’s answers will be known. The information from the questionnaires will be used to help plan future programs about violent behavior to help young people your age.

The questionnaire is not a test. There is no pass or fail, and it does not have any effect on your school grades or status in school. The choice to participate or not to participate is left up to each individual student. You will not put your name on the questionnaire, and there will be no way to find out your name. You may withdraw from the study at any time up to the time you turn in the questionnaire.

I have read the above statements and understand that this study will not have any effect on my school grades. I understand that all information will be kept confidential.

______ Yes, I will participate in the study.
______ No, I do not wish to participate in the study

Student’s Signature ____________________________ Date ________________________
APPENDIX G

CONSENT FORM OF PARENT/GUARDIAN
My name is Jean E. Szorady. I am a registered nurse and a graduate nursing student at Mississippi University for women in Columbus, Mississippi. I am conducting a research study on the knowledge and attitudes of middle-school students on the risks of violent behavior. I would like your child to participate in my study. I am asking all the students in his or her class to participate. The study will require completing a questionnaire just before listening to a 50-minute teaching program. One month later, another questionnaire will be filled out. All the answers on everyone's questionnaires will be grouped together into general answers so no one person's answers will be known. The information obtained from the questionnaires will be used to help plan future programs to teach students how to manage conflict without resorting to violence.

The questionnaire is not a test. There is no pass or fail, and it does not have any effect on his or her school grades or status in school. The choice to participate or not to participate is left up to each individual student, who must also have his or her parent's or guardian's permission. Your child will not put his or her name on the questionnaire, and there will be no way to find out the name. Your child may withdraw from the study at any time up to the time he or she turns in the questionnaire.

I have read the above statements and understand that this study will not have any effect on my child's school grades. I understand that all information will be kept confidential.

Yes, I will allow my child to participate in the study.

No, I do not wish for my child to participate in the study.

Parent's or Guardian's Signature  Date