Nursing Interventions for Bullying in a Kindergarten to Grade Eight School

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Bullying in schools is an issue that is gaining recognition as a serious health concern due to its many physical and emotional effects (Abada, Hou, & Ram, 2008; Black, Washington, Trent, Harner, & Pollock, 2009). The focus of this paper is limited to bullying between peers from kindergarten to grade eight which takes place on school grounds. The concept of bullying from the literature will be explored, as well as the concerns surrounding bullying including the current trends in Canada and the effects of bullying and victimization. Thereafter, the paper will describe three interventions targeted at bullying which can be implemented by a public health nurse at a kindergarten to grade eight Canadian school.

Concept of Bullying

Olweus (1994), one of the seminal researchers on the topic of bullying, identified three key components that distinguish the act of bullying from other forms of aggression: the bully has the intent to harm, the bullying occurs “repeatedly and over time”, and a power differential exists between the bully and the victim (p.1173). Craig and Pepler (2003), leading Canadian researchers in the field, add that bullying is stressful for the victim. They also highlight that the imbalance of power is reinforced through each act of bullying, creating a cycle from which the victim finds it difficult to escape. Craig and Pepler indicate that external interventions may be necessary to break the cycle of bullying.

Types of bullying are often classified in the literature as direct or indirect bullying (Craig & Pepler, 2003; Mishna & Alaggia, 2005; Olweus, 1994). Direct bullying is described as physical or verbal assaults on the victim which are fairly obvious in nature, such as hitting, kicking, threats, and name-calling. Indirect bullying is aimed at damaging the victim’s social status and is often much less detectable, including gossiping, spreading rumours, and convincing
others to socially exclude the victim. Boys experience and commit higher rates of direct bullying while girls are more often the targets of indirect bullying (Craig & Pepler, 2003; Olweus, 1994). Olweus (1994) also established that boys bullied more often than girls.

Another aspect of the concept of bullying relates to the characteristics of bullies and victims as described here from the works of Smokowski and Kopasz (2005) and Olweus (1994). Victims are generally younger, smaller, less popular, and physically weaker than those who bully them. They typically have a passive or submissive attitude, and may be seen as targets that cannot retaliate. Parents of victims are often characterized as overprotective. Bullies tend to exhibit aggressive behaviour in general, even towards adults, and seem to find reward in dominance over others. Denial of the extent to which they bully is common. Bullies may come from homes where the parenting style is either authoritarian or permissive, and the aggressive behaviours of the child are viewed as normal.

**Trends and Concerns Related to Bullying**

Many Canadian children will be exposed to bullying at school. According to Statistics Canada (2009) in the *2008/2009 Census at School*, a total of 35.5% of elementary students reported being bullied within the last month. Overall, higher rates were reported for girls (37.5%) than for boys (33.3%) although more boys (5.2%) than girls (4.3%) reported having been bullied in the highest frequency category of ten or more incidents in the last month. This trend was also observed in secondary school students although the overall rate declined to 22.5%.

A more in-depth survey of physical aggression, the Health Behaviour in School-Aged Children Survey (or HBSC), is conducted every four years by the World Health Organization for children in grades six to ten. Pickett, Ianotti, Simons-Morton, and Dostaler (2009) analyzed trends from the HBSC in the 2001 to 2002 academic year. In the Canadian data, they found that
the highest rates of experienced physical aggression were reported by the youngest students and by boys in every age group. The survey also stratified responses by four different environmental variables, and the authors found the highest rates of physical aggression for both sexes consistently occurred where socioeconomic status, parental support, peer support, and satisfaction with the school environment were lowest. Craig and Pepler (2003) identify Canada’s rates of bullying and being bullied as in the top third of all 36 countries participating in the 2002 HBSC. The Public Health Agency of Canada (2008) reports that a slight decrease has been seen in the overall rates of bullying between the 2002 and 2006 HBSC surveys.

Concerns about bullying arise from the plethora of effects on the mental and physical health of a victimized child. Research indicates that victims of bullying have an increased incidence of anxiety, depression, low self-esteem, and thoughts of suicide (Abada et al., 2008; Obadina, 2009; Whitted & Dupper, 2005). Physical and psychosomatic complaints are also higher among victims (Abada et al., 2008; Smokowski & Kopasz, 2005). Victims’ grades may suffer if they create negative associations with school and stay away from school to avoid bullies (Abada et al., 2008; Black et al., 2008; Whitted & Dupper, 2005). Abada et al. (2008) assert that support from family and more importantly from peers can be protective factors against some of these effects while immigrants, children from single-parent families, and girls are at higher risk of suffering these effects over the long-term. Mishna and Alaggia (2005) identified a further risk phenomenon; the victims who were bullied most often, those individuals in most need of assistance, were the least likely to report being bullied.

Bullying affects not only the victims. Bullies may also suffer from depression and psychosomatic complaints (Fekkes, Pijpers, & Verloove-Vanhorick, 2006). Whitted and Dupper (2005) assert that bullying disrupts the entire learning environment, and even those children who
have never been bullied may be inhibited by fears of becoming a target. Additionally, they point out that being a bystander can be distressing to students.

Many researchers believe that the effects of bullying extend well beyond the school years. Pepler, Jiang, Craig, & Connoly (2008) indicate that bullying among children may affect both the bullies’ and the victims’ chances of forming healthy relationships later in life. Furthermore, boys who bullied as children were up to four times more likely to be involved in criminal activities by early adulthood (Olweus, 1994; Smokowski & Kopasz, 2005).

Interventions in a Kindergarten to Grade Eight School

The following interventions to reduce bullying are designed for a public health nurse working in a kindergarten to grade eight school in Canada.

**Intervention One: Motivate Staff Compliance**

According to Fekkes et al. (2006), in schools where anti-bullying programs were implemented, it was found that the incidence of bullying decreased in the first year of implementation, yet the rate increased again during the second year. This outcome was hypothesized to be the result of staff complacency resulting from the false impression that bullying was under control. This intervention is designed to increase staff awareness and keep staff compliance high. Without staff compliance, few of the interventions can be successful. The two components of this intervention are ongoing assessment of bullying in the school and staff training.

**Ongoing assessment.** Whitted and Dupper (2005) found that staff had a poor understanding of what constituted bullying in the eyes of the students; thus, staff often failed to react to instances of bullying. The authors advocated the need for assessment to address this issue. Craig and Pepler (2003) have developed a simple four question survey for students as a
risk assessment tool to determine whether, as the bully or the victim, “how frequently bullying occurs…over what period of time…in how many different places or relationships…[and] how serious the aggressive behaviour and the impact associated with the bullying is” (p.580-581). Once a term, this anonymous survey could be administered by the public health nurse, and the results could be shared with the staff during special training or regular staff meetings. In addition, Obadina (2009) suggests establishing a hotline and/or a comment box where students could anonymously report bullying. While it may not be possible to address the reported incidents directly, the nurse could keep staff informed in order to focus surveillance and motivate a continued staff effort.

**Staff Training.** Staff training is widely recommended in order to increase awareness and provide guidelines to staff (Fekkes et al., 2006; Obadina, 2009; Whitted & Dupper, 2005). Staff training could be provided by the nurse during an in-service day, and would include information and discussion about the concept, current trends, and the effects of bullying as outlined above. The nurse would also share assessment results at this time. An administrator would describe school policy with regards to guidelines of what constitutes bullying behaviour and expected disciplinary procedures. The nurse would also review all interventions being implemented as part of the overall anti-bullying strategy.

**Intervention Two: Modification of High-Risk Environments**

Within the school setting, bullying is most likely to occur in less supervised areas (Smokowski & Kopasz, 2005). Playgrounds, lunchrooms, and hallways are locations with the highest incidence of bullying (Black et al., 2008). Moreover, it is known that bullies tend to victimize children who are younger and weaker than themselves (Kvarme, 2008; Olweus, 1994). Thus, the following components of the intervention are designed to create an increase in
appropriate supervision and to separate bullies from potential victims in high-risk school settings.

**Increase supervision in the playground and lunchrooms.** The nurse will seek support from the administration in creating a schedule of supervision that allocates a minimum of one adult supervisor for every 30 students for each recess and lunch period. To supplement the staffing needs for this endeavor, the nurse will send a letter home to parents and a note in the school newsletter requesting parent volunteers. All parent volunteers will be asked to complete a Child Abuse Registry check. Supervisors will be required to attend an orientation facilitated by the public health nurse or an administrator which defines unacceptable behaviour and appropriate disciplinary actions as per school policy. Supervisors on the playground will be encouraged to join in on student activities to discourage less obvious forms of bullying; Black et al.(2008) claim this strategy is well-received by students.

**Supervision in hallways.** The public health nurse can recommend the following measures to increase supervision during busy times and limit student access to hallways when supervision is unavailable. School hallways are most busy before and after school, and during break times between class, recess, and lunch. At these times, educational assistants not assigned to a particular student could be asked to supervise the hallways. Teachers could be encouraged to remain near the doors of their classrooms in order to monitor activity both in the hallways and in their own classrooms. During times when an entire class is moving from one room to another, a staff member will escort the students. Outside of break time, teachers will restrict the number of students who are allowed to leave the classrooms and reasonably limit the amount of time out of the classroom. All teachers can be asked to keep classroom doors open to facilitate some level of
hallway monitoring at all times. Video security cameras may be installed in hallways to discourage obvious bullying.

**Separating bullies from potential victims.** Based on the above premise that victims are often younger than those who bully them, the public health nurse can recommend the following strategies to minimize the exposure of younger students to older students. The first strategy is to stagger recess times into two or three groups by age, depending on what the school schedule permits. For example at lunchtime, kindergarten to grade three students could use the lunchroom while grade four to eight students use the playground, then switch after half an hour. A second strategy is to allocate different areas of the playground to different grades on a rotating basis. For example, at one recess, kindergarten students might only be allowed on the play structure. Play with older students might be permitted in common areas but would still give all younger students a safe option.

**Intervention Three: Universal Education of Students and Parents**

While the percentage of students who are bullies, victims, or both is alarming, the majority of students are neither a bully nor a victim (Craig & Pepler, 2003). However, the presence of students who observe bullying without intervening may play a crucial role in reinforcing the bully’s behaviour (Bauer, Lozano, & Rivara, 2007). Whitted and Dupper (2005) argue that bystanders can be taught to reduce bullying by intervening, reporting incidents to adults, and by social inclusion and support of the victim. They claim that the most effective interventions “seek to change the culture and the climate of the school” (p.169). Recall also Craig and Pepler’s (2003) assertion that victims are unlikely to escape bullying on their own due to the fact that power differentials increase with each interaction with the bully. A meta-analysis on the effectiveness of anti-bullying interventions concluded that interventions targeted to all
students, especially those with a cognitive component such as social problem-solving, were successful in reducing bullying (Wilson & Lipsey, 2007). Drolet, Paquin, and Soutyrine (2006) as well as Snokowski and Kopasz (2005) contend that parents must also be included in the process of changing the social skills of the students. Thus, the following intervention is intended to educate both students and parents about bullying with particular emphasis on bystanders can contribute to helping victims and reducing bullying. Components of the intervention include a community event, classroom meetings, and distribution of handouts to students and parents.

**Community event.** Black et al. (2008) suggest that a community event focused on bullying and hosted by the school can be used both to signal change and to promote awareness. They also note that student involvement in the event increases parental attendance. The public health nurse would request the involvement of school staff by helping the younger students make creative posters to share their ideas about how bullying feels or how to reduce bullying, as well as posters outlining the school rules with regards to bullying. Older students would be responsible for putting together a song or skit about bullying for a performance at the event. Refreshments will be served, and anti-bullying colouring sheets provided to the younger children.

**Classroom meetings.** The nurse will recommend that the school implements classroom meetings on the topic of bullying to educate students about techniques to deal with bullying and to influence the attitude of the class towards bullying behaviour. Olweus (1994) includes classroom meetings as a key component of his Bullying Prevention Program. In his analysis of the effectiveness of the program, he singled out this one component as notably reducing rates of bullying. Since the publication of this key finding, classroom meetings have been widely adopted as part of various anti-bullying campaigns in schools (Black et al., 2008; Snokowski & Kopasz,
Classroom meetings are to be held weekly. Black et al. (2008) identify that a barrier to implementation was the teachers’ view that the meetings would take up valuable class time until it was pointed out that a reduction in bullying behaviour would increase available learning time in the long run. Each meeting should allow the students an opportunity to voice their experiences and opinions about bullying, and reinforce strategies to deal with bullying. The initial classroom meetings could be led by the public health nurse in order to present information on bullying and related strategies, as well as to model the meeting for teachers. Subsequent meetings could be led by the teacher and be based on information and scenarios provided by the public health nurse. The public health nurse could use a teaching technique designed by Morrison (2009), titled “What Would You Do, What If It’s You?” (p.201). In this tool, Morrison has laid out presentation information and strategies to share with the students, as well as some example scenarios of bullying. For the purposes of this intervention, Morrison’s technique could be adapted as follows. Each week, a different group of three students could be presented with one scenario of bullying. At the next class meeting, the students would act out the scene and present a possible solution; one student would take the role of the bully, one the victim, and one the bystander. For very young grades, teachers, educational assistants, or older students might need to act out the scenarios. After the presentation, the class could evaluate the scenario with guidance from the teacher. Classes will be reminded that befriending the victim is one way to provide support (Snokowski & Kopasz, 2005).

**Distribution of handouts.** Bastable (2006) recommends the use of written materials as a valuable tool for health education. The nurse would provide a handout for the students to take home in order to educate the parents about the issues of bullying and provide parents with some skills to share with their children. Winnipeg School Division 1 (2008) has put together two
excellent handouts titled “Making a Difference in Bullying: What Parents of Elementary School Children Need to Know” and “Making a Difference in Bullying: What Parents of Teens Need to Know”.

Conclusion

Bullying is a complex issue with serious short and long-term mental and physical effects on a child’s health. Victims may need assistance from others, including a public health nurse, in order to reduce bullying or its effects. Increasing staff awareness as a means of motivating compliance, modifying high-risk school settings, and educating students and parents are three interventions which could be implemented by a public health nurse to reduce bullying in schools.
References


http://ww.wsd1.org/parents/documents/Bullying-Elementarybooklet.pdf
