

Mental Health Approaches to Violence Prevention in Schools

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Violence in schools has been linked over and over again to mental health issues. One February afternoon in 1984, a man named Tyrone Mitchell randomly fired shots onto the campus of a Los Angeles elementary school. The gunfire continued for 90 minutes and during that time students were terrorized, two children were killed, and other children and staff members were injured. Much later, Mr. Mitchell's mental health history revealed that he had grown up in south central Los Angeles near the school, in an exceptionally religious family. He always presented school discipline problems. Tyrone became psychotic; the precipitating event for that psychosis was the death of his entire family at Jonestown. He was hospitalized for depression; he was in despair. The shooting took place after his release from a Los Angeles hospital. His history helps us to understand that there are circumstances preceding school violence.

There have been other examples of school violence perpetrated by those who have a history of needing help with mental health issues. The FBI has released a report on school violence that indicates that violent offenders have just as many issues around depression and suicide as they do around homicidal impulses. The World Health Organization viewed all possible causes of disability (medical and psychiatric) throughout the world and has gleaned the fact that major depression is the leading cause of disability throughout the world. Closer to home, the U.S. Surgeon General published the first national report about mental health disorders in

1999. At that time it was disclosed that one-fifth of all children have mental health issues in any one year severe enough to require the intervention of a mental health professional. The issues include school phobia, anxiety disorders, and depression. Barriers to getting help include the stigma associated with obtaining that help, lack of communication between school and home, ignorance of risk factors for violence by school personnel, and lack of counseling resources within schools.

Each year there are 32,000 suicides in the United States. This number has not changed significantly over the past several years; however, the population at risk for committing suicide is now younger (14–17 year-olds). Teens are at an impulsive age, and children often have poor judgment, but children who complete suicide also have a preexisting mental health problem, which most often is depression. Childhood depression does not appear the same as adult depression. We associate adult depression with withdrawal from social contacts, increased sleep time, failure to get dressed and do meaningful work during the day, etc. Childhood depression, on the other hand, can present as aggressive behavior toward others; these children are agitated, irritable and anxious. They present a discipline problem. The depressed child may also exhibit somatic symptoms that bring him or her to the school nurse.

In helping to evaluate the threat that a student might pose to himself or to others, the FBI has published a report on school shootings to the time of the Columbine HS event. The major points of this FBI report

included the profile of an individual who is at risk for violent behavior:

- Personality and history
 - The child did not take responsibility for any self-inflicted trouble.
 - The child demonstrated themes of violence in many areas.
 - The child held grudges over years.
 - There was a leakage of violent themes into many areas; classmates know.
- Family dynamics
 - The family is afraid of the student; the parent–child relationship is conflicted.
 - The family has normalized pathological behavior at home for years.
 - The child's deviant behavior is "explained away."
 - There is accessibility to a weapon.
 - Other observable signs and symptoms are present before an incident.
- School dynamics
 - Stressful interactions within the school community may precede any violent acting out.
- Social dynamics
 - How well does the child in question interact with community, family, friends?

What about the children who have been the victims of violence or who have witnessed violence in their everyday lives? Studies have shown that children who are exposed to life-threatening violence often have experienced a number of mental health conditions, including posttraumatic stress syndrome and depression. These children cannot concentrate and cannot do well academically; their absences increase. Few

children of violence receive any sort of mental health help. Those who do, however, enjoy a significant level of symptom reduction and an accompanying improvement in academic performance. Parents of children receiving mental health services report an improved parent-child relationship. If school nurses, who often see children out of the academic context, can assess their pain and connect them with help, their suffering can be alleviated. Perhaps, too, further violence can be forestalled.

What, then, is good mental health in children? It is a condition demonstrated by children in the ability to work, to learn and to love. We can each contribute to the good mental health of the children we see every day by being alert and attentive to the pos-

sibility of mental distress among those we serve and by doing something about it.

AUTHOR'S NOTE:

We are trained professionals who know the importance of listening to children, both for what they say and what they do not say. We might look with a jaundiced eye at frequent fliers, questioning their latest sickness (thinking subject phobia, or depression, or bullying by others, or lack of preparedness for class, etc.) wondering whether to be tough or more sympathetic, to listen at length and refer, or hurry the child to class. The sorting out of these issues is a science and an art. There is no checklist that will give us an easy way to discern an answer. There are flags, however, that will signal us to listen carefully. There are teachers to

confer with — in the hall as we pass by, or by chance here or there, or even formally — who can help us try to make sense of what we hear. We can communicate with families. We can help to find a way to connect these children who are in desperate mental health difficulties with someone who can actually help them move away from their pain, before it is too late for them and for others.

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