



**The Effectiveness of Violence Prevention Program on Violence
of Thai-High School Adolescents**

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ชื่อวิทยานิพนธ์	ประสิทธิผลของโปรแกรมการป้องกันความรุนแรง ต่อความรุนแรง ของนักเรียนวัยรุ่นไทย ในโรงเรียนมัธยมศึกษา
ผู้เขียน	นางวินีกาญจน์ คงสุวรรณ
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บทคัดย่อ

การใช้ความรุนแรงในวัยรุ่นมีจำนวนมากขึ้น และเป็นปัญหาสังคมที่ควรได้รับการดูแล การศึกษาครั้งนี้มีวัตถุประสงค์เพื่อศึกษาประสิทธิผลของโปรแกรมการป้องกันความรุนแรงต่อความรุนแรงของนักเรียนวัยรุ่นไทยในโรงเรียนมัธยมศึกษา โปรแกรมสร้างขึ้นจากทฤษฎีความพร้อมในการดูแลตนเองและแนวคิดความรุนแรง ทำการทดสอบประสิทธิผลโดยใช้รูปแบบการวิจัยเชิงทดลอง ซึ่งศึกษาเปรียบเทียบระหว่างช่วงเวลา ที่มีกลุ่มตัวอย่างเป็นนักเรียนวัยรุ่น 45 คน อายุ 12-15 ปี ประเมินประสิทธิผลของโปรแกรมโดยใช้แบบวัดพฤติกรรมก้าวร้าว แบบวัดทัศนคติทางบวกต่อการใช้ความรุนแรง แบบวัดทักษะการจัดการความรุนแรง ได้แก่ ทักษะการสร้างสัมพันธภาพระหว่างบุคคล การเผชิญกับภาวะอารมณ์ และความเครียด ทักษะการแก้ไขปัญหา และความรับผิดชอบต่อสังคม และใช้การสังเกต พฤติกรรมการใช้ความรุนแรงทางร่างกาย

และทางวาจา จากระยะเริ่มต้นในสัปดาห์แรก หลังจากนั้นนักเรียนยังคงได้รับการดูแลตามสภาพ เดิมของโรงเรียนตลอด 12 สัปดาห์ แล้วจึงดำเนินการให้การดูแลตามโปรแกรมการป้องกันความ รุนแรงอีก 12 สัปดาห์ ได้ประเมินความพึงพอใจของนักเรียนต่อประสิทธิผลของโปรแกรม โดยใช้ แบบสอบถามความพึงพอใจในการปฏิบัติดูแลตนเอง 3 ระยะคือ ระยะของการพิจารณา ระยะ การตัดสินใจซึ่งจะนำไปสู่การปฏิบัติ ระยะดำเนินการปฏิบัติ และประเมินความสามารถในการ ปฏิบัติ วิเคราะห์ผลของโปรแกรมโดยใช้วิธีการแจกแจงความถี่ หาค่าเฉลี่ย และส่วนเบี่ยงเบน มาตรฐาน และใช้สถิติการวัดซ้ำโดยวิเคราะห์ความแปรปรวนทางเดียว

ผลการศึกษาพบว่า คะแนนพฤติกรรมก้าวร้าว และทัศนคติทางบวกต่อการใช้ความ รุนแรงลดลงหลังจากนักเรียนได้รับโปรแกรมการป้องกันการใช้ความรุนแรง และยังพบว่าคะแนน ทักษะการจัดการความรุนแรงสูงขึ้นในทุกด้าน จากการสังเกต พบว่ามีค่าเฉลี่ยของพฤติกรรม ก้าวร้าวทางร่างกาย และพฤติกรรมก้าวร้าวทางวาจา ลดลงในทุกพฤติกรรม

ผลการประเมินความพึงพอใจของนักเรียนในการเข้าร่วมโปรแกรม พบว่ามีค่าเฉลี่ยอยู่ใน ระดับสูงทั้ง 3 ระยะในการปฏิบัติดูแลตนเอง จึงเป็นไปได้ว่า โปรแกรมการป้องกันความ รุนแรงมีประสิทธิผลในการลดพฤติกรรมก้าวร้าว และลดทัศนคติทางบวกต่อการใช้ความรุนแรง ได้ และยังเพิ่มทักษะในการจัดการความรุนแรง โปรแกรมนี้สามารถนำไปใช้ในการศึกษาวิจัย ต่อเนื่องเพื่อขยายผลต่อการจัดการศึกษา และนำไปประยุกต์ใช้ในระบบการบริการทางการ พยาบาล รวมถึงหน่วยงานที่มีภารกิจต่อการแก้ไขปัญหาความรุนแรงในสังคมไทย ต่อไป

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ABSTRACT

Violence among adolescents has increasingly become recognized as a critical social problem. The purpose of this study was to evaluate the effectiveness of a violence prevention program for Thai-High School Adolescents. This program was based on Self-Care Deficit Theory of Nursing and Violence Concepts.

The sample included 45 adolescent students, aged 12-15 years, with moderate to high scores of aggressive behavior and favorable attitudes toward violence. The subjects were purposively selected to participate in regular care for 12 weeks, and then received the violence prevention program for 12 weeks. Within group, repeated measure design was used to examine the effectiveness of the program. Data was gathered using Aggressive Behavior Scale (ABS), Attitude Toward Violence Scale (ATVS), Violent Management Skills Test (VMST), and Observational Aggressive Behavior Scale (O-ABS). Students' satisfaction of the Violence Prevention Program Questionnaire was rated for each phase of self-care operation: *estimative*, *transitive*, and *productive phases*. Data were analyzed using descriptive statistics and repeated measure One-Way ANOVA.

The findings revealed that comparison of the scores of subjects at three different time points from the regular care period to the intervention period: 0 week pre-regular care, 12 weeks pre-intervention, and 24 weeks post-intervention. There was significantly decreased ($p < .001$), for ABS, ATVS, and significantly increased for VMST scores, including Interpersonal Relationship Skills ($p < .001$), Coping with Emotion and Stress ($p < .001$), Problem Solving Skills ($p < .05$), and Social Responsibility Skills ($p < .001$). The frequency of physical and verbal aggressive behaviors event decreased after attending the program. Student's satisfaction of the violence prevention program revealed a high level of every phases of self-care operation.

This study suggested that the violence prevention program could reduce aggressive behavior and favorable attitudes toward violence including enhancing violence management skills among adolescents. Suggestions to extend the application of this program for education in various contexts and to expand knowledge for nursing and other disciplines are being discussed.

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CHAPTER 1

INTRODUCTION

Background and Significance of the Study

Violence has increasingly become recognized as a critical social problem that requires vital attention globally. Violence has always been part of the human experience in all parts of the world. Worldwide, around 520,000, people die each year, or approximately 1,400 every day (WHO, 2004) as a result of interpersonal violence. The World Health Organization has ranked the problem of violence as critical and cautioned the entire world to be on the alert for this problem (WHO, 2005). Violence among adolescents is especially a global public health problem as reflected by approximately 875,000 children and adolescents under the age of 18 years who died as a result of it in 2002 (WHO, 2006). In Thailand, violence is a serious problem. A report on violence and health indicates that death and disability caused by violence has made it a leading public health issue (Ministry of Public Health, 2006). A study entitled, Trend and Epidemiology Report on Violence, National Injury Surveillance of Thailand 2000-2005, reported that a total of 29,000-45,000 acts of violence were committed by adolescents (Department of Disease Control, 2007). Statistics in 2005 recorded that 5.7 percent of persons who had committed violence against others were between the ages of 12 and 18, showing an increase of 22.1 percent in one year (National Police Unit, 2005).

Violence among adolescents causes injury, loss of competence, disability and death worldwide (WHO, 2005), affecting not only themselves, but also their families,

community and society (Thongkliang, 2003). The summary of a report of the situation of children and adolescents in 2004-2005 found violence to be a major risk factor directly affecting the physical and psychological health of Thai adolescents (Ministry of Social Development and Human Security, 2005). Thus, the impact of violence on adolescents can be classified into two categories: physical and psychosocial.

Physical impacts included injury, disability and death. The Center for Disease Control analyzed the prevalence of physical violence among high school students and its association with five risk behaviors namely sexual intercourse, attempted suicide, substance abuse, episodic heavy drinking, and fighting (Black et al., 2006). Physical violence often consists of hitting, kicking and punching (Heffman, 1994). If the severity of a physical attack increases, it will lead to death which may also be considered as murder (Kongsakon, 2005). The results of previous studies indicated that those adolescents who saw their parents and other family members using violence developed health problems (Carmona, 2004; Myers et al., 2000; UNICEF, 2000). Besides, the children who experience violence in the family may suffer from changes and serious behavioral problems, as well as growth, and learning problems which may lead to violent behavior or alienation from society later in life (Kongsakon, 2005). In addition, adolescents who are prone to violence could become addicted to drugs as a way of solving problems or use physical violence since they desire acceptance in their relationships with others (Benedictis et al., 2004).

As for the psychosocial impacts, most adolescents who engage in violence may have suffered from a recent loss, disappointment or rejection, felt alienated or disenfranchised, experienced academic failure, or fallen into alcohol or other drug

abuse. In many cases, the adolescents may try to solve their problems through dependence on drugs, trying to avoid stress causing situations and may even inflict hurt upon themselves (Beauchesne, Kelley, & Lawrence, 1997; Myers et al., 2000). The psychological impacts affects not only adolescents directly but also their education, teachers, family and society. Sura-arunsumrit (2003) found that psychological problems have impacted adolescent student offenders at secondary schools in Southern Thailand. Their impacts can be grouped into three categories. First, for the perpetrators, psychiatric disorders such as learning disabilities, an immature personality and behavioral disorders increase the risk of violence. Secondly, for the victims, a reaction of grief and acute stress along with shock, anger, sadness, and hopelessness in dealing with loss are identified. Lastly, those students who are indirectly involved in the situation may experience the shock and numbness of losing friends, which can be detected as acute stress reaction.

In addition, the early onset of aggressive behavior in childhood puts them at increased risk of antisocial behavior and criminal involvement later in life (Center for School Mental Health Assistance, 2002). In some adolescent students who have violent problems manifested in fighting, bullying, verbal conflict, and interruptive behavior, they may create a disruptive and disorderly learning environment leading to ineffective utilization of educational resources, and also the wastage of teacher time in trying to solve their problems instead of spending time on educating (Srikumardthai, 2003; Sutin, 1996). Moreover, the impacts may be revealed when the adolescents go to school. They will have inadequate relationships with others and try to escape facing serious situations (UNICEF, 2000). Sometimes they may express violent behavior and

may be depressed and have a feeling of low self-esteem (Ministry of Public Health, 2006).

For these reasons, many researchers around the world and also in Thailand encourage projects for the prevention of violence. They formulate policies that address the problems of violence and search for unique methodologies required to effectively influence adolescents to minimize their risk behaviors (International Clinical Epidemiology Network, 2005). Therefore, school health promotion programs are one of the most promising means of improving adolescent health (Ruangkanchanasetr, 2005) by having students engage in activities to gain knowledge of difficulties in adolescence to cultivate a negative attitude toward the use of violence and to acquire new violent management skills in order to prevent adopting violent behavior.

A systematic review of school violence, violence in adolescents, and violence prevention among Thai adolescents found a slight increase in the amount of research in the promotion of mental health and the prevention of violence in adolescents. There were similar studies indicating that violence prevention programs should be encouraged to develop violence management skills for life-long learning in order to enhance self-care capabilities in managing violence among adolescents (Bussing, Koro-Ljungberg, & Williamson, 2006; Cull, 1996; Ervin, 1998; Renker, 1998; Rew, 1990; Stewart, 2001; Snyder, 1987; Vollmer et al., 1992). The promotion of adolescent's self-care has been recognized as an important aspect of developing demand management strategies on physical and psychological effects (Chapple & Rogers, 1999; Paniagua, 2002).

The adolescent's self-care capability for violence management could be increased and improved by gaining knowledge, changing attitudes and developing violence management skills. Moreover, self-care is not a limited activity but also includes services obtained from the family, neighbors, and many volunteer groups in the community (Rice, 1998). Self-care for managing signs of illness in adolescents reinforces their capability to search for and to retain optimum physical and psychological health in each life situation (Horneffer, 2006). Valuing self-care is a crucial key stage in the development of humans because it is related to feelings and thoughts as well as behavior which has a vital impact on the use of violence (Orem, 2001). As the self-care capability is strengthened, those factors influencing self-care, such as beliefs, values concerning good health, and the perception of self-efficacy are likewise reinforced (Orem, 2001). In addition, not only does self-care assist in the prevention of the occurrence of inappropriate behavior, it also enhances capacity to solve problems thus improving the quality of life (Thrasher, 2002).

Accordingly, society must share the responsibility of health care as social values and beliefs are influenced by the individual's perceptions, choices, and decisions (Ross, 2002). Therefore, the role of professional nursing is to promote well-being or the quality of life through education, restorative and supportive care, and research (Thrasher, 2002). Furthermore, nursing as a human science seeks to understand the meaning of the lived experience. These experiences are always shaped by politics, social structures, and culture. Besides, power comes through reflection, understanding, and action (Hall, 1999; Milio, 2006), whereas promoting self-care capability is directly linked to the social environment as an influence of behavioral risk factors (Lalonde, 1974). These are crucial to the role of nursing practice and have

to include strategy, procedures and activities to assist adolescents, families, and the community to learn how to take care of oneself and when to seek assistance from teachers or health officials. Thus, good quality nursing practice should strive to assist adolescents to acquire the capability of effective decision management to deal with violent signs and to provide suitable health care service resources, especially the supportive systems, namely school and family (Irwin, 2006; Orem, 2001).

In Thailand, intervention studies derived from a nursing perspective could not be found, although there have been a few research studies on violence management and violence prevention programs from an educational and psychological perspective. Especially in nursing practice, available strategies, procedures and activities can be used to assist adolescents, families, and the community to learn how to take care of themselves and assist adolescents to acquire the capability of effective decision management to control their tendencies towards violence and to promote the usage of appropriate health service resources such as family, school and community.

Orem's conceptual model of nursing also shares the philosophical ideology of self-care that is consistent with contemporary notions of care in patient groups. Encouraging self-care is increasingly important among adolescents to prevent hazards (Orem, 2001). Furthermore, education about lifestyle, a crucial component of nursing patients with illness prevention, is inherently dependent upon the individual's ability to perform self-care. In addition, the notion of a supportive-educative nursing system complies with the generalized trust towards both individualized patient education, information needs assessment and emotional support that dominates the literature in this area (Ervin, 1998).

Orem's Self-Care Deficit Nursing Theory can be useful for those adolescents who behave violently in estimating their self-care ability of controlling violence and in self-care practice (Cull, 1996), and in promoting both autonomy and ongoing follow-up of management as well as reducing recidivism in adolescents who are prone to using violence (Cutler, 2001). Besides, multiple aberrant and aggressive behaviors could be reduced, while fulfillment from concurrent development of self-care skills contribute to self-care achievement tasks which can increase markedly (Vollmer et al, 1992).

Additionally, a few research studies have been conducted in schools, and the results revealed explicitly that violence prevention programs in schools involve key stakeholders such as teachers, peers, and family who constitute significant environmental factors of the adolescent. By doing so, this will assist the adolescents to learn appropriate and inappropriate behaviors and to provide the opportunity to share beliefs for working together from a variety of viewpoints in order to deal with violent incidents. Particularly in Thailand, there are guidelines for the prevention of violence in high school adolescents for inappropriate behavioral and psychological problems, for instance, drug addiction, unruly behavior, and delinquency (Mental Health Department, 2001). Furthermore, the Ministry of Education is concerned with issues of violence both in primary and secondary schools, especially in high schools where adjustments in learning about life security are expected to occur (Limparatanagorn, 2004). In addition, nowadays, the Ministry of Justice (2006) requires conflicts to be resolved by using cooperative processes in schools. The objective of the Ministry of Justice is to solve adolescent conflicts in cooperation with schools.

The violence prevention program in schools displays results which confirm its effectiveness as a strategy for preventing violence in adolescents (National Crime Prevention Center, 2001; Wilson & Lipsey, 2005). Violence prevention programs in schools can fill an important gap in health care services in various ways such as adolescent students and families seeking information and guidance about health related violence issues. Leadership in schools is provided by teachers and community representatives who plan and implement strategies for promoting self-care behavior and health promotion activities of adolescents with violent tendencies. In addition, knowledge of self-care practices for adolescents from various sociocultural backgrounds can be incorporated into school violence prevention programs (McCaleb & Cull, 2000). Ultimately, schools can provide a variety of human resources and services interacting especially in order to control environmental hazards and/or assist community members to overcome the effects of such hazards. However, there are limitations to the use of violence prevention programs with adolescent students because violence is multi-factored and requires a multi-disciplinary approach. Both multidisciplinary team and time are essential for assured results. In fact, results depend on the policy of each school and the degree of cooperation between the school and various disciplines. So, these problems and difficulties will continue and require work over a long period of time with multidisciplinary teams that are involved with the family and community.

The essential structure of preventing problem behavior in adolescents exists in policies school that promote health in Thailand, and which address the concerns of the World Health Organization. A health promoting school model constantly strengthens its capacity as a healthy setting for living, learning and working (Department of

Health, 2006) using strategies involving community members, group processes, political processes, and communication. Trained school personnel and stakeholders can deliver those interventions based on a scheduled plan of health promoting school policies. Above all, existing self-care conceptualizations and frameworks, although developed appropriately, are rarely applied to children and adolescents, less so to those with a history of violence (McCaleb & Edgil, 1994; Moore, 1995; Roberts, 1988, as cited in Hinds et al., 2000). A similar pattern is likewise evident in Thailand as can be seen in the increasing number of violent adolescents in Thai society.

It is important to formulate a violence prevention program based on Orem's self-care theory aimed at developing adolescents' capabilities to respond to their self-care needs for managing violence through 3 phases of self-care: *estimative, transitive, and productive operations* (Orem, 2001). The program comprises four helping methods such as teaching, guiding, supporting, and providing environment for developing adolescents' attitude and skills capabilities towards violence to care for themselves.

The researcher believes that the violence prevention intervention will help adolescent students adopt self-care operations in the management of violence through reducing aggressive behavior, promoting a negative attitude toward violence and increasing violence management skills. This study focuses on Thai adolescent students attending a school in Muang District, Songkhla Province, Southern Thailand where there already exists some research investigating violence among high school adolescents in Songkhla (Kasamge, 2001, as cited in Thongkliang, 2003).

The violence prevention program in this study focuses on the supportive system within an educational environment, particularly the key stakeholders such as

school staff, students, and parents whereby these parties share their views on violence and strategies suited for managing violence in adolescents. Perceptions of the effectiveness of the intervention program for violence management in Thai adolescent students in the violence prevention program, and of their peers, their parents/guardians, and their teachers were tested in the study to confirm the effectiveness and feasibility of the program in the Thai context. The results of the study will ensue in a violence prevention program, and knowledge on the subject, will cultivate negative attitudes toward the use of violence, develop violence management skills and guidelines for improving self-care practices for adolescents in Thailand.

Objective of the Study

The objective of the study is to examine the effectiveness of a violence prevention program among Thai-high school adolescence on aggressive behaviors, attitudes toward violence, and violence management skills after students have undergone a violence prevention program. The study will also examine the satisfaction of the violence prevention program.

Research Questions

1. After Thai adolescent students attend the violence prevention program
 - 1.1 Will they have a lower score of aggressive behaviors including physical and verbal aggression as observed under the behavioral observation?

1.2 Will they have a lower score of favorable attitudes toward violence?

1.3 Will they have a higher score of violence management skills?

2. Are Thai adolescents satisfied with the program?

Conceptual Framework

The violence prevention program in this study was constructed based on the synthesis of the Self-Care Deficit Nursing Theory of Dorothea Orem (2001) and violence concept from concept analysis process. Self-care is understood to be the activities that the individual initiates and performs on one's own behalf in maintaining life and well being (Orem, 2001). Since the development of adolescents is threatened by external and internal violence risks factors, incorporating the theory concerning violence management would provide a clearer perspective of the phenomena. The strategies on a violence prevention program for adolescents are composed of help methods including teaching, guiding, supporting, and providing a suitable environment for self-care development requisites in order to prevent hazards. Self-care requisites consist of problem solving skills, coping with emotions and stress, interpersonal relationship skills, and social responsibility toward violence.

A self-care operation is a deliberate action that has 3 phases: *estimative*, *transitive*, and *productive*. Orem (2001) remarked that the *estimative phase* includes investigation, proceeding to knowledge of violence management and the meaning of developing abilities on violence prevention including reflective understanding and judgment about situations, and includes how a situation can be changed. The *transitive phase* is for making judgments and decisions about violence management to

prevent a propensity to violence, concluding with decisions about the ends to be sought and the means to be used. The *productive phase* is carrying out and developing violence management, proceeding from the decision about what will be done and the design for doing it, to the production of action sequences through which the end is reached and the goal attained or not attained. This also includes evaluation of the plan.

Orem (2001) proposed that as individuals participate in their own self-care, they use their developed and operational skills to manage themselves, whereas, the activities of self-care are learned according to beliefs, habits, and practices that characterize the cultural way of life of the group to which the individual belongs. Furthermore, Orem (1995) describes basic conditioning factors (BCF) that influence an individual's ability to perform in self-care activities or that can modify the kind or amount of self-care required. The BCF related to adolescent violence are age, health state, life experiences and environment factors such as peer, teacher, and family (Cull, 1996; Mc-Caleb & Edgil, 1994).

Therefore, the violence prevention program will motivate adolescent students to carry out self-care practices to control signs of violence, aggressive behaviors, and favorable attitudes toward violence. It involves promoting violence management skills. The adolescents who undergo the violence prevention program are expected to be able to perform deliberate actions to prevent the signs of violence. The conceptual framework for this study is shown in Figure 1.

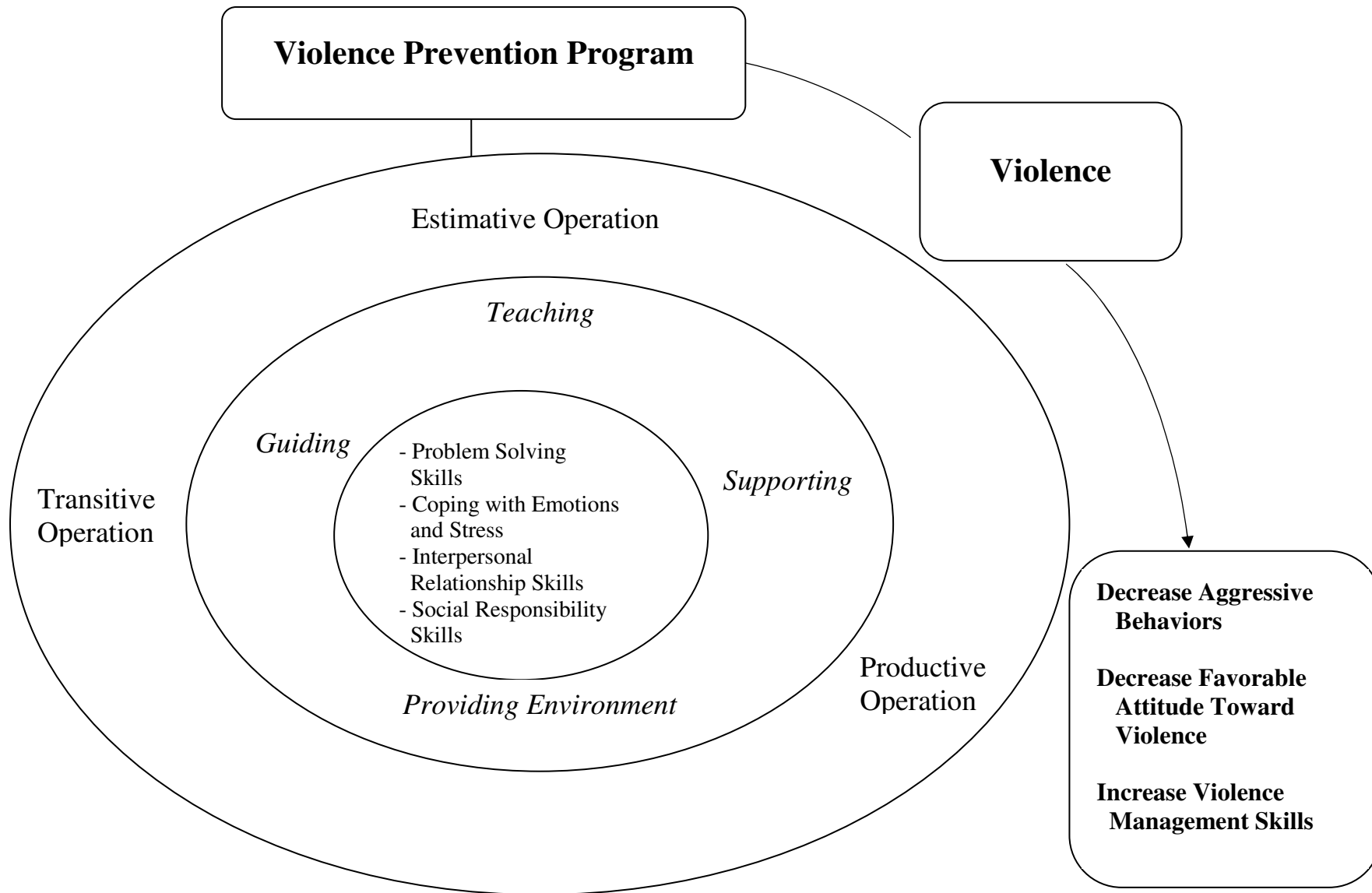


Figure 1 Conceptual framework of the study

Hypothesis

1. Adolescent students have lower scores of aggressive behaviors including physical and verbal aggressive behaviors as observed after attending a violence prevention program.
2. Adolescent students have lower scores of favorable attitudes toward violence after attending a violence prevention program.
3. Adolescent students have higher scores of violence management skills after attending a violence prevention program.

Definition of Terms

1. *The violence prevention program* is an intervention that was developed by the researcher with the aim of reducing aggressive behavior, of reducing favorable attitudes toward violence, and of enhancing violent management skills in Thai adolescent students. The violence prevention program utilizes Orem's Self-Care Deficit Nursing Theory and violence concepts through the processes of self-care operation, namely, *estimative*, *transitive*, and *productive phases* (Orem, 2001). The effectiveness of the program is assessed by using the Aggressive Behavior Scale (ABS), Attitude Toward Violence Scale (ATVS), Violent Management Skills Test (VMST).

In addition, the Satisfaction of the Violence Prevention Program is assessed by the Satisfaction of the Violence Prevention Program Questionnaire. The higher score is the score of satisfaction with the violence prevention program.

2. *Violence in adolescents* refers to three attributes namely aggressive behavior, favorable attitude toward violence, and violence management skills. These attributes are defined as follows:

2.1 Aggressive Behavior refers to the stage of violent behavior which is used as a substitute for thought and not thought as a prelude to violent action. These involve severe harmful action and injury towards another person, or causing suffering both physically and/or psychologically, and include destroying objects or property.

Aggressive behavior is divided into 2 types, verbal and physical. The meaning of each term is as follows:

2.1.1 Physical aggressive behavior refers to an action of making oneself and/or the other person undergo both physical and psychological harm such as causing damage to person, object or property.

2.1.2 Verbal aggressive behavior refers to speech causing oneself or the other person suffering, shame, sadness, frustration and anger.

Aggressive behavior was assessed by using the Aggressive Behavior Scale, and a teacher's observation using the Observational Aggressive Behaviors Scale (O-ABS) (Bandura, 1986; Berkowitz & Rothman, 1965; Buss & Perry, 1992; Sutin, 1996). The higher the score is on each scale, the higher the aggressive behavior.

2.2 Favorable attitude toward violence refers to feelings or opinions of adolescent students toward violence in terms of liking and agreeing with the use of violence as a learnt experience, adjusting to the tendency of adolescent students to violence when congruent with their own emotions and beliefs.

Favorable Attitude Toward Violence is assessed by Attitude Toward Violence Scale (Kretech, Crutchfield & Ballachy, 1962; Pandaeng, 2004). The lower score is the score of unfavorable attitudes toward violence.

2.3 Violent management skills refers to the ability of managing or avoiding favorable attitudes toward violence or aggressive behavior leading to the use of violence as well as its prevention in adolescents. These consist of 4 aspects: problem solving skills, coping with emotions and stress, interpersonal relationship skills, and social responsibility skills. Violence management skills are assessed by using the Violence Management Skills Test (Limparatanagorn, 2004; Tungklave, 2005; WHO, 1994). The higher the score is in each sub-skill, the higher the violence management skills. The meaning of each term is as follows:

2.3.1 Problem solving skills refers to the ability to deal with the dilemma of violence involved in realized courses of violent action, searching for alternative courses of action and analyzing the advantages or disadvantages of each choice; it is also concerned with the capacity to assess and to make a decision to solve the difficulty through the use of non-violence.

2.3.2 Coping with emotion and stress refers to the ability of being aware of oneself emotionally and to handle stress in an appropriate behavior. Adolescent students who have stress related problems are able to develop techniques to deal with emotions, such as anger, for example, consulting with someone or trying to avoid a crisis situation that would cause aggressive behavior.

2.3.3 Interpersonal relationship skills refers to the capability of carrying on interpersonal relationships with others, namely, peers, teachers, parents

and so forth. Being able to maintain good quality interpersonal relationships is as crucial to living in society as are happiness and contentment.

2.3.4 Social responsibility skills refers to the sensation in oneself of realizing that one is a part of society and that one has responsibility either on growth or declination which is related to self-esteem. If the student has a sense of self-esteem, then he or she will have the motivation to behave appropriately towards another person and to society.

3. *Regular Care* is the usual counseling services and organization system regularly available at high school provided by the teachers who are guidance teachers, class room-teachers, and teachers in charge of the disciplinary department. School counselors search for ways to take care of and assist students especially in solving problem corresponding exactly to the needs of each student. The goal is to reduce student problems, and spend less time, perhaps about 30 to 40 minutes per person in an individual session. In some cases, problems need to be solved directly making the students feel that their situation has improved.

CHAPTER 2

LITERATURE REVIEW

The review of literature in this chapter is organized into three major parts. The first part is concerned with high-school adolescents. The second part covers the concept of violence among adolescents. The third part concerns theories and concepts in the application of a violence prevention program. The literature can be outlined as follows:

1. Thai High-School Adolescents
 - 1.1 Nature of High School Adolescents
 - 1.2 High-School System
 - 1.3 Violence Prevention Program
2. Concept of Violence
 - 2.1 Types of violence
 - 2.2 Factors associated with violence in adolescence
 - 2.3 Assessment Tools for Violence
 - 2.4 Violence prevention
 - 2.5 Effective Violence Prevention Programs for Thai adolescents
3. Theoretical Basis for the Violence Prevention Program
 - 3.1 The theories related to Violence Prevention Programs
 - 3.2 Self-Care Deficit Nursing Theory
 - 3.2.1 Self-care requisites of adolescents
 - 3.2.2 Conceptual structure of self-care operations for violence
in violent adolescents

The significance in sequence of each term in the literature reviewed is as follows:

1. Thai High-School Adolescents

Violence among adolescents has increased in Thai high school settings (Thongkliang, 2003). The Thai Youth Risk Behavior Survey (Rungkanchanasetr et al., 2005) found that 6.3% of adolescents had carried a weapon on school property and 8.5 had carried a weapon in other places, respectively, whereas 28.9 % and 31.5% of adolescents had been involved in a violent event that occurred respectively either on or outside of school property, respectively. In addition, from 2005-2006, the number of adolescents who committed crimes across Thailand had increased from 12,423 to 17,629 cases (Department of Juvenile Observation and Protection, 2006).

Therefore, in order to comprehend violence in Thai high-school adolescents it is necessary to realize the nature of adolescents in high schools, the high-school system, and the high-school health service. The term of each is as follows:

1.1 Nature of High-School Adolescents

It is understood that early adolescence covers the years from 12 to 15, particularly with regard to the character of high-school adolescents. The development of the adolescent is divided into 5 aspects, namely, physical, psychological, societal, cultural and environmental (Birckhead, 1989). Erickson's psychosocial study of personality development stated that the developmental traits of adolescents can lead to violence when there is confusion between identity and role. The problems of

adolescents, faced with stressful surroundings bring about the psychological and social conflicts of this developmental period. They have to learn to cope appropriately and formulate a socially acceptable role as they enter young adulthood. Then, when the adolescents do not complete their psychological tasks and, therefore, acquire what Erikson calls a “negative identity” in society, violence within society becomes a sign of their failure.

Moreover, the cultural dimension, as with environmental factors, also appears to be in the background during adolescence. Most attitudes that growing adolescents adopt reflect their own personal experiences with members of differing cultures and religions in their association either with peers in school or with teachers and administrators who make up the culture of their communities. The environmental organization, the importance of ecological structure is related to the other impending stressors that need confrontation and resolution. One obvious area of environmental impact on the growing adolescent is the effect of the condition of the immediate area surrounding the adolescent’s school such as gangs, delinquency, and environmental attitudes which will have strong effects on the development of the adolescent. If there is a permissive atmosphere, drug and gang activities in the form of delinquent acts will be highly visible. If there is a strong negative atmosphere regarding drugs, gangs, and delinquency, the adolescent most likely will subscribe to those negative values. Adolescents are quick to absorb apathetic attitudes, and can become withdrawn and violent (Birckhead, 1989). What is mentioned above, in general, is useful for analyzing the dimensions of the ever changing adolescent’s nature, relating to the world through the high-school system.

1.2 High-School System

This research defines high school as an educational institution ranging from 1-6 years of high school under the Basic Education Commission, Ministry of Education, Thailand. Tumchai (1995) has described the responsibilities and duties of high schools as follows:

1.2.1 High-School Roles

- 1) Teaching and guiding adolescent students to be good people and to be well principled, able to study in higher education as well as to have social responsibilities to self, family, and society.
- 2) Teaching and creating good attitudes, traits and skills for enhancing comprehension about living and employment.
- 3) School has a role in community service
- 4) School has a role of cultural promotion
- 5) Propagates information
- 6) It arranges entertainment activities
- 7) It provides useful information and occupational guidance

In addition, high-school organization, especially the administration, has significance in developing the adolescent's personality and appropriate behavior in order to become mature adults. Even school does not have the direct duty or responsibility of preventing crimes, it does have a significant role similar to that of a family. School is the institution which has the responsibility of teaching, guiding, and regulating adolescent students, promoting an acceptable personality and behavior both in academic studies and recreational activities. Thus, there are a number of

undertakings in which a school administrator will have influence in order to prevent adolescent violence (Tongtun, 1993).

1.2.2 School Health Service

The adolescent who is a victim of violence or manifests aggressive or harmful behavior at school needs to get support and assistance. The most important is seeing that an adolescent is evaluated and gets assistance with continual follow up (Edward, 1999). School health services could be defined as having four aspects, as follows:

- 1) Enhancing School Health Promotion in all schools.
- 2) To have a screening system for adolescent students at risk or who have violent tendencies, as well as potential victims.
- 3) The system of primary health care in school by the school's inner personnel, such as teachers, friends or other volunteer groups, etc.
- 4) Collaboration between school, family and other community organizations to set up restraints to protect and treat members of the community.

In addition, the high-school system needs to arrange screening, diagnosis, and treatment starting with adolescent students so that the data will divide students into 3 categories (Tumchai, 1995):

- 1) Normal group defines students who have been screened using a diversity of data and are within the normal group level.
- 2) Risk group consists of adolescent students placed in the risk group through screening. The school will have to assist them and help them solve their problems.

3) Abnormal group defines adolescent students who need to be assisted by the school, and whose problems have to be resolved.

Besides, placing the students into 3 groups is useful to school guidance teacher who will find ways to assist students appropriately, particularly solving problems much more directly and in a short time. Therefore, guidelines for data analysis of screening adolescent student is under the judgment of counselor teacher and also hold the basis for screening to be the typical of school. The standard or guideline would be accepted by the school committee concerning the setting of the rule on violence situation or how much frequency of behavior to be grouped in the risk or assistance.

The screening problematic behavior can be considerate from problematic behavior characteristic into 5 items as follows;

- 1) Adolescent behavior and their expressive behavior are differs from normal of general people
- 2) They demonstrate appropriate behavior which may be inappropriate behavior in accordance with age, time and location
- 3) It has an effect on relationship with other person
- 4) It results to life living, education, adaptation in society
- 5) Frequency, severity and duration of that problematic behavior

Thus, the adolescent who performed violence behavior and having educational problem is the one who takes risk to involve with the violence and should get them in order to screen about victimization and appearance of violence. The adolescent who live within conflict situation, fighting and starve or low earning be supposed to have a history of violence in the family. For example, counseling process makes the adolescent talk about violence in their lives (Edward, 1999).

1.3 Violence Prevention Program

The patterns of violence prevention program attempt to deal with the concept of violence from various perspectives and are the goal of projects or organizations. Moreover, these patterns are derived from many parts of society including schools, the workplace, other institutions and systems of care, namely, the health care system, the judicial process, and child and adolescent foundations; however, most methods continue to work effectively in both the short and long term as well as follow up if well coordinated.

In Thailand, guidelines for violence prevention for adolescents emerge in assisting the mental health of high school students. The Mental Health Department (2001) has projects to prepare opportunities for the people in the area or for that community to participate using specific patterns and guidelines in taking care of, assisting, planning, and developing activities dealing with violent events (Kongsuwan, 2005), encouraging self-care behavior for preventing the use of violence (Soungsuda, Kongsuwan, & Toegani, 2005), and assisting people to explain and identify guidelines used in solving problems of violence, environment and atmosphere that have impact on violence (Ministry of Public Health, 2006).

The underpinning of the public health model calls for community action to influence one or more critical factors into 3 characteristics; primary, secondary and tertiary prevention. This structure involves a preventive and responsible public health team (Department of Health, 2006). Particularly, the primary universal violence prevention pattern could be started with expectant parents as early as in the first week of the mother's pregnancy, or can support the parents at a later point of their children's education to follow preventive strategies to reach those who are most

desperately in need of support (Chinlumprasert, 2003; The Organization for child and adolescent development at the instruction of princess Sirinthorn, 2005). Particularly, violence prevention will succeed if it is applied systematically starting from early adolescence (Ruangkanchanasctr, 2005; Tungklave, 2005; Tuntipivatanskun, 2003).

2. Concept of Violence

The concept of violence is derived from the proceedings of concept analysis using Walker & Avant's strategies (Walker & Avant, 1995). All of the definitions from various articles, literature, dictionary and thesaurus definitions (Campbell, 2004; David et al., 2005; Farrington, 2001; Kermit, 2002; Mizen, 2002; Mosby's Medical, Nursing, and Allied Health Dictionary, 1994; Miller, 1987; Swannell, 1992; The Grolier International Dictionary, 1992; Webster's Encyclopedic Unabridged Dictionary of the English Language, 1983; WHO, 2004; Wordnet, 2001) related to the meaning of violence can be categorized into two major attributes as follows:

The action of causing harm

This means that the negative capability of action is used as a substitute for thought and non-thought, a prelude to action. This would include high risk actions for self-directed harm; the action directed towards another person or against a group or community including aggressive body language, verbalization of hostility, boasting to others about prior abuse, increased motor activity, overt and aggressive acts.

The severity of harmful actions

This means that it causes somebody to suffer, to be upset or to have difficulties, to commit terrible crimes, apply physical force. The resulting severity of

violence will be shown in physical and psychological harm: injury, death, mal-development or deprivation; to violate someone’s sense of justice.

2.1. Types of violence

The World Health Organization (WHO, 2004) categorized the typology of violence into three sub-types: self-directed, interpersonal, and collective as displayed in Figure 2.

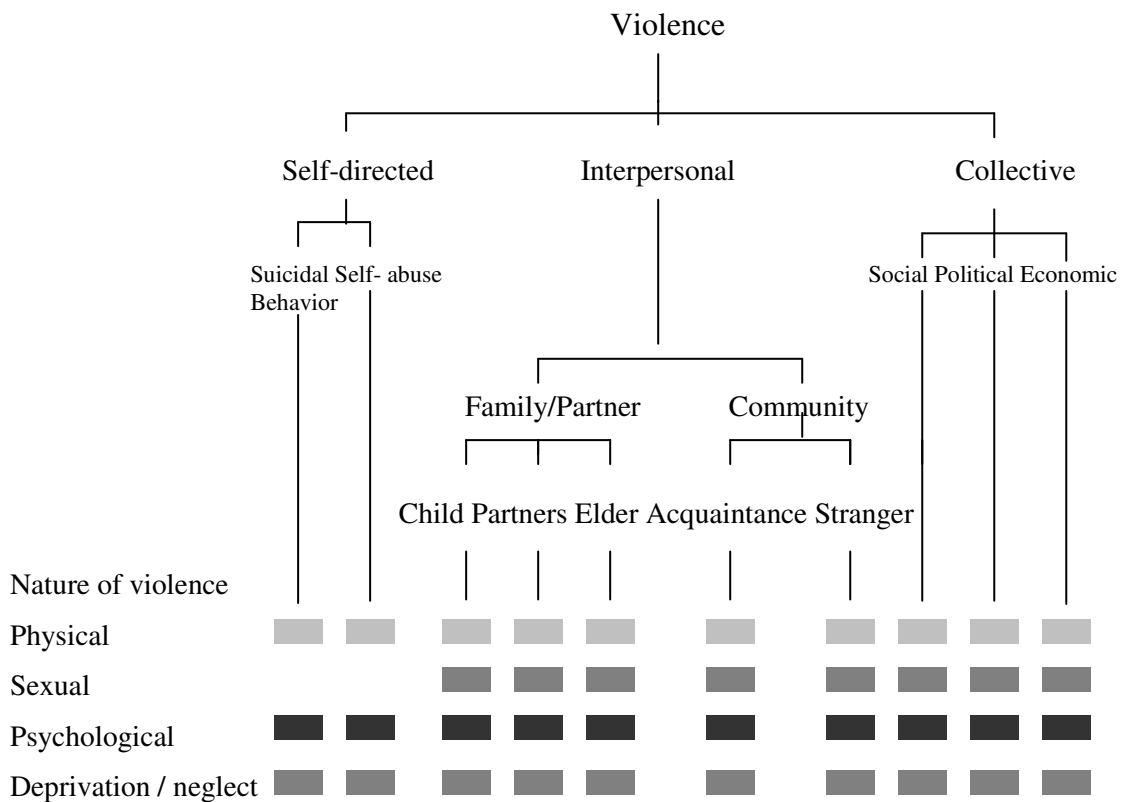


Figure 2 A typology of violence (WHO, 2004)

Figure 2 depicts the typology of violence, proposed by the World Health Organization (WHO, 2004). It is composed of three sub-types of violence

self-directed, interpersonal, or collective. The meaning of each type is as follows:

2.1.1 Self-directed violence is subdivided into suicidal behavior and self-abuse. The former includes suicidal thoughts, attempted suicides – also called “para suicide” or “deliberate self-injury” in some countries – and completed suicides. Self-abuse, in contrast, includes acts such as self-mutilation. Therefore, self-directed violence refers to violence in which the perpetrator and the victim are the same individual and is subdivided into self-abuse and suicide.

2.1.2 Interpersonal violence is divided into two subcategories: family/partner and community. Violence perpetrated by the family or intimate partner is violence largely between family members or intimate partners, usually, though not exclusively, taking place in the home while community violence is violence between individuals who are unrelated, and who may or may not know each other, generally taking place outside the home. The former group includes forms of violence such as child abuse, intimate partner violence and abuse of the elderly. The latter includes youth violence, accidental acts of violence, rape or sexual assault by strangers, and violence in institutional settings such as schools, workplaces, prisons and nursing homes.

2.1.3 Collective violence is subdivided into social, political and economic violence. Unlike the other two broad categories, the subcategories of collective violence suggest possible motives for violence committed by larger groups of individuals or by states. Collective violence that is committed to advance a particular social agenda includes, for example, crimes of hate committed by organized groups, terrorist acts and mob violence. Political violence includes war and related violent conflicts, state violence and similar acts carried out by larger groups. Economic violence includes attacks by larger groups motivated by economic gain such as attacks

carried out with the purpose of disrupting economic activity, denying access to essential services, or creating economic division and fragmentation. Clearly, acts committed by larger groups can have multiple motives.

The nature of violent acts was illustrated in figure 2, which may comprise physical, sexual, psychological aspects and may involve deprivation or neglect. The horizontal array in figure 2 shows who is affected, and the vertical array describes how they are affected. These four types of violent acts occur in each of the broad categories and their subcategories described above – with the exception of self-directed violence. For instance, violence against children committed within the home can include physical, sexual and psychological abuse, as well as neglect. Community violence can include physical assaults between young people, sexual violence in the workplace and neglect of older people in long-term care facilities. Political violence can include such acts as rape during conflicts, and physical and psychological warfare. Although not universally accepted, the classification of violence according to its type and mode of occurrence shown in the given figure provides a useful framework for understanding the often complex patterns of violence (WHO, 2004).

Research results found all three sub-types such as self-directed, interpersonal, and collective violence involved in the nature of violent acts in Thailand. Particularly, various types of violence, such as physical, psychological, and sexual types, were more prevalent among adolescents. These violent acts were especially manifested in terms of bullying, intimidation, threats, verbal and non-verbal aggression, sexual harassment, using weapons, harm directed to one's own self and towards others (Juwong, 1998; Tuntipivatanskun, 2003).

2.2 Factors associated with violence in adolescence

Violence in adolescents is the result of a multitude of factors. The ecological model in Figure 3 is based on evidence that no single factor can explain why some people or groups, particularly adolescents, are at a higher risk of interpersonal violence while others are more protected from it. Instead, the model views interpersonal violence as the outcome of interaction among many factors at four levels: the individual, relationships, the community and society. In this model the interaction between factors at different levels is just as important as the influence of factors within a single level.

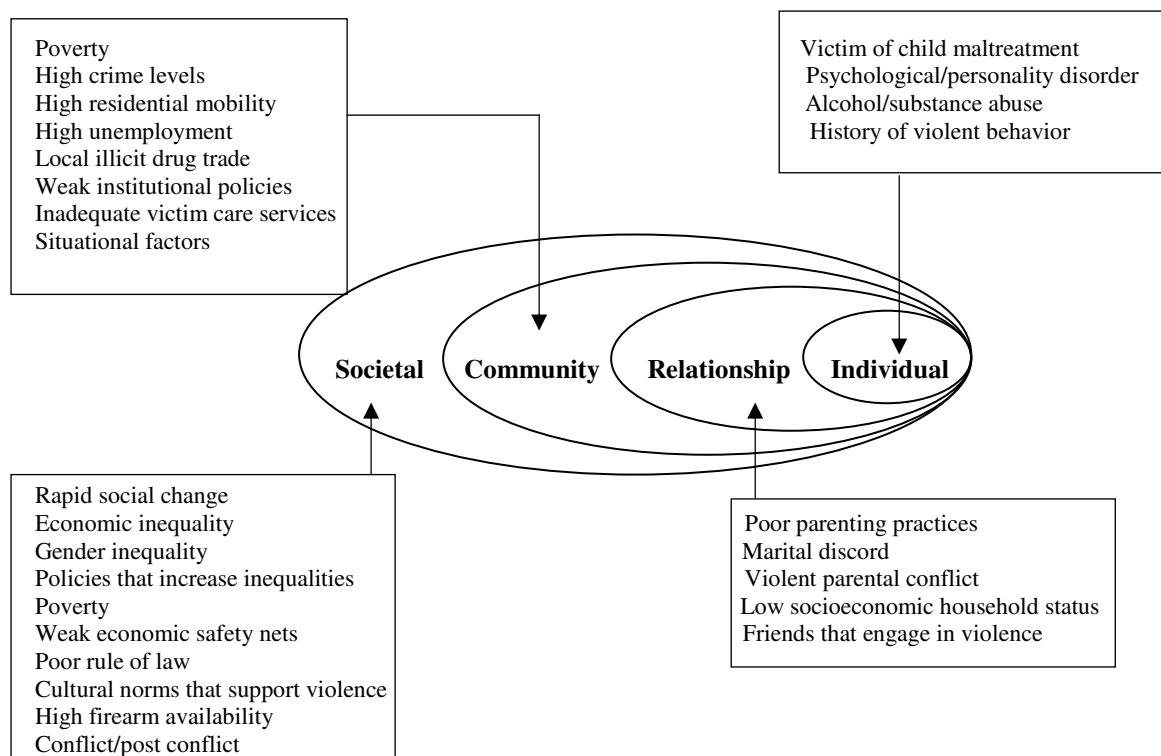


Figure 3 Ecological model showing shared risk factors for sub-types of interpersonal violence (WHO, 2004).

Figure 3 lists a number of these cross-cutting risk factors at each of the four levels of the ecological model. The meaning of each term is as follows:

2.2.1 At the individual level, personal history and biological factors influence how individuals behave and their likelihood of becoming a victim or a perpetrator of violence. Among these factors are being a victim of child maltreatment, psychological or personality disorders, alcohol and/or substance abuse, and a history of behaving aggressively or having experienced violence (WHO, 2004).

A literature review of biological factors supports that 43% of juvenile murderers have had brain damage (UNICEF, 2000) and brain chemical deficiency, especially neurotransmitters, serotonin and noradrenalin, which affect and regulate aggressive behavior (Fields & McNamara, 2003). Additionally, much research has found that the problem of violence may be caused or affected by physical factors, by inadequate food or rest (UNICEF, 2000; Myers et al, 2000; Carmona, 2004). Moreover, studies have found that in Thai adolescents, alcohol or drug addiction may lead to the use of violence (Buajaroen et al., 2004).

2.2.2 Relationships, such as those with family, friends, intimate partners and peers, may also influence the risk of becoming a victim or perpetrator of violence. For example, a poor relationship with a parent or having violent friends as well as having low socioeconomic household status, may influence, whether a young person engages in or becomes a victim of violence (WHO, 2004).

The results of abundant research support the premise that personal relationships influence the risk of violence especially in families with problems, for example, mental illness, abuse of alcohol and other drugs by family members, large family size, stressful life events, family disorganization, and poor parental bonding

(Glicken, 2004). Accordingly, the report of the child and adolescent situation in Thailand, 2005-2006, found that the lack of caring, unconcern, being overly protective or overly restrictive led to weakness in character of adolescents, causing possible risky behavior and violence (Ministry of Social Development and Human Security, 2005).

In addition, intimates and peers are important violence risk factors particularly in adolescents who are developing their sexual identity. Some adolescents would like to be accepted as friends or as a leader or obtain the acceptance of someone from the opposite sex. Besides, friends and sexual partners have a great effect on adolescents through their speech and acts of violence (Srimala, 2004). Because violence among intimates and peers may be associated with a lack of self-regulation, attempts are made to project an acceptable self-image. There is a need to express one's own attitudes and to receive honor from others within the group (Thaweekoon, 1995).

2.2.3 Community contexts in which social relationships occur such as schools, neighborhoods and workplaces, also influence the likelihood of violence. Risk factors here may include the level of unemployment, weak institutional policies, population density and mobility, the availability of local drugs or weapons, high crime levels, and inadequate victim care services (Metropolitan Area Child Study Research Group, 2002; WHO, 2004).

In Thailand, one factor regarding institutional policies of schools and curricula, principally the component of educational institutions, especially teachers and the environment around the adolescents, have a great effect. For instance, it causes a decrease in learning motivation, a lack in the teacher as a role model and life skills training inappropriate for the student's self-confidence and self-development.

These factors may cause the adolescent student to lack self-esteem and either follow or be influenced by the group (Ministry of Social Development and Human Security, 2005).

Moreover, community violence is related to high levels of unemployment, crowded housing, and low levels of community participation and organization, weapon and drug distribution networks, increased school dropout rates, alcohol and other drug abuse, and sexual abuse during adolescence (Center for School Mental Health Assistance, 2002). Problems of violence have been found among vocational students including the use of weapons as well as fighting, a chronic problem of Thai adolescents (Sukka, 2003).

2.2.4 Societal factors influence whether violence is encouraged or inhibited. These factors include economic and social policies that maintain socioeconomic inequalities between people, the availability of weapons, and social and cultural norms such as those relating to male dominance over females, parental dominance over children, poor rule of law, high firearm availability, and cultural norms that endorse violence as an acceptable method to resolve conflicts (WHO, 2004).

Worldwide it can be pointed out that violence in a minority of adolescents is as a result of social and cultural problems in this group should be prevented. It is also realized worldwide that the risk violence (National Mental Health Information Center, 2007). In addition, social conditions which differentiate between religions, cultures, and races with their distinct beliefs and different lifestyles may lead to misunderstandings between peoples as well as quarrels resulting in violence between groups (Carmona, 2004).

The unrest and unsettled situation in the southern part of Thailand for the past 14 years (1993-2007), especially in the three provinces of Pattani, Yala and Narathiwat, has seen the use of violence by terrorists such as shooting government officials and the population at large, burning schools, bombing government institutions and other places. This situation demonstrates risk factors of cultural norms and religion among some of the Thai-Muslim adolescents who had different beliefs and were encouraged and guided in the wrong way by the terrorists to create a violent situation (Ministry of Social Development and Human Security, 2005; Kongsuwan, 2004).

Rapid social change and economic inequality have also been risk factors in Thailand. The Ministry of Social Development and Human Security reported in 2005 that 95.9% of Thai adolescents spend time on the internet (Ministry of Social Development and Human Security, 2005). The relationship between the attitudes of adolescents to violent news and other violence from internet affects their attitudes toward violence (Pandaeng, 2004; Thaweekoon, 1995). Besides, studies on the effects of television and video games indicate that violent images in media may encourage the severity of violence; that young people have come to accept the use of violence as a way to solve problems; that they may imitate the violence which they observe (American Medical Association, 2001; Funk, 2005).

Ultimately, many factors are associated with violence in adolescence while an accumulation of risk factors is more important in predicting violent behavior than the presence of any single factor. The more risk factors a young person is exposed to, the greater the possibility that he or she will become violent. Thus, it is critical that we

take care of adolescents to protect them and encourage them in enhancing their self-care efficiency for facing many problems in real life.

2.3 Assessment Tools for Violence

There are various types of existing violence assessment tools. They measure in adolescents responses to aggressive or violent behaviors, and violent injuries (Mytton et al., 2009). Many tools are intended to be used to assess factors such as aggressive fantasies, beliefs supporting aggression, and aggressive behavior (Dahlberg et al., 2005).

In Thailand, the Strengths and Difficulties Questionnaire (SDQ) (Chaninyutawong, 2001) is used in assessing behavioral problems of adolescents and the Ministry of Education has allowed it to be used in schools. This tool covers 4 behavior aspects: emotions, attention deficit, delinquency, and interpersonal relationships using only 25 questions. However, this tool is too short and too broad to cover violent behavior. In addition, the Thai Youth Checklist (TYC) (Suwanlard & Chaisit, 2004) was modified from the Child Behavior Checklist (CBCL) - Thai Version (Achenbach & Edelbrock, 1983) which is promoted by the Mental Health Department. This tool assesses 3 categories of behavior problems, 8 sub-categories with 143 items on a 3 point response format. This scale has many more items with 8 concepts of behavior problems (anxiety/depression, social problems, somatic complaints, withdrawal, thought problems, attention problems, delinquent behavior, and aggressive behavior). The TYC is difficult to administer as scoring takes considerable time; however, it can be used to assess and identify behavior problems as a whole rather than to assess violent behavioral problems.

In this study, there are 4 assessment tools for violence which are available to Thai adolescents. The reason why each tool should be used is as follows;

2.3.1 Aggressive Behavior Scale (ABS)

A systematic review from various research perspectives on adolescent violence using existing assessment tools in both Thailand and other countries indicates that the Aggressive Behavior Scale is the most prevalent assessment tool to assess the propensity of violence (Mytton et al., 2009; Fields & McNamara, 2003; Whitaker et al., 2005; Sutin, 2004).

Extreme violence is rare in schools since the evidence suggests that early aggression can lead to later, more extreme forms of violence (Dishion, Reid, & Patterson, 1988; Loeber et al., 1993, as cited in Leff et al., 2001). It is appropriate for designing programs attempting to reduce aggressive behaviors such as fighting, name-calling, bullying, and general threats that can create a negative school climate and lead to more serious violence in adolescent students (Rippon, 2000; Wilson & Lipsey, 2005; Kayopulpakon, 1998). Consequently, Ervin (1998) indicated that self-care learning in relation to aggressive behavior in adolescents in early predictors of aggression with general guidelines will be utilized for adolescent students to deal with violent situations.

2.3.2 Observational Aggressive Behavior Scale (O-ABS)

The Observational Aggressive Behavior Scale (O-ABS) (Buss & Perry, 1992; Bandura, 1986; Sutin, 1996) was developed from the concept of both verbal and physical aggressive behavior. This tool was used to observe both physical and verbal

behavior and these were recorded by two observers indicating frequency of occurrence.

The development of the scale, the Aggression Observation Scale for Group Psychotherapy (AOSGP), is described and includes pilot testing and reliability and validity findings (Lanza et al., 2009). It was found that during treatment that an observational scale to record aggressive behaviors, defenses, and interventions mentioned in the literature reviews, had been developed. The items focused on spoken material and were on a continuum of increasing group member's awareness of and responsibility for their anger. The process items were directed to underlying psychodynamic issues on a continuum from avoiding anger, to indirect and then direct expression of anger.

2.3.3 Attitude Toward Violence Scale (ATVS)

Attitudes toward violence are developed throughout an individual's lifetime and can reflect his environment, the perceptions of significant others, and personal experiences in life. The negative attitudes of students can also have a negative effect on a developing adolescent's attitude (Center for Disease Control and Prevention, 1993; Royal & Roberts, 1987). Previous experiences and contact with disabled people, ethnicity and family values contribute to attitude development (Brillhart et al., 1990; Westbrook, Legge, & Pennay, 1993). According to, results of a study by the Organization for Child and Adolescent Development at the instruction of Princess Sirinthorn (2005) on violence management in vocational students in the Bangkok Metropolis, the importance of attitudes toward violence by students who used violence or assaulted another school could be seen. So, this point according to

Thaweekoon (1995) studies the effectiveness of psychological traits training for the prevention of violent behavior in vocational college students especially attitude training able to directly the affect attitudes toward violence. In addition, attitude training to promote the potentiality of adolescents to deal with violent problems was recommended by the researchers (Pandaeng, 2005; Srimala, 2004; Thaweekoon, 1995).

2.3.4 Violence Management Skills Test (VMST)

A self-care agency can help them to examine their values and beliefs in the context of past experiences and present situations, realizing that not only the individual knows the importance of life events, to identify strengths and weaknesses and to develop or maintain problem solving skills as advocate, but also provides information in a way that they can use by realizing that clinical knowledge or expertise is not the same as knowledge or expertise about the client's life (Thrasher, 2002). Thus, violence management skills are essential for adolescents.

Violence management skills refer to the implementation of self-care for managing or avoiding favorable attitudes toward violence and aggressive behavior leading to the use of violence, as well as the prevention of violence in adolescents. According to the literature reviews, even though there are a number of violence management skills, however, only 4 are available to Thai adolescents. They are problem solving skills (Thrasher, 2002; Snyder, 1987; Velsor-Friedrich, Pigott & Louloudes, 2004; Sansrisa, 2000; Auekit, 1998; Srimala, 2004; Limparatanagorn, 2004; Chinlumprasert, 2003), coping with emotion and stress (McCaleb, & Cull, 2000; Thrasher, 2002; Hinds, 2000; Auekit, 1998; Srimala, 2004; Limparatanagorn,

2004), interpersonal relationship skills (Snyder, 1987; Peravanakul & Wiwatkunupakan, 1999; Jansuk, 1998; Limparatanagorn, 2004), and social responsibility (WHO, 1994; McCaleb & Cull, 2000; Kotepatnanon, 2000; Limparatanagorn, 2004; Tungklave, 2005).

Adolescents can be encouraged to learn violence management for reducing aggressive behavior, having a positive attitude toward violence, and enhancing violence management skills such as problem solving skills, coping with emotion and stress, interpersonal relationship skills and social responsibility. These components are able to help adolescents learn what to do to manage signs of violence by themselves and what not to do in their gradually widening areas of daily life. They will develop behavioral repertoires for self-care practice when various combinations of conditions and circumstances prevail in themselves or in their environments (Orem, 2001).

2.4 Violence prevention

2.4.1 Concepts of violence prevention

Violence prevention is an expanding science. It is a new science and a multidisciplinary one that aims to reduce recidivism rates among adolescents and change violence related attitudes, beliefs, and behaviors (Lutzker, 2005). In addition, it is able to prevent injury occurring from violence and also control to minimize the extent of injury, disability or death. Violence prevention through widespread adoption of effective prevention programs employs scientists from multidisciplinary backgrounds (e.g., psychology, sociology, criminology, epidemiologists, economics, and anthropology), public health specialists, communication specialists, and

administrative staff (California Department of Education, 2003; Hammond et al., 2005).

Furthermore, violence prevention concepts can vary considerably in various approaches (Schick & Cierpka, 2005). They can focus on the child's development, on fostering parenting competences, on the promotion of the competences of educators and teachers to build strong and supportive relationships, or they can try to positively influence the psychosocial environment of children and their families.

2.4.2 Types of prevention on violence in adolescents

There are various types of patterns of violence prevention in adolescents since the problem of violence does not arise only from one aspect. Several patterns created by the practitioner concerned with violence problems, so that prevention has to receive coordination from every component of society including schools, the working place, other institutions and the system of law (Bell, 2005). In addition, World Health Organization (WHO, 2002) divided patterns of violence prevention into 4 aspects such as the prevention to the individual, interpersonal relationships, to the community and to society (WHO, 2002) as follows:

1. Prevention by the individual

This aspect has 2 objectives: firstly, to support and create a negative attitude toward violence and to support and create appropriate behavior in adolescents before growing up to be adults. Secondly, to change the attitude and behavior of the individual not to be violent and to reduce the risk of violence through the following approaches:

1.1 Provide equal educational opportunity in the school system, especially for poor students, to study primary school or occupational training and to gain knowledge related to violence.

1.2 Promote and prevent bullying starting from pre-elementary school; promote interpersonal relationships particularly amongst adolescents and encourage them to develop life skills for dealing with anger, for problem solving, for building morals and ethics.

1.3 Offer therapy in controlling crises, such as counseling, particularly for the victims of violence; promote groups to deal with violence and mental abnormalities, including suicidal behavior.

1.4 To treat people who are at risk, who may hurt themselves, particularly from severe violence and aggressive disorders. In addition, set up treatment programs for those in the normal category who make mistakes, and for those tortured or bullied. Set up programs that use group processes for training regarding sexual roles, life skill practice, anger management and social responsibility.

2. Prevention in interpersonal relationship

Prevention of interpersonal relationship means the promotion of good relationships within the family and solving inappropriate relationships. It may be the relationship between the victim and the person who makes a mistake, such as conflict in marital life, lacking a close relationship between parents and child, or negative influence from a person or friend close to that individual. Methods that can be used are as follows:

2.1 Training parents and children to have a goal to improve their relationship; encourage parents to train the child; assist in developing self-management abilities for children at risk of being bullied by the parents; prevent crime in the future.

2.2 To provide counseling and advise adolescent couples who take risks or demonstrate aggressive behavior against themselves and others, whose actions are lacking in direction or do not follow rules and society's norms.

2.3 Family therapy has the goal of improving and solving problems of communication and relationships between members of the family and to give them skills training to solve problems.

2.4 Home visits consist of visits by the nurse or health care provider to promote care, and advice the child at risk of being hurt or having deviant behavior, that may lead to the use of violence.

2.5 Training in relationship skills. This training of various groups may be for both males and females to learn sexual roles or about relationships between peers and others.

3. Prevention in the community

This aims at enhancing awareness and gaining greater attention about violence in society, encourages the community to play a role in problem solving, and to promote having a caring system for the victim who receives the impact of violence by following these procedures:

3.1 Educating the public through campaigns in schools, the workplace, through nursing and other institutions, using various media, leading to the prevention of violence in the community.

3.2 Improving the environment and determining the risk of violence such as having better street lighting, increased safety in schools, and getting rid of a negative environment, all affect child development.

3.3 Promoting activities especially courses for adolescents, for example, sports, music, art, and drama.

3.4 Encouraging members of various groups in the community to cooperate with the community by training volunteers to have ability and to manage violence of various types and keep the peace in the community.

3.5 Building teamwork in the caring system setting. This could involve the exchange of data or information, knowledge, expertise in order to decrease problems of violence in the community in places such as the school, workplace, immigration office and hospital.

4. Social prevention

This prevention aims at cultural, social and economic factors particularly changing the law, policies, social and cultural beliefs in the following ways:

4.1 Improve and resolve the judicial process and promulgate laws that are right and fair to people, for example, legislation about sexual violence, physical violence, especially child abuse, in schools, the home or other places. Such cases should be reported.

4.2 Participation with commitment of various countries to prevent violence. This revision or change of policy is to solve poverty, inequality and to promote the strength of the family involved with the strengthening of laws about weapon usage through policy and legislation.

4.3 Adapt and change cultural and social beliefs with regards to sexual roles, race, race discrimination, traditions that lead to violence.

2.5 Effective Violence Prevention Programs for Thai adolescents

Research on violence prevention programs is limited especially in Thailand. Several programs from a systematic review of literature have been found to be not directly effective in reducing violence. Thus, there is a necessity to develop an effective prevention program dealing with violence among adolescents. Effective violence prevention programs should have the following key dimensions:

2.5.1 Violence prevention programs need to begin with a strong theoretical model and empirically tested methods that are adapted to the Thai population for which the program is intended.

2.5.2 The programs should receive the aid of a panel of experts from a variety of backgrounds and from the local community stakeholders for their development. These panels should be composed and should encourage collaboration amongst adolescents, teachers and parents, focusing on the strengths of the teachers, parents and staff involved (Cooper et al., 2003; Webster-Stratton & Taylor, 2001).

2.5.3 The programs must also consider the developmental level of the participants and their cultural background to increase the program's relevance to them (Center for School Mental Health Assistance, 2002; Elliott, Williams, & Hamburg, 1998). In addition, the participants can provide insights into the types of violence experienced, the extent of the problem, and the adolescents themselves.

2.5.4 Research on early intervention programs have found that the most effective programs utilize several strategies including empowerment in violent management skills for adolescents through incorporating physical and psychological components. In addition, previous reviews of 200 intervention studies found the “best” intervention programs included life skills training (Dahlberg & Potter, 2001; Dusenburg et al., 1997).

2.5.5 In the design of the program it should be realized that risk and protective factors should be addressed, and that important factors for success in implementing the program are to focus on distinct problems, appropriate programs for the specific target population, ensure involvement of the participant, staff and family, incorporate motivation and effective project leadership, have an effective program director, well-trained and motivated staff, plentiful resources and implement the program with fidelity to its design (National Mental Health Information Center, 2005).

2.5.6 The programs should incorporate measurable outcome indices to assess the impact of the prevention program in order to insure that the program is effective in decreasing violence (Samples & Aber, 1998; Seechalalai, 2004).

However, violence prevention interventions have generally targeted adolescents and their families. Therefore, such families might be overwhelmed with other problems and might lack sustained interest in or ability to commit to regular home visitation. They might also be hard to reach and hard to retain in the program because of frequent life transitions. Also, in the violence prevention program personnel may be hard to recruit, train, and retain due to low pay and difficult work conditions. It has also been noted that assistants may require more training and supervision than

professionals. Besides, there have very often been families with severe violence problems who find it difficult to accept help due to feelings of shame or mistrust in public institutions. To adequately support these families and children, opportunities outside the family environment must also be taken. Then, schools are especially suited for the conduction of long-term curricula and allow a direct and permanent transfer of the learned competences to real life situations (Brookmeyer, Henrich, & Schwab-Stone, 2005; Hausman, 1996; Schick & Cierpka, 2005; Walker et al., 1988).

In addition, the task of violence prevention is too large to be handled by a single unit. Thus researchers should seek to engage a variety of partners to combat violence: federal agencies, provincial and local health departments, school-based organizations, advocacy groups, community-based organizations, the media, and private industry. Leadership can be provided in the field of violence prevention by bringing these varied partners together through conferences and other forums, and by coordinating the effort to conduct and disseminate evidenced-based programs and practices to prevent violence (Center for Mental Health Services, 2006; Hammond et al., 2005).

Thus, existing knowledge leads to understanding the variety of violence preventive interventions that have been both effective and ineffective, and the limitations and strengths of the outcomes in each study. These studies have already confirmed the confidence of the researcher to develop the new knowledge, and a violence prevention program strongly designed and efficient for adolescents in violence management.

Accordingly, adolescents will be able to take better care of themselves in school or in the family as they reach their adulthood. Also, the violence prevention program

will enhance the value of the nursing practitioner to promote self-care competence of adolescents in life skills to prevent the use of violence in Thai society.

3. Theoretical Basis for the Violence Prevention Program

3.1 Theories related to violence prevention programs

Numerous theoretical explanations for the present proliferation of violence among adolescents exist. The researcher offers an indication of seven theories of adolescent violence and the major philosophies involved in each theory which have been used as a guide in developing a violence prevention program for adolescents. The 7 theories are: (1) Social Learning Theory, (2) Attachment Theory, (3) Attribution Theory, (4) Feminist Theory, (5) Resilience Theory, (6) Developmental Theory, and (7) Eclectic Theory. These are discussed and highlighted as follows:

3.1.1 Social Learning Theory

Social Learning Theory (Bandura, 1986) is the most popular explanation at this time, and it hinges on the assumption that violent behaviors among adolescence are learned from adolescence observing and modeling the violent behavior of those around them, or in the media. Bandura (Bandura, 1977) identifies observational learning as the means of acquiring interactional skills, in which the imitated behavior of adult role models tend to be reinforced in the child (O'Leary, 1988). In addition, Social Learning Theory acknowledges that the media and cultural factors are persuasive influences on one's personal understanding of interpersonal violence (Miedzian, 1995). Through the entertainment media, adolescents are introduced to powerful examples of coercive and sexist models of relationships (Barongan & Hall,

1995), so parents and people in the social environment heavily influence violent behavior among adolescents (Prothrow-Stith, 1991).

3.1.2 Attachment Theory

Bowlby (Bowlby, 1982) proposes that children form mental representations of relationships based on their history with significant caregivers. This cognitive-affective understanding of all elements in the relationship (the relationship, the self, and the other) is thought to function as both a prototype and template for forging future relationships. At the onset of adolescence, attachment needs gradually shift from parents to peers, with the notion that the continuity in attachment models between childhood and adolescence should be greater than between childhood and adulthood (Hazan & Shaver, 1987). An insecure attachment style appears to describe a high-risk group for both victim and offender in adolescent close relationships, particularly for adolescent males with a history of child maltreatment (Wekerle & Wolfe, 1998). Thus, Attachment Theory considers males and females from maltreatment backgrounds to be equally at-risk for relationship violence.

3.1.3 Attribution Theory

A third explanation for adolescent violence can be found in Attribution Theory, which holds that people try to make sense of their environments by identifying what they believe to be the causes, or underpinnings of the events they have experienced. In other words, people make inferences about events that transpire in their lives, and then act on those assumptions. While some people make relatively accurate attributions, others may make very distorted or inaccurate inferences about the events happening around them (Weiner, 1986). Among violent adolescents, attribution theorists believe that routine assumptions are made regarding the cruel or

malevolent intentions of others, and that these assumptions are generally unfounded. Thus, attribution theorists would hold that adolescents making faulty attributions should be trained to rethink these situations and realize that adversity does not arise solely through the bad intentions of others around them. From this theory, adolescents would be taught to reframe their ideas about the causality of their experiences.

3.1.4 Feminist Theory

Dobash and Walker (Dobash & Dobash, 1992; Walker, 1989) identifies relationship violence as gender-specific, with males as offenders and females as victims, except in same sex relationships. Physical danger is viewed as a dominant feature in assaultive male interactions (Browne, 1993). Feminist Theory locates relationship violence within the pervading traditional power structures of male dominance and female subservience, highlighting the themes of power inequality and active devaluation of women. It points to the violence-facilitating effect of normative socialization practices that promote rigid gender roles (Miedzian, 1995; Serbin, Powlishta, & Gulko, 1993). For instance, males are socialized to be aggressive, dominant, competitive, care-taking, and low in the direct expression of emergency emotions such as fear, distress, and concern. In contrast, females are encouraged to be passive, compliant, cooperative, care-giving, and low in the direct expression of anger (Dutton, 1995).

3.1.5 Resilience Theory

The violent behavior of adolescence lies in Resilience Theory (Bernard, 1991), which posits that some children are insulated from violence by various protective factors, most of which are assumed to be environmental. The theory helps to explain why not every adolescent raised in an impoverished, violent neighborhood

turns to violence in his own behavior. Resilient adolescents are thought to be protected by a number of factors including involvement in productive, meaningful activities, the presence of one or more supportive adults in their lives, and higher expectations from those around them. Resilience theorists would recommend that changes be made in the environments of children and adolescents so that the factors protecting adolescents from potential violence can be maximized. Thus, children should be exposed to new social situations where they are given support from adults and to expectations that they will accomplish some positive pro social short- and long-term goals.

3.1.6 Developmental Theory

The developmental perspective of psychopathology offers an important explanation of adolescent violence. The development of interpersonal and social-cognitive behavioral processes is thought to lead to aggressive behaviors and placing children at risk for future behavioral problems. The aim of programs from this perspective is to change violent behavior by implementing specific strategies to alter the child's maladaptive development. In other words, it is the process of a child's developing maladaptive behaviors that is important here, and researchers utilize a contextual approach toward understanding developmental psychopathology (Cicchetti & Toth, 1998).

3.1.7 Eclectic Theory

In addition, while each of these theories contributes uniquely to our understanding of adolescent violence, violence is multi-determined. Fields and McNamara (2003) proposed that a theory is only as good as the evidence that supports it. Eclectic Theory is the one theory which explains the problem of adolescent

violence, and it is possible that a blending of the aforementioned approaches might result in the most comprehensive treatment program for adolescent violence due to the numerous variables including the family situation, community, and mass media that have been linked in some way to adolescent violence in the past. Moreover, each of these theoretical approaches suggests different directions for intervention efforts.

3.2 Orem's Self-Care Deficit Nursing Theory

In this study, the violence prevention program is synthesized from a supportive education nursing system of the Self-Care Deficit Nursing Theory (Orem, 2001). It is a specific program for developing adolescents' capabilities in violence prevention for their self-care needs for preventing signs of violence: aggressive behavior and a positive attitude toward violence.

Underpinning Orem's Self-Care Deficit Nursing Theory is the operational basis to guide the study: nurses will assist adolescents to meet health deviation self-care requisites. As signs of violence are considered, adolescents have unique needs and ways of thinking, and behave according to their social and cultural environments: peers, teachers, parents. The goal of violence care is to assist adolescents to manage their signs of violence, to know therapeutic self-care demands by controlling their signs of violence and by regulating themselves physically and psychologically to prevent hazards, and by adopting effective self-care practices. However, self-care deficits occur due to limitations of self-care operations: estimative, transitive and operative self-care capabilities (Orem, 2001).

Increasing an adolescent's ability to deal with the complexity of concrete situations in a nursing practice situation requires knowing the conditioning effects,

that is, the way the person is affected. Basic conditioning factors are based on the premise that persons seek and receive attention (Orem, 2001). The elements of information about basic conditioning factors to identify self-care capabilities and limitations of adolescents are related to the substantive components of a self-care agency on violent management. These consist of peer, teacher, and family.

For an effective approach for the adolescent, the nurse should plan an intervention program particularly for adolescents who have signs of violence and limitations in self-care. Goal setting is needed to achieve desirable outcomes to reduce aggressive behavior, to foster a negative attitude toward violence, and to enhance violent management skills. These goals can be effectively achieved through school-based and nursing-based collaboration. Nurse and participant as well as peers, teachers and parents are all required in this partnership of interaction, particularly in exchanging practical information and for communication. The nurse plays the role of supportive assistant providing helping methods by teaching, guiding, supporting, and providing the environmental condition to develop the adolescent's abilities.

Thus, a violence prevention program will be able to assist by emphasizing adolescents' self-care, which is the capacity to reflect upon their experience of self and environment. This provides a guide to empower adolescents to engage in the deliberate action of self-care (Fitzpatrick & Whall, 1989). The program will develop goals and action with the participation of researcher and participants such as students, teachers, and parents as representatives of the neighborhood of the adolescent. It will provide direction and instruction to assist adolescents to learn how to care for themselves.

3.2.1 Self-Care Requisites of Adolescent

Adolescence, a critical period of development, is a dynamic and uncertain period between childhood and adulthood (Edelman & Mandel, 1998; Murray & Zentner, 1997; Slusher, 1999). This is a time when teenagers discover ways to become independent, and it is also a time for learning appropriate behavior as opposed to violent behavior (Ervin, 1998).

Development occurs physically, cognitively, emotionally, and socially, and results in ever changing self-care requisites. Exhibiting violent behavior is a phenomenon that is more likely important at a stage of adolescent life. They can have violent signs that interfere with the way they think, feel, and act. Adolescent needs generate “self-care requisites” such as safety and prevention from hazards. Therefore, the developmental self-care requisites are associated with the adolescent developmental process with conditions and events occurring during various stages of the life cycle, and events that can harmfully affect development. They are not able to regulate themselves. In this view, an adolescent’s capability to meet their own needs, and thus to care for themselves is disrupted (Edwards, 2001). Adolescents have unique needs and ways of thinking, and behave according to their social and cultural environments as influenced by peers, teachers, and parents (Orem, 2001). Signs of violence may indicate the need to obtain help as soon as possible because a variety of signs of violence may point to mental health disorders or serious emotional disturbances as well as aggressive behavior disorders in adolescents (National Mental Health Information Center, 2007).

Universal self-care requisites are “common to all human beings during all stages of the life cycle and are associated with life processes, with the maintenance of

the integrity of human structure and functioning, and with general well-being (Orem, 1995). Eight universal self-care requisites are suggested: air, water, food, elimination, activity and rest, solitude and social interaction, prevention from hazards, and a sense of normalcy (Orem, 2001). Developmental self-care requisites of adolescents are identified as requisites associated with human developmental processes and with conditions and events occurring during various stages of the life cycle. Satisfaction of developmental self-care requisites are assumed to contribute to the promotion of age/stage appropriate development and to the prevention of developmental delays (Orem, 2001). Thus, developmental self-care requisites are associated with the adolescent developmental process with conditions and events occurring during various stages of the life cycle and events that can harmfully affect development.

Self-care is an action system (Taylor, 2001, as cited in Alligood & Tomey, 2002). Self-care must be learned and it must be performed deliberately and continuously in time and in conformity with the regulatory requirements of individuals (Orem, 2001). These requirements are associated with their stages of growth and development, states of health, specific features of health or developmental states, levels of energy expenditure, and environmental factors of adolescents (Taylor, 2001, as cited in Alligood & Tomey, 2002). Therefore, the types of self-care requisites of high-risk violent adolescents are identified in terms of the development of self-care requisites (Spitzer, Bar-Tal, & Ziv, 1996). These are associated with adolescent growth and developmental processes and with conditions and events occurring during various stages of the life cycle and events that can harmfully affect development.

A person performs actions or a sequence of actions to reach a goal or to achieve a result with three phases of deliberate action of self-care practice within concrete situations of action. The *estimative* ability is an initial condition that leads to deliberate action performed by the individual. This phase of the *transitive* proceeds from reflective understanding and judgment about the situation, including how a situation can be changed, concluding with a decision about the ends to be sought and the means to be used; the next stage includes the decision about what will be done and the design for doing it, or, in other words, the *productive* operation of action sequences through which the end is reached, and the goal achieved or not achieved.

As mentioned previously, Orem (2001) defines self-care as the practice of activities that the individual initiates and performs on one's own behalf in maintaining life and well being. Self-care actions are directed toward meeting three different types of self-care requisites: universal, developmental, and health deviation requisites. Meeting health deviation requisites may aid in the control of pathology in its early stages and in the prevention of defect and disability. Effective meeting of universal and developmental self-care requisites is essential when there is pathology in order to maintain human structure and functioning and to promote development and thereby contribute to rehabilitation (Kathy, 2006).

The effective performance in response to three types of requisites known as therapeutic self-care demands will facilitate the productivity of human and environmental conditions that 1) support life processes, 2) maintain human structure and human functioning within a normal range, 3) support development in accordance with the human potential, 4) prevent injury and pathological states, 5) contribute to regulation or control of the effects of injury and pathology, 6) contribute to the cure or

regulation of pathological processes, and 7) promote general well being (Orem, 2001). The success in personal endeavors towards achieving those conditions reflects the soundness or wholeness of developed human structures and of bodily and mental functioning as “health”. Therefore, these seven conditions are within the domain of a person’s ability to regulate or control, so the effects of injury, whether physiologically or psychologically, is a significant outcome of the prevention of hazards through nursing care. This statement signifies the importance of self-care practice. It implies that signs of violence in adolescents can be maintained within a normal or appropriate level of human behavior while reducing both their aggressive behavior and a positive attitude toward the use of violence and enhancing violent management skills if they are able to perform successful self-care. The demonstration of the effective performance in meeting these requisites enables adolescents to regulate or control themselves to manage violent tendencies and to learn to deal with potentially violent situations not only in their schools or family but also in the community.

In addition, Orem (2001) mentions that self-care is a learning behavior and this is the practice of activities to control or regulate internal and external factors that affect the smooth activity of a person’s own functional and developmental processes or contribute to a person’s personal well-being. Then, self-care practice will encourage adolescents to develop ability to attend to specific things such as the capability to manage violence, so this includes the ability to exclude other things as associated with violence management. A self-care agency contributes to understanding their characteristics and the meaning of the characteristics, the ability to apprehend the need to change or regulate the things observed, the ability to acquire knowledge of appropriate courses of action for regulation, the ability to decide what

to do for managing violent situations, and the ability to act to achieve change or regulate themselves to prevent violence usage. The content of self-care agency derives from its proper objectives, developing self-care requisites, whatever those requisites are at specific moments. The adequacy of self-care agency is measured in terms of the relationship of the number and kinds of operations that a person can engage in and the operations required calculating and meeting an existing or projected therapeutic self-care demand. Moreover, determining the adequacy of self-care agency is essential if judgments about the presence or absence of self-care deficits are to be made.

Thus, self-care agency is understood as developing capabilities of individuals to engage in the named self-care operations in order to know self-care requisites and the means of fulfilling them within time and place frames of references. While such capabilities to engage in the named operations are understood as self-care agency, the actual engagement of persons in the operations within time and place frames of reference is self-care (Orem, 2001). Therefore, enhancing *estimative* and *transitive* capabilities of knowing and fostering a negative attitude toward violence, especially the capability to recognize signs of violence as well as enhancing the self-care ability in violence management, could facilitate the development of the self-care capability in adolescents to a level of operative ability.

Adolescent's self-care has three specific phases. The first phase is holding on to requisites of knowledge and attitudes about violence that have revealed some characteristics for the nurse in outlining the violence prevention program. The second phase is an empirical knowledge of events and of internal and external conditions and factors as well as an antecedent knowledge to facilitate the adolescent in making observations, attaching meaning to their observations as well as correlating the

meaning of events and conditions with possible courses of the performance of action. Phase three deals with the real creation of the operation of self-care. Therefore, the concept of self-care as a deliberate action is reduced to form a basis for two dependent variables of this study: comprehension of violence and self-care agency on violence of adolescent students showing signs of violence.

An important aspect of this determination is diagnosing the abilities of an individual to engage in self-care or dependent-care now or in the future and appraising these abilities in relation to the adolescent's therapeutic self-care demands. That helps the nurse to accurately diagnose self-care agency, and have a rational basis for (1) making judgments about existing or projected self-care deficits and the reasons for their existence, (2) selecting valid and reliable methods of helping, or (3) prescribing and designing nursing systems.

Therefore, when an individual's self-care requisites are met through self-care practice, the goal of self-care is accomplished. When these requisites are not met through self-care practice, a deficit exists. Adolescent' self-care requisites are met ideally through self-care practice. The practice is affected by self-care agency and the basic conditioning factors (Orem, 2001). Accordingly, the Self-Care Deficit Nursing Theory firmly explains why and how an adolescent care for themselves and includes the concepts of self-care agency, basic conditioning factors, and therapeutic self-care demands which self-care requisites are also incorporated into the theory and provide the basis for undertaking self-care (Johnson & Webber, 2005). Therefore, adolescents can use self-care practices to manage violent signs based on rationales on how to prevent or interrupt relations between causative agents of violence and violence risk

factors or the environment that together establishes the conditions necessary for violence management to develop.

Orem specifies five methods that nurses' use to help develop the self-care needs such as guiding and directing, providing physical or psychological support, providing and maintaining an environment that supports personal development, and teaching (Orem, 2001, as cited in Johnson & Webber, 2005). Therefore, through the nursing system, the nurse will assess the individual's self-care deficits and plans, implement and evaluate nursing actions directed toward supplementing them (Hanucharunkul, 2001). Then, the practice of nursing includes making a comprehensive determination of the reasons why adolescents can be helped through nursing.

3.2.2 Self-care practices on violence in adolescents

The violence prevention program represents a supportive-developmental nursing system designed to improve self-care abilities, and self-care practices. This concept would be more effective when used with adolescent students who can perform all self-care actions requiring controlled movement while engaging in self-care agency development.

Requirement for self-care is known as therapeutic self-care demands (TSCD). Therefore, the therapeutic self-care demands are considered as a major concern in this study in order to assist adolescent high-risk groups to meet their self-care agency, to be performed to prevent aggressive behavior, promote negative attitudes toward violence and enhance violence management skills. The requirements for violence prevention are specified in relation to what is known about violence management (1)

adolescent structure and functioning as concerned with attributes of violence usage and (2) specific violence signs or interferences with the normal adolescent condition. The effective meeting of the universal self-care requisites adjusted to age, environmental conditions, and the adolescent's health and developmental state is health care at the primary level of violence prevention. Orem (2001) acknowledges the importance of nursing intervention that helps the person in managing their health problems. While, there have been many studies on self-care based on Orem's Self-Care Deficit Nursing Theory, however, there is little evidence that sustained research programs are developing and expanding the theory (Taylor et al., 2000). Thus, the innovative nursing program should take adolescent's self-care perspectives into account and attempt to integrate the supportive developmental nursing program into nursing practices.

This study examines the effectiveness of violence prevention programs based on Orem's Self-Care Deficit Nursing Theory through focus on self-care practices of adolescent students. The results are expected to be used as guidelines for nurses to provide leadership in schools and within the family in planning and implementing strategies for promoting self-care behavior on violence in adolescents. In particular, the successful performance of self-care depends on developmental stage, health, sociocultural orientation, available resources, and life experience. The role of health care providers is to assist adolescents to manage their health and well-being. To be motivated for self-care, it is important that adolescents believe that there are viable solutions for their physical and psychological concerns (Ditto, Jemmott, & Darley, 1988).

Thus, self-care practices on violence for high-risk adolescent students who have violent signs would be set on a specification of significant activities that they should carry out for reducing aggressive behavior (Sutin, 1996), favorable attitude toward violence (Pandaeng, 2005), and enhancing violence management skills (Limparatanagorn, 2004).

3.2.3 Conceptual structure of self-care operations of adolescents regarding violence

An identification of sub operations of the estimative, transitional, and production operations of self-care was developed to provide insight into the three operational capabilities, so their results are identified in sequential relationships in Figure 4.

Conceptual structure: adolescent capabilities to perform self-care operations



Operations

Results

Estimative Phase: adolescent students will know self-care requisites and meaning of developing abilities to prevent violence by themselves.

Investigation of internal and external conditions of adolescent students and violence risks factors significant to self-care demands for violence prevention

Investigation of the meaning, regulating and the means available for characterized condition and factors and their regulation on violence situations.

Investigation of the question: How can existent conditions and factors be regulated (i.e., changed or maintained)?

- Empirical knowledge of self and environment such as teacher, peer, and parent concerned with violence in an adolescent.
- Experiential knowing (based in part on acquired technical knowledge) of the meaning of the existent conditions and factors for life health, and well-being of adolescent students from their experience.
- Technical knowledge of what can be effective regulation on violence management as used to deal with violent situations.
- Strategies on violence prevention for adolescents

- 1) Problem solving skills
- 2) Coping with emotion and stress
- 3) Interpersonal relationship skills
- 4) Social responsibility skills

Transitional Phase: adolescent students will make judgments and decisions about self-care on violence

Reflection to determine which course of self-care on violence should be followed. Deciding what to do in violent situations with respect to self-care on violence prevention.

- An affirming judgment that one course of self-care on attitude toward violence and violence management are preferred, or that a series of courses is preferred, or that none should be pursued.
- A decision to engage in or not engage in specific regulatory self-care operations on violence management.



Figure 4 Conceptual structure: adolescent capabilities to perform self-care operations on violence

Figure 4 is the summary of the essence of self-care operations associated with violence. There are 3 operational capabilities based on these 3 phases as follows:

The first phase is the *estimative phase* involving knowledge related to signs of violence, violence risk factors and effective violence prevention for adolescents who are able to gain knowledge and have an image about their situation. This also covers their health history, performance of physical examinations including assessing their health compromising behaviors, their developmental stage, cognitive thinking, and support systems of their capability to make appropriate estimations and also evaluate their self-care abilities.

The second phase is *a transitive* capability which is attending to the decision-making procedure. This phase is a crucial step in self-care (Utz, 1990). In this phase, the health care provider should ask the adolescents how they feel about their symptoms of violence or violent encounters. In other words, whether they feel satisfied, regretful, or guilty. They should be asked whether they are trying to manage signs of violence and are trying to perform self-care and whether their behavior is associated with self-care activities of violence management.

The third phase is *productive* competence in achieving self-care agency. This would determine what the adolescent needs to do in order to manage violent signs. It can be used as the criterion in following up on their activities. The result is to judge whether it is a suitable action to perform or not, how to control one's performance, the effect and outcome, the conclusion and decision making for subsequent actions. Therefore, it includes increasing self-esteem with appropriate self-care operations, creativity and forming new behavior or maintaining good behavior in terms of self-

care agency. It means that if there is evidence indicating that desirable goals are not met or other actions may provide better results, they may adjust his or her actions accordingly.

In addition, the strategies on violence prevention program for adolescents use helping methods such as teaching, guiding, supporting, and providing an environment for self-care development which would make the adolescents be active participants in their own self-care practice. For this reason, the researcher is interested in studying the effects of the program on self-care practice for high-risk adolescents. The results will be used as a guideline in planning and providing care for continuous self-care performance.

Summary

The self-care operation process is composed of 3 phases that enables adolescents to gain knowledge and comprehension about signs of violence, violence risk factors as well as to acquire the ability to reflect on negative attitudes toward violence, and to achieve the operative capability that can lead them to taking care of themselves and promote their self-care practices (Orem, 2001). The first phase is the *estimative phase*. It is the operation of seeking both from experience and knowledge, whereas, phase 2 is a *transitive phase*; it considers the capability of decision making for self-care agency. Phase 3 is a *productive phase*. It is the production to achieve in self-care agency, phase 3 is involved with the evaluation of self-operation results to judge whether they are suitable to carry out or not. It looks at performance control and its effect and results, as well as conclusions and decision making in subsequent

actions, including having a sense of dignity and increasing self-esteem with appropriate self-care operations, creativity and forming new behavior traits or maintaining good behavior in patterns of self-care agency for prevention of violence.

CHAPTER 3

METHODOLOGY

This chapter describes research methodology approaches to test the violence prevention program as compared to regular care. The topics of this chapter consist of research design, population and sampling, settings, instrumentation, protection of human subjects' rights, data collection, intervention procedures, strategies to minimize threats to internal validity, and statistical analysis of the data.

Research Design

The research utilized a within group, repeated measures design (Creswell, 2009) to examine the effectiveness of a violence prevention program for adolescents. This research design had one group sample but indicated the data of two periods as summarized in Figure 5:

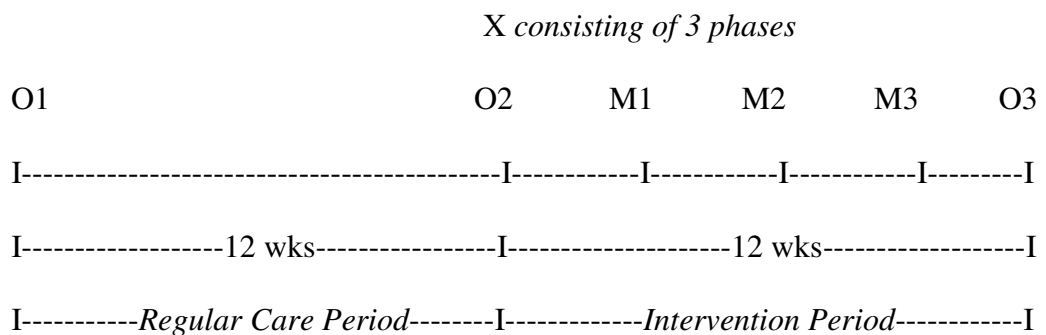


Figure 5 Research design of the study

O1 was baseline data or pre-test of the regular care period.

O2 was data or post-test scores of the regular care period and pre-test scores of the intervention period.

O3 was data or post-test of the intervention period when the program was completed.

X was an intervention, violence prevention program.

M1 was the *estimative phase* to establish understanding of signs of violence and mutual goal setting for violence management.

M2 was the *transitive phase* to prepare the adolescents to practice self-care activities.

M3 was the *productive phase* to perform self-care with regard to aggressive behavior, favorable attitudes towards violence and violence management skills.

Control of Confounding Factors

Basic conditioning factors are age, gender, school environment, and other conditions affecting the abilities of persons engaged in self-care. McCaleb and Edgil (1994) indicated that age influenced knowledge and attitudes towards self-care practices in early, middle, and late adolescence while McCaleb and Cull (2000) pointed to family life experiences and school environment in predicting self-care ability in adolescents. Dysfunctional family organization and the lack of social support were significant as predictors of physical abuse (Renker, 1998). Moreover, some of the negative psychological changes associated with adolescent development resulted from a mismatch between the needs of developing adolescents and the

opportunities afforded them by their social environments namely school and family (Eccles, Midgley, & Wigfield, 1993). Cull (1996) reported that significant influences on adolescents who were exposed to violence were self-care practices as related to gender, age, presence of health problems, and the environment. At the same time, if parents were not educated, they themselves could be victims of violence. Thus, to maximize the internal validity of this study, a recruitment process was used to control the effects of gender, age, and school environment on violence management.

Setting

A public high school located in Muang District, Songkhla Province was selected where the incidence of behavioral problems ranged from bullying to aggressive behavior, fighting, etc. Moreover, this high school was representative of adolescent students who had signs of violence within the general framework of the research criteria, and supported the school health promotion policy which was attentive to preventing inappropriate behavioral problems amongst adolescent students.

Regular care

Generally, Student screening was carried out from the student's anecdotal record, and they were divided into 2 groups - a normal group and a risk/problematic group. The risk/problematic group consisted of those students who were having problems as screened by the standards used by the school and which attempted to assist, prevent or solve the problem in accordance with the case.

Regular care was a single 30 to 40 minutes general health education session with the guidance teacher. The guidance teacher used interviews to comprehensively assess the student's problems. Then, after identifying and describing the student's problem in detail, he/she provided instructive information. It was suggested to the students that they disengaged themselves from their negative thoughts and try to find ways of making themselves feel better.

The selection of the school was determined using the following criteria:

1. The school had a high incidence of adolescent students who demonstrated signs of violence. This selection was based on the incidences of student behavioral problems statistics reported ranging from violence such as bullying, aggressive behavior, fighting, etc. Moreover, as the study required a considerable length of time, the school needed to be willing to participate. In this case, the researcher received good cooperation and participation from the school.

2. Some teachers were assigned by the administrators to be guidance teachers to take care of adolescent students, to follow up or to control students in order to exhibit appropriate behavior, and to be responsible for school safety.

Population and Sample

The target population of this study was public high school students in Muang District, Songkhla Province in Southern Thailand with moderate to high aggressive behavior, favorable attitudes toward violence, and violent management skills.

Inclusion criteria

- 1) Ages were from 12 to 15.
- 2) No prior history of being diagnosed or treated for the use of violence and substance abuse.
- 3) Had a score ≥ 78 on the Aggressive Behavior Scale (ABS);
- 4) Had a score ≥ 2.00 on the favorable Attitude Toward Violence Scale (ATVS);
- 5) Had a score ≤ 2.33 on the Interpersonal Relationship Skills (IRS), Coping with Emotion and Stress (CES), and Problem Solving Skills (PPS); and
- 6) Had a score ≤ 3.67 on the Social Responsibility Scale (SRS).

Sample size

The approximate sample size was determined based on statistical power, significance level of .05 ($\alpha = .05$), and desired power of .80. An adequate sample size for t-test was calculated based on the following formula (Cohen, 1988; p. 53).

$$N = \frac{n_{.10}}{100 d^2} + 1$$

Where N was the sample of the study.

$n_{.10}$ was the necessary sample size for the given significance criterion (α).

d was the effect size index for t-test of means in a standard unit, which was calculated from the following formula (Cohen, 1988; p. 20).

$$d = \frac{M_A - M_B}{\sigma}$$

M_A, M_B were population means, and

σ was the common within-population standard deviation,
(since they are assumed equal) ($\sigma_A = \sigma_B$)

The sample size of this study was calculated for the given significance of .05, and desired power of .80. The expected mean difference ($M_A - M_B$) of the effect of a primary care-based intervention on violent behavior and injury with power to detect an effect size was .40 ($p < .05$) (Borowsky, 2004). The effect of health program applying life skills to prevent violent behavior in Thai-adolescents with statistically significant difference (Limparatanagorn, 2004) which had the power to detect an effect size was .34 ($p < .05$). The researcher's estimated value was based on the results of the intervention studies on Thai-adolescents, which investigated the effect of violence prevention (Sutin, 1996). The mean and standard deviation of violent behaviors was calculated by using the formula (Cohen, 1988; p. 20):

$$d = \frac{M_A - M_B}{\sigma}$$

$$d = \frac{2.27 - 2.15}{.235} = 0.51$$

$n_{.10} = 1237$ with the desired power at $d = .10$, power = .80, significance level = .05. (Table 2.4.1; Cohen 1988; p. 54):

$$N = \frac{n_{.10}}{100 d^2} + 1$$

$$N = \frac{1237}{100 (.51)^2} + 1 = 48.5$$

The adequate sample size for t-test, t significance level of .05 and power of .80, should be at least 48 subjects in each group.

However, the researcher selected 45 subjects since classrooms had only 45 students. In order to control confounding variables, the researcher had to focus only on one classroom, thus, in this study the sample was a group of 45 students.

Sample selection

The students in the 7th grade or Mattayom # 1, aged from 12 to 15 who attended a high school in Muang District, were screened for violent tendencies using the Aggressive Behavior Scale (ABS), Attitude Toward Violence Scale (ATVS), and Violence Management Skills Test (VMST). After the sample adolescents were recruited utilizing the inclusion criteria described above, all students were approached and given an overview of the study during the period of pre-regular care.

As a preliminary step, the adolescents were pre-tested on the outcome of the violence prevention program assessed by ABS, ATVS, and VMST in the pre-regular care period. Thus, after completing the period of regular care, the students were post-tested assessed by ABS, ATVS, and VMST. Then, after the period of violence prevention intervention ended, they were assessed using the same instruments as in post-intervention, and their satisfaction of the program was assessed by the Students' Satisfaction of the Violence Prevention Program Questionnaire which was later included in the intervention period. In addition, during the regular care period and intervention period, the adolescent students were observed by the Observational Aggressive Behaviors Scale (O-ABS).

Instrumentation

The research instrument in this study had three categories: a demographic data form, a measure of outcomes, and a satisfaction of the violence prevention program. Outcome measures comprised aggressive behavior scores, favorable attitude toward violence scores, and violence management skills scores. In addition, the student's satisfaction of the program was measured by the satisfaction of the violence prevention program scores.

1. Demographic data

This study used the demographic data form, developed by the researcher based on a review of literature which showed the influence of violence among adolescents. This included personal information such as gender, religion, parental marital status, persons living with student, number of offspring in the family, student's leisure activities, family's monthly income, father and mother's educational levels, father and mother's occupations, students' violence experience in the family and types of violence, students' violence at the school and types of violence.

2. Outcome measures

This study used four assessments to appraise the signs of violence in adolescents. Violent behavior was assessed by a self-rating measure on the Aggressive Behavior Scale (ABS) and was observed by the Observational Aggressive Behavior Scale (O-ABS). Favorable attitude toward violence was assessed by the

Attitude Toward Violence Scale (ATVS), and violence management skills were assessed by the Violence Management Skills Test (VMST).

In addition, another instrument measured the student's satisfaction regarding the program in order to evaluate the satisfaction and feasibility of the program among the students in the intervention period and was called Students' Satisfaction of the Violence Prevention Program Questionnaire.

The outcome measurements utilized the following 4 tools:

1. Aggressive Behavior Scale

1.1 Aggressive Behavior Scale (ABS) (Buss & Perry, 1992; Bandura, 1986; Sutin, 1996) was a 58-item self-rated assessment of aggressive behaviors. ABS items assess both verbal aggression and non-verbal aggression. Verbal aggression would cover, for example, loudly blaming or insulting another person whereas non-verbal aggression could be the use of physical violence against others or objects. For example, if somebody harmed you, you would try to find the opportunity to harm that person back. Respondents rated their experience of the use of violence both previously and presently on a scale of 0 (none of the time, never), 1 (1-2 times for every 10 times/ rarely), 2 (3-5 times for every 10 times/ sometimes), 3 (6-8 times for every 10 times/ usually) and 4 (9 to 10 times for every 10 times/ frequently).

The Sutin (1996) Thai translation of ABS defines scores of 0 to 77 as mild aggression, 78 to 155 as moderate aggression, and 156 to 232 as high aggression. An alpha coefficient for the internal consistency of the Thai translated ABS was .95. The research results from the study confirmed that the ABS efficiently differentiates between aggressive and non-aggressive behavior in Thai adolescents (Sutin, 1996).

In this study, the researcher measured the ABS internal consistency alpha coefficient was .95.

1.2 Observational Aggressive Behavior Scale (O-ABS)

The Observational Aggressive Behavior Scale (O-ABS) (Buss & Perry, 1992; Bandura, 1986; Sutin, 1996) was developed from the concept of aggressive behavior comprising both verbal and physical aggression. This tool was used to observe both kinds of behaviors and these behaviors were recorded by two observers indicating the frequency of occurrence.

Cohen's kappa coefficient (Cohen, 1960) was a statistical measure of inter-rater agreement applied in this study. The equation for K was:

$$K = \frac{\text{Pr}(a) - \text{Pr}(e)}{1 - \text{Pr}(e)}$$

$\text{Pr}(a)$ was the relative number of agreed observations among raters

$\text{Pr}(e)$ was the hypothetical probability of chance agreements

Two observers recorded both physical and verbal behavior indicating frequency of aggression. In this study, a Kappa $> .70$ was considered satisfactory.

2. *Favorable Attitude Towards Violence Scale*

Favorable Attitude Towards Violence Scale (ATVS) (Brillhart et al., 1990; Kretch et al., 1990, as cited in Pandaeng, 2004; Westbrook, Legge, & Pennay, 1993) was a 33-item self-rated assessment of attitude toward violence. ATVS items have 3 components, namely, the cognitive, affective and behavioral components of attitude toward violence. This tool comprised two dimensions which were positive attitude toward violence and negative attitude toward violence. Respondents rated

their positive attitude toward violence on a 4-point scale (1= strongly disagree, 2= disagree, 3= agree, 4= strongly agree), and the respondents rated unfavorable attitude toward violence on a 4-point scale (1= strongly agree, 2= agree, 3= disagree, 4= strongly disagree).

In earlier study, higher levels of scores using this tool were found for adolescents who self-reported a history of violent victimization (Funk, 2005). The Pandaeng (2004) Thai translation of ATVS defines the total scores of 1.00 to 2.00 as mild, 2.01 to 3.00 as moderate, and 3.01 to 4.00 as high level of favorable attitude toward violence. An alpha coefficient for the internal consistency of the Thai translated ABS was .85. The research results from the study confirmed that the ATVS efficiently differentiated favorable attitudes toward violence of Thai high school students (Sutin, 1996). In this study, the researcher measured the ATVS internal consistency alpha coefficient was .96.

3. Violence Management Skills Test

Violence Management Skills Test (VMST) (Limparatanagorn, 2004; Tungklave, 2005; WHO, 1994) was developed from life skills concepts to directly assess violence management skills. The Violence Management Skills Test is composed of 4 parts. The first tool consists of 3 parts: problem solving skills (12 items), coping with emotions and stress skills (19 items), and interpersonal relationship skills (13 items). These 44 items were self-rated on a 3-point scale (1= not true, 2= somewhat true, 3= true). The Limparatanagorn (2004) Thai translation of VMST defines scores of all three violence management skills for each test item as 1.00 to 1.66 as being mild, 1.67 to 2.33 as moderate, and 2.34 to 3.00

as high. An alpha coefficient for internal consistency of the Thai translated VMST problem solving scores was 0.64, coping with emotions and stress skills scores was 0.82, interpersonal relationship skills scores was 0.75. The research results likewise confirmed that the VMST showed efficient differentiation between the violent group and non-violent group of Thai adolescents (Katesing, 1995). In this study, the researcher measured the VMST internal consistency alpha coefficient in each Violence Management sub-skill: Interpersonal Relationship Scale was .94, Coping with Emotion and Stress was .91, and Problem Solving was .93.

The second part of violence management skills test was Social Responsibility Scale (SRS) (Berkowitz, Leonard, & Lutterman, 1986; Tungklave, 2005; WHO, 1994). This tool was composed of 47 self-rated assessment items on social responsibility. SRS items have 4 categories, namely, political responsibility, responsibility to family, responsibility to school, and responsibility to friends. Respondents rated their responsibility on a 4-point scale to positive questions (4= the most true, 3= somewhat true, 2= true, 1= not true) and negative questions (1= the most true, 2= true, 3= somewhat true, 4= not true).

The Tungklave (2005) Thai translation of SRS defines scores of 1 to 2.33 as mild, 2.34 to 3.67 as moderate, and 3.68 to 4.00 as a high level of social responsibility. An alpha coefficient for internal consistency of the Thai translated SRS was 0.87. In this study, the researcher measured the SRS internal consistency alpha coefficient was .96.

4. Students' Satisfaction of the Violence Prevention Program

Questionnaire

The satisfaction of the program questionnaire was designed by the researcher to assess the students' satisfaction of the violence prevention program's effectiveness. The researcher generated the questionnaire from literature that reviewed the evaluation of violence projects (Cooper et al., 2003). Before the study, all items were assessed for content validity and item clarity by psychiatric nurses, community health nurses, psychologists, adolescents, teachers, and parents. This tool was composed of a 12-item self-reporting instrument in each phase of self-care operation. Each item was rated on a 5-point (1 to 5) scale, ranging from 1 (low) to 5 (high). Total scores on the questionnaire ranged from 12 to 60. As a result of pre-testing, the items were demonstrated to be valid and considered to be comprehensive. The researcher defined scores of 1 to 2.67 as mild, 2.68 to 4.35 as moderate, and 4.36 to 5.00 as a high level of satisfaction. The alpha coefficient for internal consistency of the students' satisfaction of the program questionnaire was .94.

Violence prevention program development

The violence prevention program was developed through the following steps:

1. A proposed program was developed through literature review on the topic of violence among adolescents. The results showed that exhibiting violent behavior was a phenomenon that was more likely at a phase in the adolescent's life. In high risk groups self-care deficit exists, thus, supporting the usefulness of Self-Care Deficit Nursing Theory within adolescent populations. It also identified the critical need for

examining self-care agency in adolescents for preventing hazards in the violence prevention program.

In addition, a framework for a model and structure of a violence prevention intervention among adolescents was developed from the literature review. There was considerable evidence that supported the efficacy of a violence intervention program among adolescents, especially for those who had aggressive behavior requiring self-care practice (Cull, 1996; Ervin, 1998; Moore, 1995; Renker, 1998; Velsor-Friedrich, Pigott & Louloudes, 2004). In addition, a violence prevention program structure required the participation of parents to share and provide an environment to encourage adolescents to perform self-care operations to meet self-care requisites (Eccles, Midgley & Wigfield, 1993; Moore & Beckwitt, 2006; Snyder, 1987). However, little research has been done, especially in Thailand, on how to manage such programs.

The violence prevention program among adolescents was a strategy to help them meet self-care requisites by promoting estimative, transitional and productive self-care operations for managing violence. This was found to be an effective approach. (Rew, 1990; Ervin, 1998). The efficacy of a violence prevention program underpinned by the Self-Care Deficit Nursing Theory has been studied extensively in adolescents with psychological and behavior problems such as attention deficit/hyperactivity disorder (Bussing, Ljungberg, & Williamson, 2006), substance use (Stewart, 2001), multiple aberrant behaviors (Vollmer et al., 1992), antisocial behavior (Snyder, 1987), mood disorders (Carol, 2001), sexual abuse (Rew, 1990), physical abuse (Renker, 1998) and delinquency (Ervin, 1998). Guidance teachers in the schools who underwent the violence prevention training course learned the

application of self-care operations to violence management among Thai adolescent students in this study.

2. A preliminary focus group discussion with interviews was conducted. Teachers, parents/guardians, and adolescent students shared their perceptions about violence among violent and non-violent adolescent students. This process required at least a list of sub themes as a guide in exploring a variety of topics in the violence prevention program. The researcher and guidance teachers provided students, classroom teachers, and parents/guardians the opportunity to brainstorm and develop activities for implementing strategies for promoting the self-care practice of violence management.

The researcher provided knowledge, and developed strategies and activities about self-care practices of adolescents for students and teachers concerning violent events such as the etiology, violence risk factors, the impact, and violence prevention, significant relationships at school and with family, oriented them about conditioning factors including how to screen for signs of violence in adolescents and how to prevent the use of violence, strategies for assessing and helping to reduce aggressive behavior, favorable attitudes toward violence, and to enhance violence management skills. Self-care abilities on the management of violence in adolescents were especially emphasized which concluded with an open group discussion.

2.1 Adolescent students, parents/guardians, and teachers were asked to brainstorm to develop effective and feasible strategies suited to their context to support the adolescent students who exhibited signs of violence. The researcher shared the main characteristics of violence prevention activities among adolescents based on the Self-Care Deficit Nursing Theory, focusing on enhancing self-care in a

violent situation. The main characteristics of such activities included (1) encouraging comprehensive understanding of violence and violence prevention, (2) providing opportunities to express cognition, attitudes, feelings, emotions, behavior as well as enhancing violence management skills, and (3) promoting self-care operations of violence management.

Based on such knowledge, students, parents/guardians, and teachers, i.e. the partners, created activities for violence prevention. The strategies consisting of 4 modules with 12 activities which were the framework of the program: (1) The students accessed a variety of literature and resources concerning issues of violence from various sources or media, (2) Using brainstorming techniques, all known data were extrapolated and listed on the board, (3) Discussion of “What we think we know from the data given of violent events” were listed, (4) Some preliminary hypotheses were formulated in the form of positives, negatives, or violence risk factors perceived at this point in the database, (5) Students were identified for their learning needs and the partners developed strategies for obtaining needed information on violence, and (6) Learning resources were identified and study assignments were distributed to the students within their groups. During the following class, all new information was shared, and hypotheses were refined.

2.2 The teachers’ participation consisted primarily of reflecting questions and thoughts back to the students or providing some guidance if the students were at an impasse. Guidance typically took the form of helpful methods (Orem, 2001) to assist students. These included (1) teaching (2) guiding (3) supporting (4) providing an environment to create self-care operations of violence management.

3. The program was revised taking into account the opinions of the participants in order to adjust the violence prevention program to make it as feasible and as accessible as possible.

4. The violence prevention intervention activities for violence management were examined by 7 experts comprising a professional nurse, a psychiatric nurse, a public health officer, an educationalist, a psychologist, and two psychiatrists to correct and suggest improvements to the content and structure of the intervention.

5. The violence prevention program was tried out with 15 students at a high school in Muang District.

The process for developing the violence prevention intervention is summarized in figure 6:

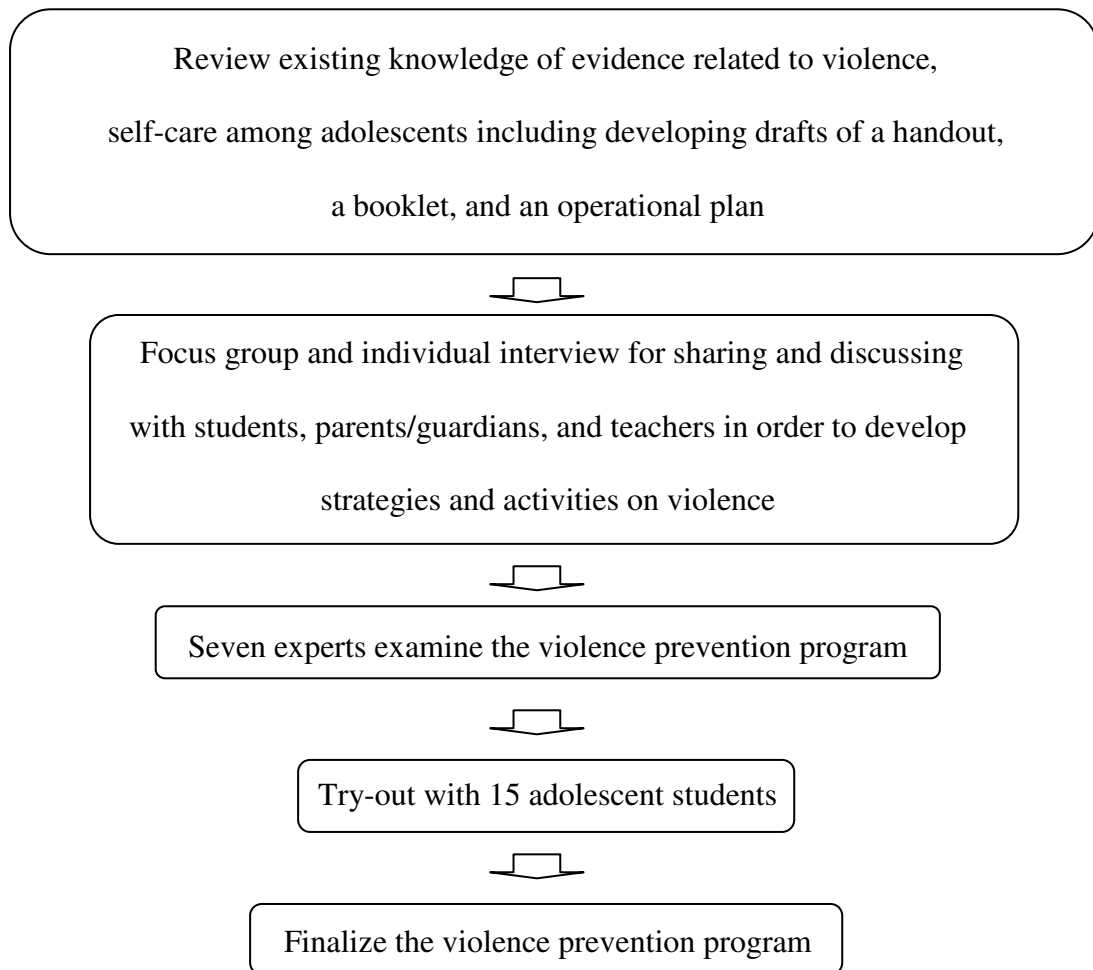


Figure 6 Process of developing a Violence Prevention Program

This experimental treatment draws on fundamental principles of Self-Care Deficit Nursing Theory (Orem, 2001) through focusing on self-care operations. The violence prevention program was scheduled once weekly for 50-60 minutes per session.

Handbook Guideline

The handbook guidelines were designed by the researcher and with the input of the participants based on literature review and preliminary qualitative study conducted in order to generate and gain more understanding about self-care practice on violence management among adolescents (Kongsuwan et al., 2008). All contents of the handbook guidelines were evaluated as appropriate by 5 experts consisting of a public health officer, two psychologists, and two educationalists.

Violent adolescent students used the handbook as a practice guideline. Adolescent students observed and noted their attitudes and actions to be carried out as well as their homework about violence management.

The handbook guideline was divided into 4 modules with 12 activities underpinning three phases of self-care operations as follows:

The first tier: *Estimative Phase*

Module 1: Stress and emotional management to prevent violence

This module was the initial activity employing strategies to share and develop positive self perception with others. The module aimed at developing an increasingly optimistic perception of self and the realization of different emotions and feelings of those all around us. There were 4 activities, as follows:

Activity 1: *Self - Map*

This activity was used to manage negative emotions which may be the cause of violence. It fostered self-perception by focusing on one's beneficial and positive

actions (Orem, 2001). In addition, self-mapping was a procedure for the adolescent to discover self and cultivate the ability to investigate internal and external conditions related to violence risk factors within one's own self. Self-investigation was especially meaningful to the adolescents to reflect on their behavior through the investigative question: How can existing violent conditions and violence risk factors be regulated, changed or maintained? Students then wrote a self-reporting anecdote and turned them in to the teacher in the next classroom.

Activity 2: Feeling Faces Chart

This activity used pictures which provided a means of looking into oneself, in order to ensure perceptions of signs of violence. It presented faces with different expressions symbolizing emotions. These helped the adolescents to assess and learn from their own emotions and stress. Understanding emotional expressions led to knowing at once what another was driving at that moment by being able to identify a violent expression.

The second tier: Transitive Phase

Activity 3: Coping with Emotion and Stress: The Case Study of "Pacha"

In this activity, adolescent students developed self-care abilities in order to understand and cope appropriately with their own emotions and stress. In the case study of "Pacha", they were able to develop techniques to face their own selves when they became stressed as in the case study, particularly, when they felt anger or tried to avoid a crisis situation. This assisted in coping and in reducing the causes of violence.

Thus, the improvement in their mood helped the adolescents to learn more easily and to benefit from the cognitive restructuring of violence that was taught later.

Activity 4: Applying Coping with Emotion and Stress Skills

Adolescent's self-care experience cultivated the ability to learn two ways of developing five-step strategies for coping with stress and developing emotional comprehension. These provided various methods of working together particularly when under stress and having negative feelings regarding everyday life. This provided a way to cope appropriately with the problem within oneself, to make oneself feel better and to choose a good course of action in a troublesome situation.

Module 2: Violence within Interpersonal Relationships

Interpersonal relationship skills refer to skills which provide the capability of adolescents to carry on interpersonal relationships, namely with peers, teachers, parents/guardians and so on. Being able to maintain good quality interpersonal relationships was crucial to living in society happily and contentedly. Details for activities 5 to 7 were as follows:

Activity 5: Interpersonal Relationship Skills with Violence

This activity was the ability to build interpersonal relationships in order to have more emphatic understanding before the relationship became negative. In a relationship in which the communication was appropriate and reasonable, there was greater validity than one in which there was negative communication or

misunderstanding that could lead to verbal violence. Thus, retaining a positive relationship through talking or continual interaction was highly encouraged.

Activity 6: Learning Empathic Understanding and Effective Communication

This activity was about the ability of the individual to create appropriately cultivated optimistic relationships. Adolescents were encouraged to develop self-determination through being able to communicate suitably with a range of people in various places and circumstances. Relationships could be destroyed through inappropriate communication, easily leading to the expression of violence. Thus, the aim was for the adolescent to operate and respond with self-care competency both verbally and physically and recognize the value of learning empathic understanding and effective communication that discouraged violence.

The Third Tier: Productive Phase

Activity 7: Applying Interpersonal Relationship Skills for Violence Prevention

Self practice was important to encourage self-examination in the activity in order to communicate appropriately. Self-awareness was promoted to cultivate a response avoiding the use of violence. Role playing was the technique that facilitated interpersonal relationships, self-care practice and elicited important thoughts and feelings. In order to get good background information on the character they were role playing, the teacher asked the adolescent students specific questions such as examples of things these people might say, ways they might react, mannerisms they could use,

things they would enjoy or not enjoy, etc., in order to give them insight into their character (Friedberg & McClure, 2002).

Module 3: Problem solving skills for preventing the use of violence

This module encouraged the ability of dealing with the problems of violence, realizing the consequences of violent acts, and searching for alternative courses of actions and analyzing the advantages or disadvantages of each choice. This skill was also concerned with the capacity to assess and to make a decision to solve the difficulty through the use of non-violence (Friedberg & McClure, 2002; Kendall, 2006).

Activity 8: Problem Solving Skills for Preventing the Use of Violence

This activity focused on searching for the procedure of dealing with problems, and analyzing advantages and disadvantages of each alternative. Adolescents were encouraged to gain more understanding of the steps of problem solving skills. The problem solving sequence involved the following 5 steps: *Stop*: What's the problem? (Problem - Problem definition), *Think*: What can I do? Brainstorm solutions (Purpose - Goal of problem solving), *Evaluate*: What's the best solution (Plans - Brainstorming solution generation), *Act*: Try it out (Predict and pick - Consequential thinking), and *React*: Did it work? This was self-evaluation of progress towards the goal and self-reinforcement for one's effort. This enhanced the use of behaviors of problem solving that prevented or reduced the likelihood of violence.

Activity 9: Learning Problem Solving Approaches - Case Study “Phuri”

Problem solving skills contributed to self-care ability for dealing with complex situations that could lead to the use of violence. Adolescents were able to cultivate problem solving abilities by learning the five steps of problem solving skills through the case study of “Phuri”. The problem solving method comprised searching for the procedure to deal with the problems, analyzing the advantages and disadvantages of each method so that it would lead to decision making suitable to that problem. This activity stated that the youth would use the correct reason and would examine that problem appropriately.

Activity 10: Developing Problem Solving Skills in Real life

Adolescents have the opportunity to confront complex or crisis situations in daily life relating to emotions and feelings, especially when they become angry and exhibit aggressive behavior. Applying the five steps of problem solving skills as a self-care practice in difficult situations may lead to the control of violence. Learning effective behavior each time could develop self-care capabilities to solve problems and effectively prevent violence.

Module 4: Social responsibility towards violence prevention

Social Responsibility was an exercise which encouraged self-perception, realizing that one was a part of society and that one has responsibility either towards one’s own growth or decline; this is related to self-esteem. If the student has a sense of self-esteem, then he or she would have the motivation to behave appropriately

towards others and to society. Moreover, adolescents would know how to make and respond to invitations, greet others, give and receive compliments, and ask for help (Friedberg & McClure, 2002). Adolescent students were informed that disagreement was a way to learn from each other about violence. In these instances, social responsibility was demonstrated through sensitivity and empathy, gentle prompts, and providing greater structure (Goldstein et al., 1987, as cited in Friedberg & McClure, 2002). They learned social responsibility from activities 11 and 12 as follows:

Activity 11: Sympathy as the Essence of Social Responsibility towards Violence Prevention: Case studies of “Sunti” and “Nuramin”

This activity pointed out that adolescents were a vital and essential part of society, so it was valuable that they gained responsibility and felt more self-esteem from others and from the environment around them. Learning violence prevention was an important aspect for adolescents in promoting social responsibility. The case studies of “Sunti” and “Nuramin” applied the quality of responsibility to their situations. This case study provided a way to learn the superior moral rank of adolescent self-care in solving all kinds of problems associated with violence and contributing towards a peaceful society.

Activity 12: Applying Social Responsibility Skills in Real Life towards Violence Prevention in Society

The most important part of this activity was essentially of social responsibility in resolving any troubled situations linked to violence, especially if directly affecting the peace of society. Responsibility was a quality that adolescents needed to practice

and to learn in order to perform efficiently. Adolescents were encouraged to cultivate responsibility through self-management in troubled situations, conflict management with peers or parents, and deliberate actions performed with responsibility for ethical reasons. They recorded the actions that they had performed responsibly and went back to share. They reflected on these within the class. They also received encouragement continuously in order to cultivate a new sense of responsibility.

In conclusion, engaging adolescent students in violence prevention access through these twelve activities was essential in promoting violence management. Besides, violent behavior generally did not motivate the youth to change themselves. Rather, they generally needed others to guide and motivate them, hence the training given (DiGiuseppe, Tafrate, & Eckhardt, 1994).

This violence prevention program, scheduled once weekly for 50-60 minutes per session, drew on fundamental principles of Self-Care Deficit Nursing Theory (Orem, 2001) by focusing on self-care operations. Moreover, social learning concepts towards aggression, especially behavioral rehearsal, sharing of practice efforts by homework review, observational modeling, and response reinforcement were produced to empower and strengthen skills in order to shape, refine, and increase self-efficacy. The framework of the violence prevention activity was illustrated by the sequence (Figure 7) as follows:

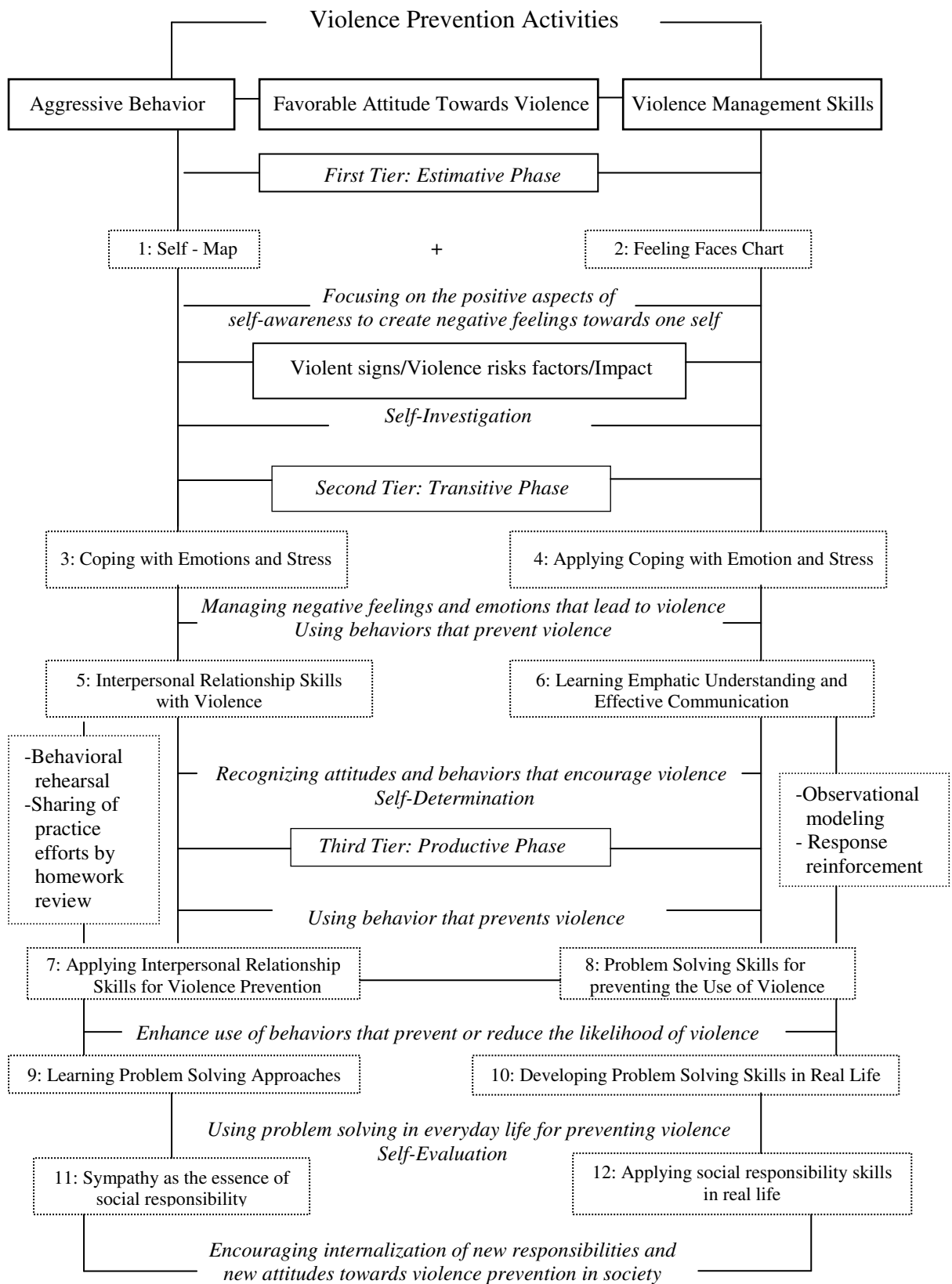


Figure 7 Violence Prevention Activities

Protection of Human Subjects' Rights

Ethical approval had been granted by the Institutional Review Board of the Faculty of Nursing, Prince of Songkla University, Thailand before collecting the data.

First, the researcher met the public high school director in Muang District, Songkhla Province, Southern Thailand. The school director was informed of the details of the study as well as the benefits and risks to the students. A letter asking for permission to collect data for screening violent students was drafted by the Faculty of Nursing, and was submitted to the school director.

After human subject approval and permission from the school directors was granted, all adolescent students were contacted by using the ABS, ATVS, and VMST to measure violence. Before using these questionnaires, the researcher explained details of the study and informed consent was proposed.

The researcher initially made appointments with prospective participants to provide a personal introduction and to inform them of the procedures of the study. They were invited to participate in the study, were assured that all information would be kept confidential, were informed of the activities in the violence prevention program and the persons involved, as well as the benefits and risks that might result from taking part in the process of the study, and that they were free to withdraw from the study at any time. For benefits of attending activities in the violence prevention program, the researcher had conducted a pilot study to confirm the efficacy of the program prior to launching this study in a real situation. Therefore, the adolescent students would be able to become more knowledgeable about violence and violence prevention and have significant experience with others in order to develop

themselves. However, there could be a risk factor since there was awareness of situations that might arise during the course of the study. For example, the subjects, while attending a particular session might show signs of violence and their condition might be worsened. In this case, the researcher would refer them to the healthcare team in the mental health and psychiatric department at Songklanagarin Psychiatric Hospital.

After the adolescent students indicated their willingness to participate, their parents/guardians were contacted and informed about the procedures of the study and the rights of their daughter/son. In addition, they formally gave prior permission for their daughter/son to participate in the study by signing a consent form.

Interestingly, in order to minimize the stigma adolescent students may have risked by participating, they were placed in a mixed class with non-violent students. This created a sense of normalcy for all the students, who were unaware that some of them had violence management problems.

Data Collection and Intervention Procedures

Data were collected continuously over a 6-month period. During the first month, an announcement was made in a high school in Muang District, to screen signs of violence in all students. The school that was selected was one with the largest number of students who had scored moderate to high on the Aggressive Behavior Scale (ABS scores = 78 to 232), Favorable Attitude Toward Violence Scale (ATVS scores = 2.01 to 3.01), and who had a score of mild to moderate on the Violence Management Skills Test (VMST scores = 1.00 to 2.33) including Interpersonal

Relationship Skills (IRS), Coping with Emotion and Stress (CES), Problem Solving Skills (PSS), and Social Responsibility Scale (SRS scores = 1.00 to 3.67).

The researcher approached the students who met all inclusion criteria and who were willing to make a commitment to the program. Their teachers/counselors also were approached. Adolescent students underwent an informed consent procedure by signing a written consent form prior to participation in the study. They were asked to complete baseline measurements and their tendency towards the use of violence was measured with ABS, ATVS, and VMST before starting the intervention implementation.

At the beginning, the period of the regular care, adolescent students were measured with three instruments, the ABS, ATVS, and VMST.

During the violence prevention program, adolescent students underwent violence prevention interventions lasting twelve weeks. The ABS and ATVS were used to evaluate signs of violence. The VMST were used to evaluate violence management skills in this period before and immediately after the final intervention. The student's satisfaction of the violence prevention program also was measured immediately after ending the intervention period as presented in Figure 8.

Particularly, the physical and verbal aggressive behaviors of the adolescent students both during the period of regular care and the intervention period were recorded by using the Observational Aggressive Behavior Scale (O-ABS).

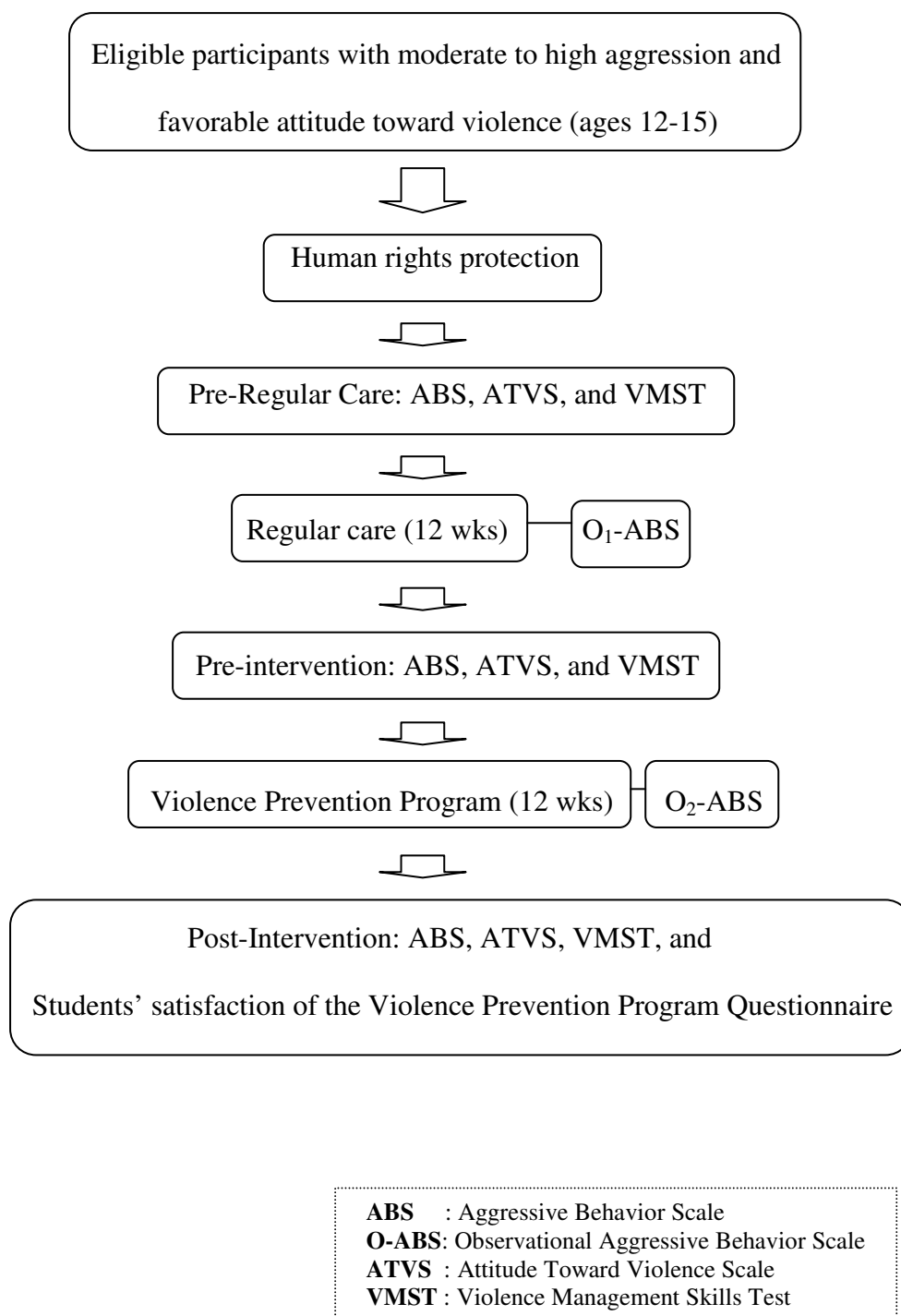


Figure 8 Data collection procedure

Violence prevention program providers

The high school in Muang District engaged teachers who provided a caring system via teacher administration, classroom teachers, and guidance teachers for their students in addition to their regular teaching. These teacher administrators and guidance teachers were required to hold at least an undergraduate degree in education and to have completed a training course in guidance counseling.

Three teachers, the teacher administrator and guidance together with the classroom teacher were responsible for recognizing and treating adolescent students who had both aggressive behavior and a tendency towards violence.

The roles of each stakeholder in the violence prevention intervention, parents/guardians, teachers, and adolescent students were defined and discussed. The roles of each group were as follows: (1) parents/guardians permitted their son/daughter to attend the violence prevention program, (2) the guidance teachers used the violence prevention methodology to encourage aggressive students to avoid their tendencies towards violence and promoted violence management skills, assessed signs and expressions of violence, and recorded changes in the students following the guidelines in the handbooks, and (3) the adolescents' peer groups were involved in the violence prevention program activities in the classroom.

For administering the violence prevention intervention, the researcher trained 3 volunteer guidance teachers to deliver 3 sessions of violence prevention intervention over a one week period. In addition, the teachers and observational research assistants were trained to rate aggressive behaviors of the adolescent students

both during regular care and the intervention period. The following were the steps of the preparation phase in the training process:

Preparation phase

Training teachers as research assistants

1. The researcher provided an overview of the study, including the research application, objectives, characteristic of the program, and the activities of the violence prevention program.

2. The researcher shared knowledge concerning concepts and principles of the violence prevention intervention. The contents of the training covered comprehensive principles about signs of violence, violence prevention, and the importance of self-care practice in violence management of adolescents as well as the empowerment and the efficacy of self-care for violence prevention.

3. The researcher explained the steps and procedures of the violence prevention intervention followed by a review of the intervention hand book guidelines.

4. The teachers were guided in the procedures to be followed according to the intervention guidelines. Guiding and supporting techniques were also added to these procedures.

5. Training was conducted using role playing techniques as per the guidelines while holding an open discussion at each step.

6. Each guidance teacher was trained to use intervention following the guidelines, with each other and with the students who were prepared to practice.

The trainers observed throughout the process and weighed the scores. In the training process, each guidance teachers was tested for accuracy, uniformity, and consistency in delivering the violence prevention intervention. This proficiency testing allowed the research team to identify any problems early and to take corrective steps.

7. Feedback was provided for each guidance teacher. Each person was trained until he/she passed with a score of more that 80 out of 100 points.

8. Sessions 2 and 3 followed the same steps as points 3 through 7 above.

Training observers

Observers were two students, with bachelor's degrees from Thaksin University, who were trained to be observers. They used O-ABS to rate the frequency of physical and verbal aggressive behaviors by the Partial-Interval Recording Method. The following were the steps in the training process:

1. Observers were trained to be observational research assistants to document the observing process by using O-ABS. Details were important for observation; for example, signs of violence behaviors were vital for the observers to recognize.

2. Videotapes of student-student interaction which showed adolescent aggressive behaviors were viewed, and the observers observed and rated their behavior along the O-ABS and then discussed specific scenes after observing the videos. Moreover, the observational training was then conducted out of the classroom in public areas and in the park. Specific situations were discussed after observation.

3. The discussion enabled the trainees to understand how these aggressive behaviors were measured. The discussion also assisted the trainees to understand how their documenting items had inter-rater agreement with the other observer.

4. With each successive observation, inter-rater concordance among trainees increased. Discussion after these encounters further enabled the trainees to understand the application of the O-ABS and the events in the sample scenes, movies, and in the public areas.

5. In the actual observation process, one observational research assistant simultaneously, but independently, observed each adolescent student's aggressive behavior for 1-hour a day 3 times before and after the period of regular care and intervention, and then the O-ABS was completed recording all aggressive behaviors.

6. The aggressive behavior carried out by the adolescent students was recorded and the incidents from the video scenes were discussed with the researcher.

7. When carrying out the aggressive behavior observational checklists for the frequency of observed items, the researcher and trainees considered an item to have been observed only if both the observer and the researcher documented the item as having been performed. At the completion of the observations, the O-ABS was checked to compare observation between observers. Then the inter-rater concordance and Cohen's Kappa coefficient were calculated. A Kappa $> .70$ was considered satisfactory.

Strategies to Minimize Threats to Internal Validity

In order to minimize threats to internal validity, a within-group, repeated measures design was used at two different periods of time: the regular care period and the intervention period.

History was considered as a main threat to internal validity on this design because there were a large number of time period observations, and there were also extraneous effects due to history or cyclic influences. These changes occurred within the study participants themselves over time and that were not related to any specific event, for example, the subjects becoming tired or more knowledgeable. Thus, it became difficult to determine whether changes observed over time could be attributed to the intervention.

Furthermore, literature has shown that among the basic characteristics of adolescent students, socioeconomic characteristics and violent experiences within the family and schools could influence the intervention. Therefore, to control threats to internal validity, the factors that could be of influence during the period of intervention and the control variables in the regular care period, differentiating this period at the point of pre-intervention measurement, were analyzed. The results indicated no significant difference between the two periods among these variables. Moreover, a major strength of a within-group, repeated measures design was that it allowed the assessment of outcome effects that were due to maturation prior to the introduction of the intervention.

Mortality was also considered as a threat to internal validity, as the participants in this study were monitored for changes of attitude and behavior for

more than six months. Moreover, to minimize the rate of participant loss and early drop out, several strategies adopted in the study were as follows: (1) participants were given a reminder either by telephone or in person two days before their appointment, and (2) if the participants failed to attend their scheduled appointments, the researcher immediately contacted them to reschedule as soon as possible.

Ceiling effect was testing an effect on the upper limit of intelligence or achievement test. It was the top score adolescent students could attain on a test regardless of what the adolescent's ability was or what he or she knew. When adolescents hit the ceiling of a test, it meant that the questions on the test were insufficiently difficult to measure true ability or knowledge. Testing was concluded when adolescents missed a specific number of sequential questions (Bainbridge, 2009).

In this study, the observations were due to a ceiling or were the truth of the matter. In addition, the within-group, repeated measures design, of this study had an adequate number of time period observations which was a distinct advantage for answering the ceiling effect.

As the researcher was concerned about a difference in quality of delivery of the violence prevention program, and in order to prevent a bias in the intervention, she trained two volunteer guidance teachers to carry out the 3 phases of the violence prevention program. Each guidance teacher was then tested for accuracy, uniformity, and consistency in delivering the violence prevention intervention and the trainers weighed their scores. Each person was trained until he/she passed with a score of more than 80 out of 100. This proficiency testing allowed the research team to identify any problems early and to take corrective steps. In the same way, two

observational research assistants who participated in the study were trained to use the O-ABS. The teachers also were tested by the researcher in their ability to screen the ABS, ATVS, and VMST until they could use it effectively.

Data Analysis

Data was analyzed using the Statistical Package. Descriptive statistics, including means, standard deviations, frequencies and percentages, were computed to summarize the data. The following statistics were applied.

1. Descriptive statistics were applied to describe the demographic, socio-economic characteristics and violent experiences of the samples, information related to adolescent students, violent experiences within family and schools.
2. The change of intervention effectiveness from the regular care period to the intervention period was examined at each of the three different time points by using Repeated Measures Analysis of Variance (ANOVA).
3. The comparison of the observed physical and verbal aggressive behavior scores during the regular care period and the intervention period was examined by frequencies and percentages.
4. The student's satisfaction of the violence prevention program effectiveness during the three phases of self-care operation was computed to describe both mean and standard deviations.

CHAPTER 4

RESULTS AND DISCUSSION

This chapter is divided into two main parts: the first part focuses on the results of the study and the other is a discussion of those results. The results and discussion are organized into three themes: (1) demographic and socioeconomic characteristics of the sample, (2) the effectiveness of the violence prevention program, and (3) student's satisfaction of the program's effectiveness.

Results

Demographic Characteristics of the Subjects

In this study, the majority of those sampled, 62.22%, were female, 37.78 % were male. Most subjects in this study, 95.56%, were Buddhists, 4.4 % were Muslim. Finding revealed that most of adolescents' parents, 88.89%, were married, 6.67% were separated, and 4.44% had passed away. Most of the subject, 86.67%, lived with parents, 11.11% lived with relatives, and 2.22% lived with others. 93.33% had 1-3 siblings. Their five favorite leisure activities were listening to music 17.78%, reading books or magazines 15.56%, playing sports 13.33%, playing computer games 13.33%, and keeping pets 11.12% (Table 1).

Socioeconomic characteristics and violent experience of the sample

In this study, 51.1% had a family monthly income of 5,000 baht and below. The educational level of father, 46.67%, and mother, 40.00%, was secondary school

level. The occupation of father, 40.00 %, and mother, 31.11 %, were employees (Table 2).

71.11 % never had any violent experience in the family. Violence in the family consisted of fighting between siblings 46.15%, parents quarreling 30.77%, and parents punishing their children 23.08%. They had seen more student violence at the school 80%, and types of violence at school consisted of gang or peer fighting 30.55%, harming individuals 27.78%, rudeness 19.44%, assault among seniors 16.67%, and punishment by teacher of offending student 5.56% (Table 3).

Table 1

Number and percentage of the subject by demographic characteristics (N=45).

Subject Characteristics	Number (%)
<i>Gender</i>	
Female	28 (62.22)
Male	17 (37.78)
<i>Religion</i>	
Buddhist	43 (95.56)
Muslim	2 (4.44)
<i>Parent Marital Status</i>	
Married	40 (88.89)
Widow/ Divorced/ Separated	3 (6.67)
Passed away	2 (4.44)

Table 1 (Continued)

Subject Characteristics	Number (%)
<i>Persons Living with Student</i>	
Parents	39 (86.67)
Relatives	5 (11.11)
Other (Landlord)	1 (2.22)
<i>Number of Sibling</i>	
1-3 siblings	42 (93.33)
4-6 siblings	3 (6.67)
<i>Leisure</i>	
Listening to music	8 (17.78)
Reading books/magazine	7 (15.56)
Sports	6 (13.33)
Playing computer games	6 (13.33)
Keeping pets	5 (11.12)
Traveling	4 (8.89)
Drawing	3 (6.67)
Playing Music	2 (4.44)
Collecting Stamps	1 (2.22)
Watching Television	1 (2.22)
Others (Helping parents buy things, sleeping)	2 (4.44)

Table 2

Number and percentage of the subject by socioeconomic characteristics (N=45).

Socioeconomic characteristics	Number (%)
<i>Family's Monthly Income (baht)</i>	
≤ 5,000	23 (51.11)
5,001-10,000	5 (11.11)
10,001-15,000	3 (6.67)
15,001-20,000	5 (11.11)
≥ 20,001	9 (20.00)
<i>Father's Educational Level</i>	
No formal schooling	1 (2.22)
Elementary	10 (22.22)
Secondary	21 (46.67)
Bachelor's degree	11 (24.45)
Higher than Bachelor's degree	2 (4.44)
<i>Mother's Educational Level</i>	
Elementary	13 (28.89)
Secondary	18 (40.00)
Bachelor's degree	11 (24.44)
Higher than Bachelor's degree	3 (6.67)

Table 2 (Continued)

Socioeconomic characteristics	Number (%)
<i>Father's Occupation</i>	
Employee	18 (40.00)
Farmer	9 (20.00)
Government officer	8 (17.78)
Tradesman	5 (11.11)
Others	5 (11.11)
<i>Mother's Occupation</i>	
Employee	14 (31.11)
Tradesman	10 (22.22)
Farmer	8 (17.78)
Government officer	7 (15.56)
Others	6 (13.33)

Table 3

Number and percentage of the subject by violence experience (N=45).

Violence experience of the subjects	Number (%)
<i>Students' violence experience in the family</i>	
No	32 (71.11)
Yes	13 (28.89)
<i>Violence Types</i>	
Fighting between siblings	6 (46.15)
Parents quarreling	4 (30.77)
Punishment by parents	3 (23.08)
<i>Students' violence experience at school</i>	
No	9 (20.00)
Yes	36 (80.00)
<i>Violence Types</i>	
Gang or peer fighting	11 (30.55)
Harming individuals	10 (27.78)
Rudeness	7 (19.44)
Assault among seniors	6 (16.67)
Punishment by teacher of offending students	2 (5.56)

The effectiveness of the Violence Prevention Program

The effectiveness of the Violence Prevention Program among adolescent students was tested using a Repeated Measures and One-way ANOVA analysis on subject's ABS, ATVS, VMST: Interpersonal Relationship Skills (IRS), Coping with Emotion and Stress (CES), and Social Responsibility Skills (SRS) scores across three time points of pre-regular care (0-week), pre-intervention (12-weeks), and post-intervention (24-weeks). The summary of repeated measures and One-way ANOVA results were presented (Table 4).

Table 4

The summary of Repeated Measures and One-Way ANOVA results (N=45).

Variables	Time						F-Value
	Pre-Regular Care		Pre-Intervention		Post-Intervention		
	(0- week)		(12-weeks)		(24-weeks)		
	Mean	SD	Mean	SD	Mean	SD	
ABS	1.72	0.25	1.67	0.24	0.85	0.33	116.48**
ATVS	2.57	0.33	2.51	0.27	2.09	0.35	53.37**
VMST							
IRS	1.93	0.29	1.87	0.24	2.39	0.24	77.99**
PSS	2.17	0.33	2.14	0.26	2.29	0.25	4.76*
CES	2.19	0.30	2.18	0.19	2.39	0.21	28.51**
SRS	2.84	0.35	2.96	0.30	3.20	0.23	13.12**

* $p < .05$, PSS: Problem Solving Skills

** $p < .001$, IRS: Interpersonal Relationship Skills, CES: Coping with Emotion and Stress, SRS: Social Responsibility Skills

Repeated Measures Analysis of Variance (ANOVA) was significantly different at .001, for ABS, ATVS, VMST; IRS, CES, SRS, and for PSS were significantly different at .05. Because the ANOVA results were significant, these need to do Least Significant Difference (LSD).

LSD was calculated comparing the scores at three different times: pre-regular care, pre-intervention, and post-intervention. The results indicated significantly different scores at three different time points, for ABS [$F_{(2, 88)} = 116.48, p < .001$], ATVS [$F_{(2, 88)} = 53.37, p < .001$], VMST; interpersonal relationship skills [$F_{(2, 88)} = 77.99, p < .001$], problem solving skills [$F_{(2, 88)} = 4.76, p < .05$], coping with emotion and stress [$F_{(2, 88)} = 28.51, p < .001$], and social responsibility skills [$F_{(2, 88)} = 13.12, p < .001$].

Comparison of the scores of subjects at three different time points across period from the period of regular care to the period of the violence prevention intervention: pre-regular care (0 week), pre-intervention (12 weeks), and post-intervention (24 weeks). The results were presented through research questions as follows:

Research Question 1:

Will adolescent students have a lower score of aggressive behaviors after attending the violence prevention program?

When comparing the Aggressive Behavior Scale (ABS) mean scores of subjects at three different times, a significant effect was found [$F_{(2, 88)} = 116.48, p < .001$].

Pairwise comparisons were computed to examine differences between ABS scores at three time points. ABS scores at post-intervention were significantly lower than at pre-intervention ($M = 1.67$, $SD = .24$; $M = 0.85$, $SD = .33$). There was no significant differences in the mean scores between pre-regular care and pre-intervention ($M = 1.72$, $SD = .25$; $M = 1.67$, $SD = .24$) (Table 5).

Table 5

Results of Comparisons: Least Significant Difference of Aggressive Behaviors

($N = 45$).

Aggressive Behaviors		Mean	Std. Error	Sig. ^a	95% Confidence Interval for Difference ^a	
					Lower	Upper
Pre-Regular care	(1)					
Pre-Intervention	(2)	.052	.027	.058	-.002	.105
Pre-Intervention	(2)					
Post-Intervention	(3)	.863	.057	.000*	.747	.979
Pre-Regular care	(1)					
Post-Intervention	(3)	.811	.054	.000*	.702	.921

* $p < .001$, ^a = Adjustment for multiple comparisons: Least Significant Difference

Research Question 2:

Will adolescent students have a lower score of favorable attitudes toward violence after attending the violence prevention program?

The Attitude Toward Violence Scale scores of subjects were compared at three different times: pre-regular care (0 week), pre-intervention (12 weeks) and post-intervention (24 weeks). A significant difference was found [$F_{(2, 88)} = 53.37$, $p < .001$].

Pairwise comparisons were computed to examine differences between ATVS scores at three different time points. ATVS scores in the post-intervention period were significantly lower than at the pre-intervention period ($M = 2.51$, $SD = .27$; $M = 2.09$, $SD = .35$). However, there was no significant difference in the mean scores between the pre-regular care period and the pre-intervention period ($M = 2.57$, $SD = .33$; $M = 2.51$, $SD = .27$) (Table 6).

Table 6

Results of Comparisons: Least Significant Difference of Favorable Attitudes Toward Violence.

Favorable Attitudes Toward Violence		Mean Difference	Std. Error	Sig. ^a	95% Confidence Interval for Difference ^a	
					Lower	Upper
Pre-Regular care	(1)					
Post-Regular care	(2)	.048	.044	.276	-.040	.136
Pre-Intervention	(2)					
Post-Intervention	(3)	.486	.058	.000*	.369	.602
Pre-Regular care	(1)					
Post-Intervention	(3)	.438	.043	.000*	.351	.524

* $p < .001$, ^a = Adjustment for multiple comparisons: Least Significant Difference

It was demonstrated that adolescent student's ABS and ATVS scores apparently decreased between the pre-regular care period and the post-intervention period (Figure 9).

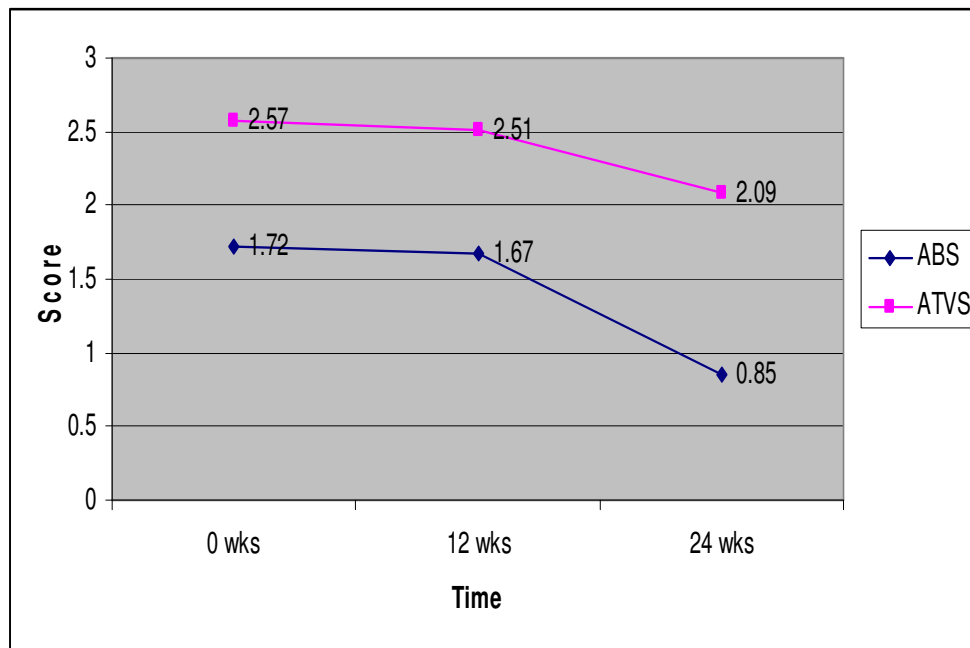


Figure 9 ABS and ATVS scores at three different time points from the pre-regular care period to the post-intervention period

Research Question 3:

Will adolescent students have a higher score of violence management skills after attending the violence prevention program?

The effectiveness of the violence prevention program on the four sub-skills of violence management, namely Interpersonal Relationship Skills, Problem Solving

Skills, Coping with Emotion and Stress, and Social Responsibility Skills were presented respectively as follows:

The Interpersonal Relationship Skills scores were examined across three different time points: pre-regular care (0 week), pre-intervention (12 weeks) and post-intervention (24 weeks). A significant difference was found [$F_{(2, 88)} = 77.99, p < .001$]. The results indicated that IRS scores at post-intervention increased significantly than the IRS scores at pre-intervention ($M = 2.39, SD = .24; M = 1.87, SD = .24$). There was no significant differences in scores between the pre-regular care period and the pre-intervention period ($M = 1.93, SD = .29; M = 1.87, SD = .24$) (Table 7).

Table 7

Results of Comparisons: Least Significant Difference of Interpersonal Relationship Skills.

Interpersonal Relationship Skills	Mean Difference	Std. Error	Sig. ^a	95% Confidence Interval for Difference ^a	
				Lower	Upper
Pre-Regular care (1)					
Pre-Intervention (2)	.058	.055	.293	-.052	.168
Pre-Intervention (2)					
Post-Intervention (3)	.458	.052	.000*	-.563	-.354
Pre-Regular care (1)					
Post-Intervention (3)	.516	.044	.000*	.427	.606

* $p < .001$, ^a = Adjustment for multiple comparisons: Least Significant Difference

Comparisons of the Problem Solving Skills (PSS) scores at three different times points: pre-regular care (0 week), pre-intervention (12 weeks) and post-intervention (24 weeks). A significant difference was found [$F_{(2, 88)} = 4.76, p < .05$]. Also, it became apparent that PSS scores at post-intervention increased significantly compared to pre-intervention (M = 2.14, SD = .26; M = 2.29, SD = .25).

There was no significant difference in scores between the pre-regular care period and the pre-intervention period ($M = 2.14$, $SD = .26$; $M = 2.17$, $SD = .33$) (Table 8).

Table 8

Results of Comparisons: Least Significant Difference of Problem Solving Skills.

Problem Solving Skills	Mean Difference	Std. Error	Sig. ^a	95% Confidence Interval for Difference ^a	
				Lower	Upper
Pre-Regular care (1)					
Pre-Intervention (2)	.024	.064	.709	-.105	.153
Pre-Intervention (2)					
Post-Intervention (3)	.124	.068	.042*	-.013	.261
Pre-Regular care (1)					
Post-Intervention (3)	.148	.048	.001**	.051	.245

* $p < .001$, ^a = Adjustment for multiple comparisons: Least Significant Difference

Coping with Emotion and Stress was calculated by comparing the scores of subjects at three different time points: pre-regular care (0 week), pre-intervention (12 weeks) and post-intervention (24 weeks). A significant difference was found [$F_{(2, 88)} = 28.51$, $p < .001$].

When examining the CES scores at three different time points, it became apparent that CES scores at post-intervention were significantly higher than at pre-intervention (M = 2.18, SD = .19; M = 2.39, SD = .21). There were no significant differences in scores between the pre-regular care period and the pre-intervention period (M = 2.18, SD = .19; M = 2.19, SD = .30) (Table 9).

Table 9

Results of Comparisons: Least Significant Difference of Coping with Emotion and Stress.

Coping with Emotion and Stress	Mean Difference	Std. Error	Sig. ^a	95% Confidence Interval for Difference ^a	
				Lower	Upper
Pre-Regular care (1)					
Pre-Intervention (2)	.214	.042	.256	.129	.298
Pre-Intervention (2)					
Post-Intervention (3)	-.208	.061	.001*	-.331	-.086
Pre-Regular care (1)					
Post-Intervention (3)	-.214	.042	.000*	-.298	-.129

* $p < .001$, a = Adjustment for multiple comparisons: Least Significant Difference

The Social Responsibility Skills scores of subjects were examined at three different times, pre-regular care (0 week), pre-intervention (12 weeks), and post-intervention (24 weeks). A significant difference was found [$F_{(2, 88)} = 13.12$, $p < .001$]. Also, the comparisons were computed to examine differences between SRS scores at three different time points. It became apparent that SRS scores at post-intervention were significantly higher than at pre-intervention ($M = 2.96$, $SD = .30$; $M = 3.20$, $SD = .23$).

There were no significant differences in scores between the pre- regular care period and the pre-intervention period ($M = 2.84$, $SD = .35$; $M = 2.96$, $SD = .30$) (Table 10).

Table 10

Results of Comparisons: Least Significant Difference of Social Responsibility Skills.

Social Responsibility Skills	Mean Difference	Std. Error	Sig. ^a	95% Confidence Interval for Difference ^a	
				Lower	Upper
Pre-Regular care (1)					
Pre-Intervention (2)	.124	.053	.152	-.020	.227
Pre-Intervention (2)					
Post-Intervention (3)	.363	.053	.000*	.257	.470
Pre-Regular care (1)					
Post- Intervention (3)	.240	.048	.000*	.155	.324

* $p < .001$, a = Adjustment for multiple comparisons: Least Significant Difference

The VMST were taken at different times, in the pre-regular care period (0 week), post-regular care period (12 weeks), and post intervention period (24 weeks). It was demonstrated that adolescent student's subscale of VMST; IRS, PSS, CES, and SRS scores obviously increased in each sub-skill of violence management from the pre-regular care period to the post intervention period (Figure 10).

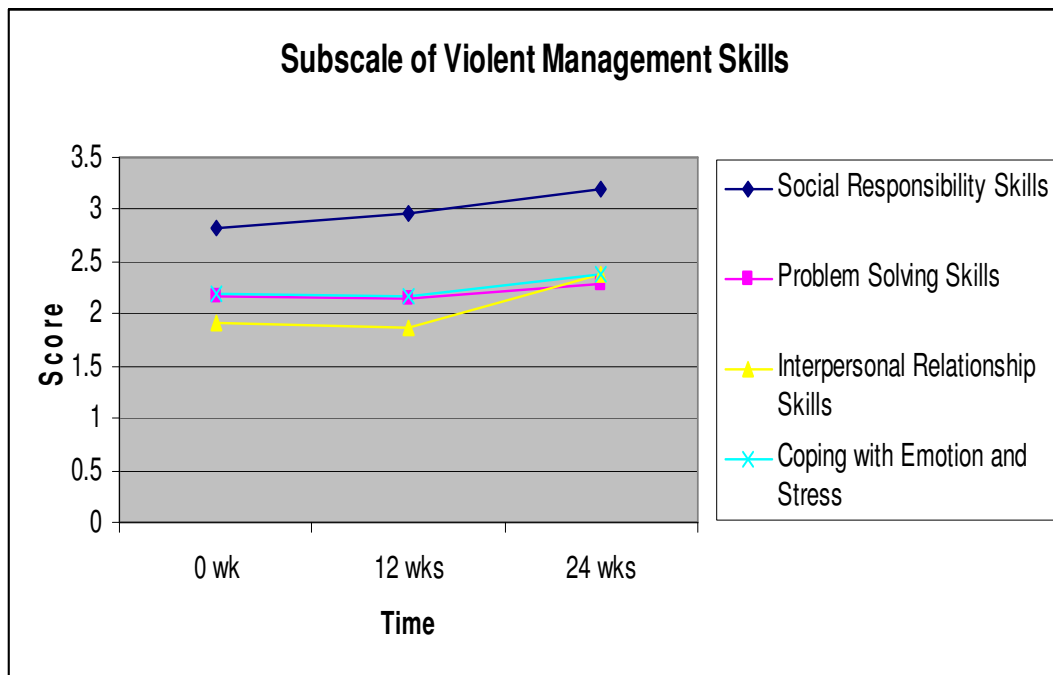


Figure 10 Subscale of VMST scores at three different time points from the pre-regular care period to the post-intervention period

Research Question 4:

Will Thai adolescents' physical and verbal aggressive behaviors under behavioral observation in the intervention period have lower scores than in the regular care period?

The results indicated that the frequency of physical aggressive behavior event in the intervention period was less than in the regular care period (Table 11).

Table 11

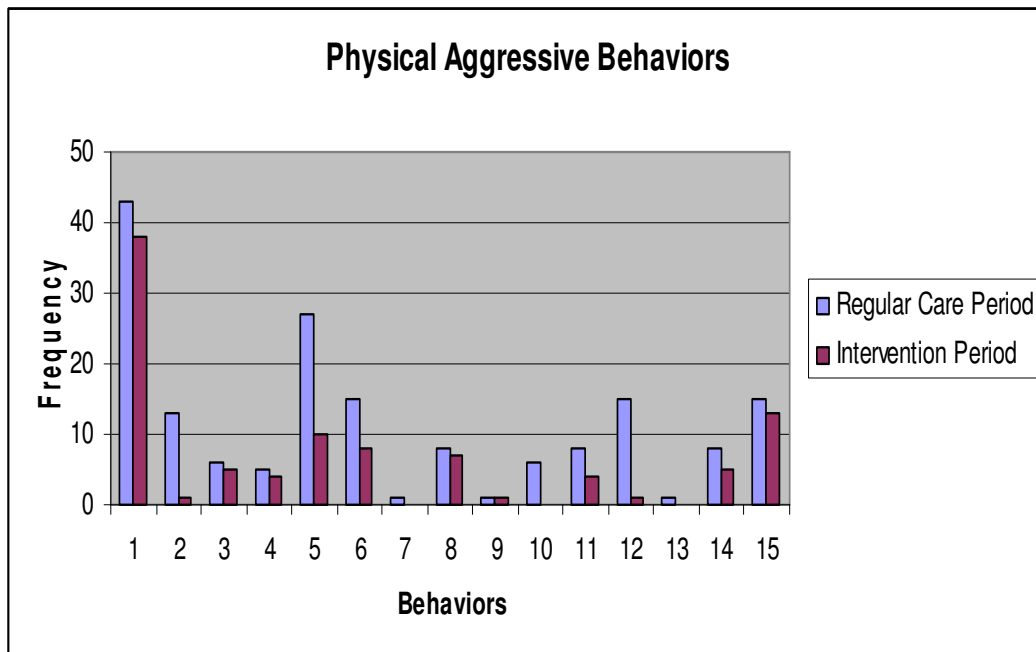
Frequency of the physical aggressive behaviors event during the regular care period and the intervention period.

Physical aggressive behaviors event	Regular care Period	Intervention Period
1. Harmful to others	43	38
2. Caused object or property damage; tore books, wrote rude language on other students' books or on desks	13	1
3. Pulled or snatched at clothes	6	5
4. Pushed somebody	5	4
5. Ridiculed	27	10
6. Threw things at another	15	8
7. Forced others to do something unwillingly	1	0
8. Messed things up	8	7
9. Hid other students' things	1	1

Table 11 (*Continued*)

Physical aggressive behaviors event	Regular care Period	Intervention Period
10. Hit somebody	6	0
11. Had fights	8	4
12. Pushed over property such as chairs, desks	15	1
13. Put up feet or middle figure to imprecate	1	0
14. Made faces	8	5
15. Banged table loudly	15	13

It was demonstrated that adolescent students' physical observational aggressive behaviors event apparently decreased in frequency during the regular care period and the intervention period as illustrated in Figure 11.



1 = Harmful to others; 2 = Caused object or property damage; 3 = Pulled or snatched of clothes; 4 = Pushed somebody; 5 = Ridiculed; 6 = Threw things at an other; 7 = Forced others to do something unwillingly; 8 = Messing things up; 9 = Hid other students' things; 10 = Hit somebody; 11 = Had fights; 12 = Pushed over property; 13 = Put up feet or middle figure to imprecate; 14 = Made faces; 15 = Banged table loudly.

Figure 11 Frequency of the physical aggressive behaviors event during the regular care period and the intervention period

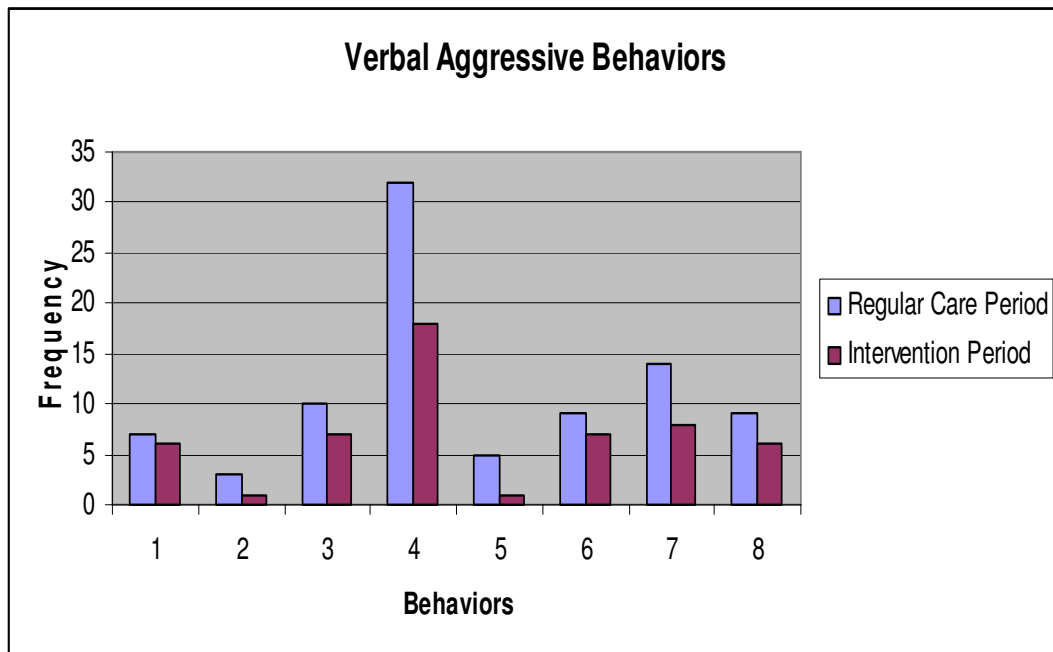
In addition, the frequency on verbal observational aggressive behaviors event in the intervention period for each verbal assault was less than in the regular care period (Table 12).

Table 12

Frequency of the verbal aggressive behaviors event during the regular care period and the intervention period.

Verbal aggressive behaviors event	Regular care Period	Intervention Period
1. Blaming	7	6
2. Teasing about the friend's and family's names	3	1
3. Criticizing	10	7
4. Shouting loudly	32	18
5. Gossiping	5	1
6. Speaking sarcastically	9	7
7. Rudeness	14	8
8. Threatening	9	6

It was demonstrated that adolescent students' verbal observational aggressive behaviors event apparently decreased in frequency during the regular care period and the intervention period as illustrated in Figure 12.



1 = Blaming; 2 = Teasing about the friend's and family's names; 3 = Criticizing; 4 = Shouting loudly;
5 = Gossiping; 6 = Speaking sarcastically; 7 = Rudeness; 8 = Threatening

Figure 12 Frequency of the verbal aggressive behaviors event during the regular care period and the intervention period

Research Question 5:

Do Thai adolescents satisfied with the program after undergoing the violence prevention program?

The mean scores of the students' satisfaction after attending the violence prevention program was measured in three phases: *estimative* ($M = 4.38$, $SD = .39$), *transitive* ($M = 4.36$, $SD = .53$), and *productive* ($M = 4.36$, $SD = .55$) (Table 13).

Table 13

The mean scores of students' satisfaction on the Violence Prevention Program effectiveness (N=45).

Students' satisfaction	Minimum	Maximum	Mean	SD	Satisfaction level
Tier 1: Estimative Phase	2.68	5.00	4.38	.39	High
Tier 2: Transitive Phase	2.68	5.00	4.36	.53	High
Tier 3: Productive Phase	2.68	5.00	4.36	.55	High

It was confirmed that adolescent students had a high level of satisfaction with each phase of self-care operation after attending the violence prevention program.

Discussion

This discussion is organized into the following three topics: (1) the demographic and socioeconomic characteristics of the subjects, (2) the effectiveness of the violence prevention program, and (3) the students' satisfaction with the violence prevention program.

The demographic and socioeconomic characteristics of the subjects

Demographic and socioeconomic characteristics are important factors which influence an adolescent's development (Anderson & Olnhausen, 1999), as well as their capacity for self-determination (Orem, 1995).

In this study, the majority of the subjects were female. Gender was an important factor, and it was found that adolescent girls expressed violent signs in early life more than adolescent males did. Interestingly, there were more females than males in this school. Therefore, adolescent girls were found to perpetrate a greater amount of violence, especially aggressive verbal behavior such as blaming, shouting loudly, gossiping, criticizing, and being rude in general more than males. This issue was raised in Maguire (2009), in which it was found that there were many early signs of violent behavioral tendencies among adolescent females. Particularly, females committed acts of minor violence, as opposed to men, who engaged in more severe physical violence. Moreover, men who committed explicitly violent acts tended to have a positive reaction to their own violent outbursts (Hester, Westmarland, & Gangoli, 2009). Saner and Ellickson (1996) asserted that adolescent girls were particularly vulnerable to violence when they have had previous negative and dysfunctional life experiences.

Furthermore, the results of this study showed that most of the adolescents' parents were married, and almost all of the adolescent students lived with their parents, so this may have been one factor influencing their personalities. The relationships within a family are important; they can affect mood and mental health, with negative relationships possibly leading to the risk of violence (Carmona, 2004;

Myers et al., 2000; UNICEF, 2000). This is supported by a report on youth in Thailand which found that the relationships in families were characterized by a lack of caring and concern on the part of the parents, which led to a weakness of character in adolescents that may be a cause of violence (Ministry of Social Development and Human Security, 2005).

Moreover, it was found that the monthly income of most of these families was quite low, usually under 5,000 baht. Most parents had, at most, secondary level education, and nearly all of the parents were employees. Related literature also indicates that the risk of becoming a victim or perpetrator of violence is greater in households with a low socioeconomic status (Saner & Ellickson, 1996; WHO, 2004). Statistics support this supposition; adolescents who come from families with relatively low incomes, educational levels, and occupations are significantly more likely to be violent (Social Development and Human Security, 2005), and this is further supported by studies on violence risk factors found in Thai adolescents (Buajaroen et al., 2004).

In this study, violence was found to occur at school, and included gang fighting, attacks on individuals, intimidating yelling, and assault, with punishment by a teacher being the usual penalty for the offending student. In Thai high schools, it was found that peers had a strong influence on adolescents. Students expressed attitudes and behaviors that they hoped would be positively accepted by their peer group (Thaweekoon, 1995), and this may have resulted in an increase in their confidence to engage in violent acts (Center for School Mental Health Assistance, 2002). Moreover, the school environment carried a number of risk factors which were linked to various types of violence among adolescent students (Saner & Ellickson,

1996). This is also supported by a previous study on adolescents in Thailand (Sutin, 1996; Limparatanagorn, 2004) which showed that in Thai high schools, students caused violence because of favorable reactions from peers and because of ineffective restrictions and punishments on the part of teachers.

This study also found that leisure activities included listening to music, reading books and magazines, and playing computer games. According to the study by The Ministry of Social Development and Human Security (2005), it was reported that Thai adolescents spent about 95% of their free time playing computer games and using the internet, and this had a negative effect on their attitudes toward violence (Pandaeng, 2004; Thaweekoon, 1995). Particularly, the imitation of game violence in real life by students was found to be a method they used to deal with stress and trouble (Coie & Dodge, 1997; Resnick et al., 1998; Saner & Ellickson, 1996). In addition, violent images in the media may have further encouraged violence, as young people came to accept the use of violence as a way to solve problems (American Medical Association, 2001; Funk, 2005). Growing anger which led to violent outbursts was particularly common (Kongsuwan et al., 2008).

The Effectiveness of the Violence Prevention Program

The findings confirmed that the violence prevention program was more effective than regular care at reducing aggressive behavior and favorable attitudes towards violence. It also enhanced violence management skills among Thai high school students.

There were two major reasons for the effectiveness of the violence prevention program: the program was driven by the theoretical foundations, and the intervention's success was due to the design of the program.

1. The program was driven by the theoretical foundations

Orem's Self-Care Deficit Nursing Theory

The effectiveness of violence prevention programs came about mostly due to the Self-Care Deficit Nursing Theory (Orem, 2001). This theory states that violence prevention programs should involve a special process as a foundation to the traditional supportive-educative nursing techniques. The goal of this process is to recognize trouble signs which lead to violence and attempt to mitigate them. This program also involves the creation of self-care skills for adolescents to manage their violent tendencies.

The finding of the study according with previous research which supported the conclusion that adolescent who behaved violently could benefit from improving their self-care ability (Cull, 1996). Similarly, Cutler (2001) found in the study that a person's improvements in self-care naturally lead to autonomy and ongoing behavioral management, as well as a lower chance of recidivism into violence. Furthermore, the reduction of aggressive behaviors could occur concurrently with the development of self-care skills, leading to a marked improvement (Vollmer et al., 1992). Likewise, McCaleb & Cull, (2000) found that the instruction of self-care practices for adolescents from various socio-cultural backgrounds was incorporated into the overall violence prevention program.

The supportive-educative nursing system has shown that when adolescents are confronted with aggression from others, highly aggressive adolescents tend to have difficulty arriving at non-aggressive solutions, and hence believe that aggression is the answer to adverse treatment by others (Dodge et al., 2003; Hudley, 1994; Lochman & Dodge, 1994). Most related literature concurs that changing self-care behavior promotes well-being among adolescents (Estes & Hart, 1993; Hartweg, 1993; National Institute of Nursing Research [NINR], 1993). Similarly, there is a positive relationship between health-promoting self-care behavior and self-care efficacy in the adolescent population (Callaghan, 2005).

Orem's self-care deficit nursing framework was developed for promoting self-care activity among adolescents as a way to manage violence involving three self-care operation phases: the *estimative*, *transitive*, and *productive*. In addition, it specified three significant activities that adolescent students must do in order to reduce aggressive behaviors and favorable attitudes towards violence, and to enhance violence management skills. The three phases are discussed respectively below.

The first phase of self-care operation enables adolescents to gain violence prevention comprehension, such as recognition of risk signs, as well as developing a distasteful attitude toward violence, which all results in leading them to take better care of themselves. Similarly, Utz (1990) found in the study that motivating self-care operation involves self-estimation and analysis of one's own experiences. The second phase involves self-consideration of an adolescent's capability, especially regarding decision making concerning self-care or reaction to a violent event. The third phase revolves around taking the necessary action to achieve self-care capability and prevent the use of violence. This phase also involves an evaluation of the self-care

effort in order to judge whether it is suitable in controlling behavior. The evaluation further involves coming to a conclusion regarding decision making in subsequent actions, valuing one's progress in self-care, one's creativity, and one's motivation (Renpenning & Taylor, 2003).

Adolescent students involved in the study were encouraged to learn and acquire the requisite violence prevention knowledge and management skills for performing self-care so that they could manage better at homes. As Howard et al. (1999) noted, many of the positive results reported in evaluation studies reflect changes in knowledge, attitudes, and responses to hypothetical situations rather than actual behavioral improvements. Thus, this study's violence prevention program focused on teaching and guiding adolescents to acquire specific skills that participants would be able to apply to life situations. The violence management skills imparted to subjects had a positive effect on adolescents (Farrell, Meyer, & White, 2001), especially those subjects who were particularly violent (Lutzker, 2006).

The violence prevention program was able to verify the success of helping methods. Gottfredson (2001) asserted that research established not only the content of prevention programs but also the most effective delivery methods urgently needed. There are four helping methods underpinning the supportive-educative nursing system (Orem, 2001): *teaching*, *guiding*, *supporting*, and *providing environment*. They are described below.

Teaching, it is the method used to convey violence management knowledge. It revolves around the description of violence management practices, both inside and outside the classroom, as well as a description of how to observe the signs of

violence. The goal is for adolescent students to come to understand violence and violence-management, and believe that such management can be successfully utilized in their relationships with other people. When the adolescents learned this over the course of the twelve weeks, oftentimes satisfaction and even inspiration arose, so this was in accordance with Orem's findings, which stressed that people form and organize knowledge about their particular self-care requisites and the ways of meeting those requisites (Renpenning & Taylor, 2003). In this study, the teachers provided strategies designed to teach adolescent students to focus on behaviors which needed to be changed in order to improve an adolescent's self-care ability. Similarly, Ervin (1998) found that teaching was required for self-care agency in the delinquent adolescents.

Guiding, it is replying to questions or overcoming problems and obstacles students face in their attempts to end violent behavior, usually by means of providing them with the right information (Orem, 2001). This method assists adolescent students by providing them with feedback and guidance until they can understand and perform the necessary activities to manage themselves in decreasing their aggression. Adolescent students were given strong encouragement, and thus gained positive feelings about their beliefs in their abilities for self-care. Guidance also aimed to help them choose the self-management options that best suited their lifestyles and offered them the greatest chance of success (Ervin, 1998). This strategy gave the subjects a stronger sense of accomplishment in self-management, which further propelled them to success (Utz, 1990).

Supporting, it is the method that helps people create enjoyment and happiness (Orem, 2001), particularly by communicating supportive messages to adolescent students during the intervention period to help correct their performance. It was performed at all times during the violence prevention program, and included physical materials such as violence management manuals. Adolescent students were always able to review and clarify any questions relating to violence and violence management, and this service greatly motivated them to manage violence. Significant, continuous support is, according to Orem, a way to promote a person's ability towards reaching achievement.

Providing environment, it aids violence management programs by providing a positive structure behind other activities for the violent adolescent students. The school administration provided nice classrooms for use by the adolescent students participating in the program. Moreover, all of the activities had various procedures and different kinds of scenarios which were conducted in a logical learning sequence. In addition, the classrooms were set up, both for group and individual work, in a way that allowed subjects the opportunity to ask questions. Each adolescent student had to record their learning experiences and return those records to the teacher, and they were then encouraged by the teacher to review and confirm their attitudes toward violence management and appropriate behavior. The positive environment leads to positive relationships developing within the group of subjects. Orem acknowledged that people generally lay out a set of actions and their proper sequence when attempting to meet self-care goals, and then they seek out the necessary materials and

environmental conditions, and put forth the required effort (Renpenning & Taylor, 2003).

The effectiveness of violence prevention activities depends on strengthening social learning skills in order to shape, refine, and increase self-efficacy. Therefore, this study discusses the significance of the Self-Care Deficit Nursing Theory as integrated with Social Learning Theory.

Social Learning Theory recognizes that adolescents are especially vulnerable to pressure from popular peers, who serve as models for deviance. Based on the Social Learning Theory, the violence prevention procedures can be discussed as follows:

Adolescents learn through observing the behavior and attitudes of others, and the outcomes of those behaviors. Bandura noted that most human behavior is learned observationally through modeling. From observing others, one forms an idea of how new behaviors are performed, and on later occasions this coded information serves as a guide for action (Bahn, 2001; Bandura, 1977). There were four procedures involved in the study: behavioral rehearsal, the sharing of behavioral practice during homework reviews, observational modeling, and response reinforcement. These are discussed below.

Behavioral Rehearsal

Adolescents need to be educated. Behavioral rehearsal is a procedure in which adolescents practice their responses in order to learn (Linehan, 1993). This procedure can be done through interaction with the teacher, peers, or other people, both inside and outside the classroom. Practicing can be either overt or subtle. Overt forms of

behavioral rehearsal are most common. For example, in a group context, group members may role play problematic situations concerning violence and aggression. This procedure is supported in that people's behavior arises from their direct past experiences (Bandura, 1986; Bandura, 1997), and the past reactions determine whether the current reaction will be positive or negative. Adolescents' aggressive behavior arises from neither an inner force nor from genetics; it is shaped and controlled only by external stimuli arising from interpersonal interaction (Bandura, 1997). In this procedure, adolescents practiced problem solving skills, coping skills, and some components of violence management skills and their accompanying emotional responses.

Sharing of Behavioral Practice Efforts during Homework Reviews

The weekly in-class sharing of homework practice efforts was an essential part of the violence prevention program. The tasks were designed to gently push the adolescents to analyze their own behavior, to validate their difficulties, and to counter their tendencies to judge themselves negatively and consider positive outcomes impossible. At the same time, to help the students develop, more violence management skill strategies were assigned for the following week, if needed. In addition, the teacher was adept at alternating attention between analysis of the week's behaviors and focus on the in-session attempts to describe, analyze, and solve problems. However, fear of criticism and anger were common emotions that interfered with one's ability to engage in and profit from sharing (Linehan, 1993). It was very important to get each adolescent to share and describe in detail their self-care improvements during the homework review.

Observational modeling

This method is a technique that facilitates the teaching of violence management skills, and it elicits important thoughts and feelings concerning interpersonal relationship skills, effective communication, coping with emotion and stress skills, and problem solving skills. In this study, scenarios and role playing were the two main sub-techniques used for observational modeling. The students received background information on the character they were role playing and then the teacher asked them specific questions. The questions concerned violent situations. For example, the adolescents could be asked about the ways they reacted to violence, the mannerisms they used, or the things they enjoyed or did not enjoy, with the purpose being to give insight into the characters (Friedberg & McClure, 2002). Observational modeling was supported by these learning procedures (Bandura, 1997). This entire theory asserts that people can learn and change their behavior by observing the behavior of models within society and learning from the consequences of their actions.

In addition, Bandura (1997) remarks that learning from models results in not only behavioral imitation, but also true intellectual understanding. Thus, observation of violence prevention role-play will help adolescents reason concerning the appropriate behaviors for various situations, and the resulting information will be a guide in their future behavior.

Response Reinforcement

In this study, response reinforcement was one of the most powerful means of shaping and strengthening procedures taught by the teacher. Response reinforcement

can modify an adolescent's self-esteem in a positive manner, increase his or her use of correct behavior, and enhance his or her sense of control over positive outcomes in self-care practice. In addition, when a person receives positive reinforcement for any behavior, that behavior tends to continue and develop (Bandura, 1997). In addition, adolescent students received certificates of achievement which reinforced their progress and made them feel proud of being in the violence prevention program. They serve to remind the students to continue their violence management efforts in the future. It was found that response reinforcement not only informed, but also motivated by demonstrating the advantages of new practices and the accompanying acceleration in learning (Bahn, 2001).

In cooperation between Orem's Self-Care Deficit Nursing Theory and Social Learning Theory, the program can enhance adolescent's self-care ability to prevent violence, according to the reasons given below:

Interestingly, adolescents were able to learn through a variety of activities, from the very easy to difficult. The researcher discussed each activity, as shown below:

The first tier was designed as an underpinning to the estimative phase of self-care management. It regards the discussion of successful violence prevention programs to reduce favorable attitudes toward violence. This tier was composed of two activities: a "Self - Map" and a "Feeling Faces Chart."

Activity 1: “*Self - Map*”

This activity was started with the initial concept of aiding in positive sharing and learning between subjects (Finch, Nelson, & Moss, 1993, cited in Kendall, 2006). This activity was also designed to increase the positive perception of oneself and help one to identify the different emotions and feelings of other people, as self-investigation of internal and external conditions was vital to the success of this activity and the entire *estimative phase* (Orem, 2001). Adolescents built relationships with other students, and this lead into activity two.

Activity 2: “*Feeling Faces Chart*”

This activity involved focusing on self-examination of emotions and feelings through pictures. Adolescents worked to increase their awareness and attention to different feelings and emotions that caused violence. It involved looking back to self-care efforts (Orem, 2001), and their own attitudes and behaviors concerning the signs of violence, violence risk factors, and the impacts of violence.

This activity caused adolescents to assess their attitudes and behaviors and to learn from it (Kendall, 2006). Consequently, an understanding of emotional expressions better allowed them to know at once what others were feeling, and when violence was imminent. Development theory indicates that adolescence is a critical period of development: a dynamic and uncertain period between childhood and adulthood with developments occurring physically, cognitively, emotionally, and socially (Edelman & Mandle, 1998; Murray & Zentner, 1997; Slusher, 1999). However, it is possible for the people to regulate themselves rationally and generate new attitudes (Taylor, 2008).

The second tier was designed as the underpinning of the transitive phase of adolescent's self-care management. This step focused on continuous reduction of favorable attitudes toward violence and aggressive behaviors by cultivating violence management skills.

The second tier consisted of four activities: “coping with emotion and stress”, “applying coping with emotion and stress”, “Interpersonal Relationships Skills with Violence”, and “Learning Empathic Understanding and Effective Communication”.

Activity 3: “Coping with Emotions and Stress”

This activity within the *transitive phase* helped adolescent students learn the scenarios to use as tools and helping methods (Orem, 2001). Violent scenarios were used for teaching self-evaluation. Adolescents developed comprehension of coping with emotion and stress through practice. They were encouraged to develop self-care abilities to cope with inappropriate emotions and to develop techniques for facing themselves when becoming stressed or feeling anger (Kendall, 2006). The students were continuously directed on what to do in violent situations with respect to self-care; this was strongly stressed in activity four.

Activity 4: “Applying Coping with Emotion and Stress”

This activity focused on managing negative feelings and emotions that lead to violence. Adolescents received instruction in various coping methods for group situations, both inside and outside the classroom, as well as continuously. This made the adolescents feel good about themselves, as they gained confidence that they could

make the best judgment in a trouble situation instead of resorting to violence (Kendell, 2006). Accordingly, this positive communication and emphatic understanding of violent events was supported by activity five.

Activity 5: “Interpersonal Relationships Skills with Violence”

This activity was all about practicing positive interpersonal relationships to develop a more emphatic understanding of others so that a negative relationship leading to violence did not arise (Lutzker, 2006). It also dealt with recognizing attitudes toward violence and aggressive behaviors that encourage violence, and retaining positive relationships by talking rather than using aggressive verbal and physical behavior (Mytton et al., 2009). In addition, adolescent students grew in their individual abilities to create optimistic relationships founded on positive communication (Friedberg & McClure, 2002). This led into activity six.

Activity 6: “Learning Emphatic Understanding and Effective Communication”

Adolescent students gained better quality relationships through their positive communication. Naturally, relationships could be destroyed through inappropriate communication, as they often lead to expressions of violence (Snyder, 1987; Peravanakul & Wiwatkunupakan, 1999; Limparatanagorn, 2004). The adolescents used what they were taught in order to respond to both verbal and physical situations with suitable communication, given the people, places, and circumstances. Orem (2001) noted that the decision to engage in or not to engage in specific self-care techniques in these situations was the key.

The third tier covered the operative phase, discussing the success of the violence prevention program in decreasing aggressive behaviors and enhancing violence management skills.

The progression of the program involved moving from activity seven through activity twelve.

Activity 7: “Applying Interpersonal Relationship Skills for Violence Prevention”

This activity increased optimism in one’s relationship skills, enhancing the use of behaviors that prevented or reduced the likelihood of violence. This activity, when performed continuously, improved self-care ability, and strengthened the ability to respond appropriately in situations to avoid violence (Mytton et al., 2009). Adolescent students had to record their self-care practice efforts, and the strategies they used for gaining self-worth from the people around them in everyday life. Moreover, the students gained the capability to solve problems in complex situations to avoid violence, which lead into activity eight.

Activity 8: “Problem Solving Skills for Preventing the Use of Violence”

The procedures for this activity consisted of uncovering problems, and dealing with and analyzing the advantages and disadvantages of each method for dealing with problems (Thrasher, 2002; Srimala, 2004). After this, adolescents reflected to determine the adequacy of their self-care performance in problem-solving situations, and whether they made suitable decisions or not for those problems. Mytton et al. (2009) stated that problem solving skills in violent situations must be used for the

correct reasons and examined thoroughly. Problem solving skills were applied in difficult situations, and approaches to these scenarios were discussed in activity nine.

Activity 9: “Learning Problem Solving Approaches”

In this activity, adolescents were supported and guided in problem solving techniques. It reduced the likelihood of the subjects participating in violent situations with other people. The adolescents learned ways to solve problems in various situations, which helped them when they found themselves getting angry and exhibiting aggressive behaviors (Friedberg & McClure, 2002). Activity ten then applied these skills to a variety of situations in daily life.

Activity 10: “Developing Problem Solving Skills in Real Life”

This activity prepared adolescents to confront complex crisis situations in daily life which were a source of violence. According to the supposition of interpersonal and social–cognitive behavioral process development, lack of problem solving skills was thought to lead to aggressive behaviors and place children at risk for future behavioral problems (Cicchetti & Toth, 1998). Thus, this activity not only increased problem solving skills but also reduced the stigma of being non-violent by changing favorable attitudes towards violence in the school setting. Adolescents deliberated on their actions and the effects in each situation, increasing their capability to prevent violence. Orem (2001) stressed that participant reflection on action and reaction were achieved through self-evaluation, and this was used to improve the subjects’ capabilities in violence prevention. The adolescents’ responsibilities concerning violence in society were covered in activity eleven.

Activity 11: *“Sympathy as the essence of Social Responsibility towards Violence Prevention”*

This activity supported adolescent students in realizing and examining not only violent events in their lives, but in society as a whole. The focus was on cases of unrest situations, and how they were peacefully resolved. Friedberg and McClure (2002) stated that adolescents can successfully learn to take responsibility for reducing violence in society. Moreover, understanding their responsibilities to other people and to society developed their self-care management to a higher degree (Orem, 2001); this came about because of their elevated sense of reasoning and greater responsibility. When violence occurred in trouble situations, such as with peers or parents, the adolescents used the process of violence prevention. In such situations, deliberate actions should be performed with responsibility and with ethical reasoning (Goldstein et al., 1987).

Activity 12: *“Applying Social Responsibility Skills in Real Life towards Violence Prevention in Society”*

Adolescent students were encouraged to continuously engage in violence management and have optimistic attitudes towards taking personal responsibility. This was further encouraged through placing stress on the students’ awareness of the benefits of a peaceful society. The adolescents were challenged to turn situations in which they faced criticism or violence into opportunities for cultivating social responsibility skills, and this helped them in their internalization of new responsibilities and attitudes towards violence prevention in society. Similarly, Callaghan (2006) found that an adolescent’s degree of responsibility was significantly

related to their level of spiritual growth. The higher an adolescent's competency, the higher was his or her ability to decide on a positive reaction to violent problems, and this in turn provided more self-esteem.

All of the above-mentioned activities promoted self-care ability among adolescents for violence prevention. Moreover, this study also provides a guide to empower adolescents to engage in the deliberate action of self-care to benefit society (Fitzpatrick & Whall, 1989). The program was developed as a series of goals accomplished through participation among peers, teachers, and the researcher, all for the purpose of providing direction and instruction to assist adolescents in learning how to care for themselves. As is widely known, self-care activity is strongly promoted for adolescents (Cull, 1996; Denyes, 1988; Ervin, 1998; Frey & Denyes, 1989; Monsen, 1988; Slusher, 1999; McCaleb & Cull, 2000; Moore & Beckwitt, 2006; Paniagua, 2002).

Participation concept

In this study, the violence prevention program was designed by developing goals and actions involving participation by parents, teachers, and peers. Tutty (2002) agreed that the violence prevention program utilized school resources in accordance with the needs of the participants. Participation by parents, teachers, and peers in the school setting on violence prevention was a process of involving key people in knowledge development, transfer and communication at the school level (Howard et al., 1999). These were becoming relatively developed as a field of practice of the study, and more knowledge would be contributed to their scope and quality. The special issues about violence including preventive violence outcome were described

by the strategies and conceptual violence prevention program. This involved efforts to reduce adolescent violence and to reduce the impact of violence on youth. The rationale for self-care activities should be promoted and the techniques for successfully involving participants are branded to organizations and agencies. It included school policy to push efforts to organize community participation in order for transactional factors to work together with democratic rights, decision-making process, expectations, information flow, representation, conflict resolution, commitment, and communication (Isaramalai, 1998, as cited in Orem, 2001).

Numerous studies have documented significant participation regarding violence, such as adolescent witness of family and community violence that must be paid special attention (Clayton, Ballif-Spanvill, & Hunsaker, 2001). Hammond et al. (2005) noted that the interventions should be designed to participate in the ways that demand adolescents of various backgrounds to attend the interventions by including culturally relevant content, incorporating multicultural issues including special methods and materials (Thornton et al., 2000), that appeal to various learning styles (Glicker, 2004).

2. The Program Design

The violence prevention program in addition was scheduled weekly for fifty to sixty minutes per session, and the entire intervention lasted twelve weeks. This was sufficient length and included a sufficient number of sessions for the program to be effective with the adolescents, as well as in the areas of instructor training and staff development (Mytton et al., 2009). It is significant to note that a violence prevention

program and its length must be sufficient to result in a mastery of violence knowledge and violence management skills in the participants at the individual and group levels, and to produce significant changes in social settings (Dahlberg & Potter, 2001; Lutzker, 2006). However, different approaches to violence prevention may be needed, and the optimal time to intervene may differ across subjects (Flannery et al., 2003).

The repeated measures design of the study gave an adequate time period for observation, and this gave the distinct advantage of generalizing the results over a long period of time. The long time period allowed the researcher to thoroughly examine the results from one group of participants. A well-controlled evaluation was implemented, testing the same group of adolescents both before and after the prevention program. Fields and McNamara (2003) supported that during the study, the students took “pre” and “post” tests; from this, the external validity of the study’s design was strengthened.

In addition, this program was designed to employ specific observation through the usage of multiple measurement procedures: self-report testimonies, school record reviews, and the observation of aggressive behaviors. These were similar to measures used in other studies on adolescent violence (Lutzker, 2006). The measurement of the outcomes and effectiveness of the program directly related to violence-reduction; it also included process measures to assess variations in treatment fidelity (Dumas et al., 2001, as cited in Lutzker, 2006). In addition, each source of data (self-reports, school records, and behavioral observations) helped decrease the degree of bias, so the measures met psychometric standards that were appropriate for the specific aim of the program (Farrell et al., 2001). The results of the observations

indicated that adolescent students wanted to participate and every person wanted to attend each week with no absences.

3. Students' Satisfaction with the Violence Prevention Program Effectiveness

Students' satisfaction with the program's effectiveness was rated for each phase of self-care operation. Satisfaction with the violence prevention program was measured by self-reporting and self-rating by means of a questionnaire. The questionnaire was divided by the three phases of self-care operation: the *estimative phase* with eleven items, the *transitive phase* with ten items, and the *productive phase* with twelve items. A variety of questions aimed to measure the students' satisfaction which was rated on a 5-point (1 to 5) scale, ranging from 1 (low) to 5 (high). A score of 1 to 2.61 was defined as mild, 2.68 to 4.35 as moderate, and 4.36 to 5.00 as a high level of satisfaction. Moreover, the subjects could make suggestions and give their opinions because open-ended questions were used.

The resulting scores showed high levels of satisfaction with the violence prevention program's effectiveness among adolescent students in each phase of the self-care operation. The responses indicated the magnitude and degree of endorsement of the program's effectiveness towards eliminating aggressive behavior. The results showed successful self-care development and the program was endorsed by the subjects. However, stress during the program was said to be a possible danger to it functioning optimally (Leighton, 2008). The student's satisfaction was influenced by self-perception, which was likely to be affected by the complexity of information processing that adolescent students do. In particular, the complexity of information

processing helps determine the extent to which adolescents consider more than one point of view in a violent situation, a process known as differentiation. Thus, the use of violence can be learned through conditioning, and it was often acquired in adolescents (Dahlberg & Potter, 2001; Glick, 2004). The method of supportive intervention was consistent with the nature of adolescents, who obtained self-care learning from friends, teachers, and parents or guardians for dealing with their problems (Taylor, 2003).

Adolescents were encouraged to feel proud that they were part of the violence prevention program, and this pride further assisted them in enhancing their awareness of violence (Arnetz & Arnetz, 2001), as well as changing their attitudes and improving their management of violence prevention (Hahn et al., 2006). In addition, the students' satisfaction with the effectiveness of the program was enhanced in each tier; this most likely meant that the students felt the program was able to help them manage aggression (Lutzker, 2006). The satisfaction probably also came about because the subjects agreed to the program (Mytton et al., 2009) and the program was not too difficult, so that they would possibly attend the program again in the future.

Thus, the research found that many participants reported satisfaction with the benefits of self-care management concerning violence prevention. The students' satisfaction not only affected their responsibility, but also their skills, knowledge, and the improvement in the quality of their lives (Paniagua, 2002; Renpenning & Taylor, 2003).

Interestingly, the violence prevention program took place within a school setting, and this program was supported by the government's policy. The Thai government has required in-school violence prevention program participation for

problematic adolescent students (Kongsuwan et al., 2008). Then, this program is the way that schools should deal with adolescent violence in Thailand for the reduction and prevention of violence.

Guidance teachers and other teachers affirmed that this program was practical and feasible for not only violence problems but other mental health problems, as it could save costs in the long term, especially if applied at an early stage. This issue was raised in the study of risk-factor research which also supported the need to take into account the timing and length of interventions in the early stage of adolescence (Ballif-Spanvill et al., 1999; Hammond et al., 2005), especially among those who display early behavioral problems. Thus, effective, early violence prevention programs for adolescents can assist in reducing the costs of violence and its impact.

Findings from previous research also supported the fact that satisfaction with the violence prevention program's effectiveness correlated with the success of its outcomes (Clayton et al., 2001). Moreover, satisfaction with the program's effectiveness improved adolescents' confidence in the effectiveness of the program, and hence their commitment (Tutty, 2002). Students actually requested to attend the next violence prevention program, as they received useful skills and experience. Low student satisfaction with the program may significantly impact the self-care abilities of the subjects in achieving their desired violence prevention outcomes (Beland, 1996). In addition, adolescent students commented that this program not only helped them gain more knowledge about violence and skills to reduce violence, but it also had the potential to increase their self-acceptance and self-esteem when dealing with other people, such as teachers, friends, peers, and their parents.

Summary

Adolescent students gained a deeper understanding of themselves while actively participating in a positive process with others which strengthened their bonds and relationships, facts which were reflected in the entries recorded in their handbooks. The information in the handbooks revealed that the students created strong, positive bonds with each other. In their self-care efforts, the adolescent students received helpful support from people important in their lives. This enhanced their capability to manage their attitudes and behaviors toward violence and to prevent violent outbursts.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

The conclusion of this research study is divided into 3 parts. The first part focuses on a summary of the study based on the research results, the second part illustrates the limitations of this study and finally, implications and recommendations of the study are presented in the third part.

Summary

The within group, repeated measures design used in this study, was one of the major design considerations in evaluating a violence prevention program. This design was particularly suited for those involved as individuals and groups working on their homework both in the classroom and at home under experimental conditions.

The study aimed at testing the effectiveness of a violence prevention program among adolescent students, in terms of aggressive behavior, favorable attitudes toward violence, violence management skills. In addition, student's satisfaction of the violence prevention program was also examined.

The study was conducted over a six-month period. The sample included 45 adolescent students who were purposively selected for the intervention. During the duration of the study, subjects received regular care for 12 weeks and then received intervention for 12 weeks. The violence prevention program comprised 3 phases underpinning the conceptual structure of adolescent's self-care operations on violence: 1) *estimative phase*, 2) *transitive phase*, and 3) *productive phase*.

Each phase contributed to developing a self-care competency for adolescent students towards their being unfavorably disposed towards violence and aggressive behaviors by including violence management skills.

The effectiveness of the violence prevention program was determined by obtained outcomes at three different times: pre-regular care (0 week), pre-intervention (12 weeks), and post-intervention (24 weeks). The outcome measures were aggressive behavior scores both on the ABS and the O-ABS, favorable ATVS, and VMST among adolescent students.

The findings revealed that the ABS scores at post-intervention decreased significantly more than at pre-intervention ($M = 1.67, SD = .24$; $M = 0.85, SD = .33$). There was significant difference in the scores at pre-regular care compared to pre-intervention ($M = 1.67, SD = .24$; $M = 1.72, SD = .25$).

Moreover, ATVS scores at post-intervention decreased significantly more than at pre-intervention ($M = 2.51, SD = .27$; $M = 2.09, SD = .35$). There was significant difference in the scores at pre-regular care compared to pre-intervention ($M = 2.57, SD = .33$; $M = 2.51, SD = .27$).

For Violence Management Skills, it was found that the VMST scores increased significantly at post-intervention rather than at pre-intervention as follows: IRS ($M = 1.87, SD = .24$; $M = 2.39, SD = .24$), PSS ($M = 2.14, SD = .26$; $M = 2.29, SD = .25$), CES ($M = 2.18, SD = .19$; $M = 2.39, SD = .21$), and SRS ($M = 2.96, SD = .30$; $M = 3.20, SD = .23$).

There was no significant difference in the scores at pre-regular care as compared to pre-intervention: IRS ($M = 1.93, SD = .29$; $M = 1.87, SD = .24$),

PSS ($M = 2.17$, $SD = .33$; $M = 2.14$, $SD = .26$), CES ($M = 2.19$, $SD = .30$; $M = 2.18$, $SD = .19$), and SRS ($M = 2.84$, $SD = .35$; $M = 2.96$, $SD = .30$).

As for student's satisfaction of the violence prevention program, the results from the mean scores indicated that their satisfaction level scored high in every phase: *estimative phase* ($M = 4.38$, $SD = .39$), *transitive phase* ($M = 4.36$, $SD = .53$), and *productive phase* ($M = 4.36$, $SD = .55$).

In summary, the violence prevention program could decrease physical and verbal aggressive behaviors, decrease favorable attitudes towards violence, and enhance violence management skills; interpersonal relationship skills, problem solving skills, coping with emotion and stress, and increase social responsibility skills among adolescent students.

Limitations of the Study

The limitation of this study was that the violence prevention program among adolescent students was verified from repeated measures based on cross sectional data; this could not refer to the sustainability of the outcomes of the variables.

Therefore, follow up study is recommended since adaptations at the individual level were not likely to persist if they were not supported within a suitable environment (Elliott & Tolan, 1999). The use of non-violence cannot be studied throughout the course of their lives (Dodge et al., 2003; Hudley, 1994; Lochman & Dodge, 1994).

In addition, within the school, there was a need to maintain an optimistic climate and long-term involvement of the school in the development of the curriculum

and interaction with the violence prevention program. In particular, all students in all years were to be continuously exposed to some violence prevention activity especially from among sophomores or seniors that were available, permitting a tracking of changes over time.

Implications and Recommendations

Implications for Research

In spite of the limitations of the present study, this research adds applicable information to the field of violence and violence management as well as to other mental health problems among adolescent students in Thai high schools. This study provides evidence that a violence prevention program may be important to the mental health and well-being of violent students. Presently, no other study in Thailand has ever examined how a violence prevention program may ameliorate each level of violence and other mental health problems as related to violence in schools. Moreover, by using the within group repeated measure, probably the most commonly utilized evaluation design, the researcher could identify whether the scores of the program participants improved afterwards. However, the other activities occurred during the weeks after the violence prevention program, other events such as media coverage about adolescent violence in the community could have created the change, rather than the program. Thus, the following implications should be encouraged as follows:

1. There should be long-term promotion to study the changes in self-care violence management performed by the students. For example, cohort study design or

randomized control trials research might be applied and conducted to ensure a better quality of life for adolescent students with violence.

2. Violence affects not only the adolescents, but also the family, health care providers and health care systems. More studies should be conducted among these latter groups regarding their roles and involvement to improve the quality of life for the adolescents.

Implications for Nursing Practice

1. The results of this study indicate that the violence prevention program could reduce violent behavior, reduce favorable attitudes toward violence, and increase violence management skills among adolescent students. Moreover, the findings confirm the appropriateness of applying this program to adolescent students. A violence prevention program is considered a new innovation of nursing practice for adolescent students in attempting to achieve the promotion of self-care performance. The program contains important nursing information and clearly indicates procedures and nursing methods. Nurses can apply this program to adolescent students to promote violence management and can provide information concerning violence, promote correct understanding and perception of violence prevention, teach necessary skills in dealing with the signs of violence, and promote self-regulation.

The adolescents and their families should also be involved in the planning and setting of goals. Personal information from each participant plays an important role in designing activities. Nurses should be facilitators, instructors and advisors constantly and continually providing an environment of service in any setting throughout the program.

2. The program can be suitably applied in the school health setting because most adolescent students prefer receiving treatment in school rather than in health care settings. In such situations, the school serves a vital and primary function, and the nurse plays a direct role in providing an environment of service to this group of adolescent students. In fact, the violence prevention program can be a part of a homeroom schedule without changing the regular schedule too much.

3. The expertise of the nurse was a key factor in maintaining the efficacy and sustainability of the program. The expertise of the professional nurse, particularly Advanced Practice Nurse (APN) in Mental Health and Psychiatric Nursing must be considered in the implementation of the violence prevention program. APN should be extensively trained to increase their expertise to become guidance teachers.

4. This study produced two violence management manuals, one for adolescent students and one for teachers. These manuals contained comprehensive information that the adolescents would need. They were carefully designed to encourage use by adolescents and teachers suggesting and could be followed easily, using clear explanations, ample repetition and suggesting specific learning methods. These manuals were useful in increasing adolescent abilities and fostering effective violence management performance.

5. The findings of this study indicated that many adolescents still needed more self-care practice in violence prevention and in violence management knowledge. Also the use of self-care behaviors to manage their aggression was not constantly or appropriately applied. Media and social activities interference, with peers or family, may have actually contributed to a worsening of violence. The findings of this study

point to the need for improved family education and implementation of violence prevention and effective methods of violence management within communities.

Development of a knowledge provision plan in the school setting or in the community for individuals and groups should be implemented. The knowledge provision plan should emphasize a thorough method of helping. This way, the nurse would more thoroughly understand the problems and needs of adolescent students. In addition, they would be able to design appropriate approaches and strategies to best tackle problems and to meet the needs of adolescent students.

Moreover, the promotion of information via media such as newspapers, radio and television would reach a wider group of people. Two-way communication should also be emphasized as it allows interaction and the exchange of ideas and experiences. This generates correct perception that meets the needs of people.

6. Violence affects both the adolescent who is the aggressor as well as the victim who suffers the effects of being bullied or victimized especially when he or she is exposed, repeatedly and over time, to negative actions on the part of one or more other students (Brookmeyer, Henrich, & Schwab-Stone, 2005). Bullying includes a wide range of behaviors from very mild, for instance, verbal taunts to extreme aggressive behaviors leading to physical injury and even death (Bosworth, Espelage, & Simon, 1999; International Clinical Epidemiology Network, 2005). Therefore, these disorders may cause a lot of suffering and require life-time treatment. The promotion of violence management will assist the adolescents in managing themselves, relieving their illness and providing psychosocial well-being. The researcher believes that integrating the violence prevention program with regular nursing would improve nursing care for adolescent students.

Implications for Nursing Education

1. Findings from this study confirm that violence management based on Self-Care Deficit Nursing Theory can be applied to adolescent students who have violent signs. Nurse educators should emphasize the concept of violence management to nursing students especially Master's students, Advanced Practice Nurses in mental health and psychiatric nursing programs, as well as making it a part of the nursing curriculum. Violence management should be added to nursing courses, especially in terms of providing care in violent situations.

2. Advanced practice nurses, and especially school nurses, community nurses, nurse practitioners (NP), clinical nurse specialists, especially in the areas of mental health and psychiatric nursing, are very likely to encounter violence and would find it necessary to deal with reactions to it. This suggests that the nursing curriculum should include elements on violence among adolescents, the problems of violence and the concerns that it generates.

Implications for Nursing Theory Development

1. The findings from this study confirm the effectiveness of the violence prevention program in violence management practices among adolescent students. The program incorporates the concept of self-care and the need for a more constructively clear model of self-care operation, particularly intervention as applied through 3 phases, *estimative*, *transitive*, and *productive*.

Deductive supportive-educative nursing systems and concepts, which are based on the principles of Self-Care Deficit Nursing Theory, lead to constructive concepts or observable statements. Nursing therapeutic innovation is based on

research. This assures the quality of nursing practice. These helpful methods of deriving knowledge should be conducted in other areas of nursing, which will greatly expand the development of new knowledge.

2. In addition the research process that can be applied in developing new nursing knowledge must be based on the nursing situation, the agreement and limitation of each method. This would be considered an advance in nursing knowledge.

Implications for Health Policy

The findings reflect the significance and necessity in providing care for adolescent students so that they are able to deal with signs of violence. School health care services must cover home health care. Certain changes should be made to public policy and the nursing service system as follows:

1. Health policies regarding health care for adolescents should be a proactive health service system for the school and community because adolescent students would rather face and learn of the problem at school and in the community rather than receive treatment at a police station or Juvenile Detention Center. The health care system at school should be efficiently provided to meet their problems and needs. Care for the adolescent students should cover physical, mental, emotional, spiritual, and social aspects. The adolescents should be encouraged in their abilities in dealing with violent situations, developing an aversion towards violence, and endeavor to enhance their violence management skills. School services and school health service activities should be continually provided for both the well-being of adolescents and for that requiring violence prevention.

2. An efficient nursing service system that promotes adolescent health should be provided; particularly Advanced Practice Nurses (APN) in the area of mental health and psychiatric care of the community hospital by way of the Contracting Unit for Primary care (CUP). Nurses play important roles such as: (1) Coordinators of health personnel in the community or other personnel in promoting health, (2) Activity providers to develop adolescent student potential in dealing with, controlling and preventing violence. Emphasis should be given to primary prevention in each period of adolescence. For example, nurses should provide knowledge of stress and emotional management to prevent the use of violence, violence with optimistic interpersonal relationships, problem solving skills for non-users of violence, and social responsibility toward violence prevention, (3) Providers of follow up assistance and advice. Empowerment and refresher training for adolescents should also be promoted so that they would be able to decide and choose appropriate health care for themselves.

Future research in this area should examine how violence prevention programs and sources of support differ across different levels of violence, as well as for other psychological problems. It may show that adolescent students who are prone to various levels of violence, along with other types of mental health problems, need different models of violence prevention programs. Further, the study should also illustrate how other types of courses may also be important for manipulation as well as preventing violence and other mental health problems. In addition, future studies should address more specifically whether the obtained improvement in psychological well-being is able to differentiate specific aspects of the combined model of violence prevention within the school, family, and society.

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APPENDICES

APPENDIX A
RESEARCH INSTRUMENTS

9. ระดับการศึกษาของบิดา
- () ไม่ได้เรียน
 - () ประถมศึกษา
 - () มัธยมศึกษา
 - () ปริญญาตรี
 - () สูงกว่าปริญญาตรี
- ระดับการศึกษาของมารดา
- () ไม่ได้เรียน
 - () ประถมศึกษา
 - () มัธยมศึกษา
 - () ปริญญาตรี
 - () สูงกว่าปริญญาตรี
10. รายได้ของครอบครัว โดยเฉลี่ย
- () ไม่แน่นอน
 - () ต่ำกว่า 2,500 บาท/เดือน
 - () 2,500 – 5,000 บาท/เดือน
 - () 5,000 – 10,000 บาท/เดือน
 - () 10,000- 15,000 บาท/เดือน
 - () 15,000- 20,000 บาท/เดือน
 - () สูงกว่า 20,000 บาท/เดือน
11. นักเรียนเคยเห็นการใช้ความรุนแรงในครอบครัวหรือไม่
- () เคย
ลักษณะของการใช้ความรุนแรงที่พบ.....
 - () ไม่เคย
12. นักเรียนเคยเห็นการใช้ความรุนแรงที่โรงเรียนหรือไม่
- () เคย
ลักษณะของการใช้ความรุนแรงที่พบ.....
 - () ไม่เคย
13. นักเรียนมักใช้เวลาว่างประกอบกิจกรรมใด (ตอบได้มากกว่า 1 ข้อ)
- () เล่นกีฬา
 - () ทำงานศิลปะ
 - () เล่นสตั๊ด
 - () อ่านหนังสือ
 - () ฟังเพลง
 - () เล่นดนตรี
 - () สะสมแสตมป์ หรือของที่ระลึกต่างๆ
 - () เล่นเกมส์คอมพิวเตอร์
 - () ไปเดินเที่ยวตามสถานที่ต่างๆ เช่น ห้างสรรพสินค้า
 - () อื่นๆ ระบุ.....

แบบสอบถามการปฏิบัติตัวของนักเรียนต่อผู้อื่น

แบบสอบถามฉบับนี้สร้างขึ้นเพื่อรวบรวมข้อเท็จจริงเกี่ยวกับ “การปฏิบัติตัวของนักเรียนต่อผู้อื่น” ข้อเท็จจริงที่ได้จากคำตอบของนักเรียน จะเป็นประโยชน์ในการศึกษาเป็นอย่างยิ่ง คำตอบแต่ละข้อของนักเรียนจะไม่มีข้อใดถูก ข้อใดผิด เพราะคำตอบของแต่ละคนตอบตามสภาพความเป็นจริง อาจจะแตกต่างกันได้ จึงใคร่ขอร้องให้นักเรียนตอบตามสภาพความเป็นจริงทุกข้อ ผู้วิจัยขอขอบคุณนักเรียนทุกคนที่ให้ความร่วมมือในการตอบ

คำชี้แจงในการตอบแบบสอบถาม

1. แบบสอบถามมีทั้งหมด 58 ข้อ แต่ละข้อจะเป็นสถานการณ์ระหว่างนักเรียนกับผู้อื่น แต่ละสถานการณ์จะแสดงถึงวิธีการปฏิบัติตัวของนักเรียนทั้งในอดีตและปัจจุบัน
2. วิธีตอบแบบสอบถาม ให้นักเรียนระลึกถึงเหตุการณ์ระหว่างตัวนักเรียนกับผู้อื่นทั้งในอดีต และปัจจุบันว่านักเรียนปฏิบัติต่อผู้อื่นอย่างไร แล้วให้กาเครื่องหมาย / ลงในคำตอบท้ายข้อความที่ตรงกับความเป็นจริงที่สุดข้อละ คำตอบ ขอให้ตอบทุกข้อ

วิธีที่นักเรียนปฏิบัติต่อผู้อื่น	ทำเป็นประจำ	ทำบ่อยๆ	ทำค่อนข้างบ่อย	ทำนานๆครั้ง	ไม่เคยทำเลย
(0) ถ้าเพื่อนมาแหย่ฉันจะโกรธและชู้เอาเขาตเขา			/		
(00) ฉันมักจะพูดถึงความไม่ดีของเพื่อนเสมอ		/			

หลักเกณฑ์ในการตอบแบบสอบถามมีดังนี้

ถ้าข้อความใดเกิดขึ้นตรงกับความเป็นจริงประมาณ 9-10 ครั้ง ใน 10 ครั้งหรือกล่าวได้ว่าเกิดขึ้นทุกครั้ง ให้นักเรียนกาเครื่องหมาย / ลงในช่อง “ทำเป็นประจำ”

ถ้าข้อความใดเกิดขึ้นตรงกับความเป็นจริงประมาณ 6-8 ครั้ง ใน 10 ครั้ง ให้นักเรียนกาเครื่องหมาย / ลงในช่อง “ทำบ่อยๆ”

ถ้าข้อความใดเกิดขึ้นตรงกับความเป็นจริงประมาณ 3-5 ครั้ง ใน 10 ครั้ง ให้นักเรียนกาเครื่องหมาย / ลงในช่อง “ทำค่อนข้างบ่อย”

ถ้าข้อความใดเกิดขึ้นตรงกับความเป็นจริงประมาณ 1-2 ครั้ง ใน 10 ครั้ง ให้นักเรียนกาเครื่องหมาย / ลงในช่อง “นานๆ ครั้ง”

ถ้าข้อความใดเป็นเหตุการณ์ที่ไม่เคยเกิดขึ้นเลย ให้นักเรียนกาเครื่องหมาย / ลงในช่อง “ไม่เคยทำเลย”

วิธีที่นักเรียนปฏิบัติต่อผู้อื่น	ทำเป็นประจำ	ทำบ่อยๆ	ทำค่อนข้างบ่อย	ทำนานๆ ครั้ง	ไม่เคยทำเลย
1. ฉันมักจะส่งเสียงดังเมื่อโกรธ และตะโกนคำเมื่อรู้สึกขัดใจ หรือไม่ได้สิ่งที่ต้องการ					
2. ฉันใช้เสียงดัง เพื่อด่าทอ หรือสบประมาทผู้อื่น เช่น “เธอเป็นคนไม่ดี”, “เธอนี่ โง่จัง”					
57. บางครั้งเมื่อไม่ได้รับความยุติธรรม ฉันจะระบายอารมณ์โดยทำให้สิ่งของเสียหาย					
58. บางครั้งเมื่อไม่พอใจผู้อื่น ฉันจะทำให้เสื้อผ้า สมุด ของเขาสกปรก					

แบบสอบถามความคิดเห็นต่อการใช้ความรุนแรง

แบบสอบถามฉบับนี้สร้างขึ้นเพื่อสอบถามความคิดเห็นต่อการใช้ความรุนแรง ข้อคิดเห็นที่ได้จากคำตอบของนักเรียน จะเป็นประโยชน์ในการศึกษาเป็นอย่างยิ่ง คำตอบแต่ละข้อของนักเรียนจะไม่มีข้อใดถูก ข้อใดผิด เพราะคำตอบของแต่ละคนตอบตามความคิดเห็นของตนเอง อาจจะแตกต่างกันได้ จึงใคร่ขอร้องให้นักเรียนตอบตามสภาพความเป็นจริงทุกข้อ ผู้วิจัยขอขอบคุณนักเรียนทุกคนที่ให้ความร่วมมือในการตอบ

คำชี้แจงในการตอบแบบสอบถาม

1. แบบสอบถามมีทั้งหมด 33 ข้อ แต่ละข้อจะเป็นการสอบถาม ความคิดเห็นในแต่ละสถานการณ์ ของความรุนแรงที่ปรากฏอยู่ในสังคม
2. วิธีตอบแบบสอบถาม ให้นักเรียนระลึกถึงเหตุการณ์ว่า นักเรียนมีความคิดเห็นอย่างไร แล้วให้กาเครื่องหมาย / ลงในคำตอบท้ายข้อความที่ตรงกับความคิดเห็นที่สุดข้อละหนึ่งคำตอบ ขอให้ตอบทุกข้อ

ความคิดเห็นของนักเรียน	เห็นด้วย อย่างยิ่ง	เห็นด้วย	ไม่เห็น ด้วย	ไม่เห็น ด้วยอย่าง ยิ่ง
(0) ถ้าเพื่อนมาแหย่ฉันจะ โกรธ ฉันควรโต้ตอบ		/		
(00) การพูดถึงความไม่ดีของคนอื่นบ้าง เป็นการ ระบายความ โกรธวิธีหนึ่ง			/	

หลักเกณฑ์ในการตอบแบบสอบถามมีดังนี้

- เห็นด้วยอย่างยิ่ง หมายถึง นักเรียนเห็นด้วยกับข้อความนั้นมาก
เห็นด้วย หมายถึง นักเรียนเห็นด้วยกับข้อความนั้น
ไม่เห็นด้วย หมายถึง นักเรียนไม่เห็นด้วยกับข้อความนั้น
ไม่เห็นด้วยอย่างยิ่ง หมายถึง นักเรียนไม่เห็นด้วยกับข้อความนั้นมาก

3. ความหมายของความรุนแรง ในที่นี้หมายถึง การกระทำใดๆ ที่เป็นการล่วงละเมิดสิทธิส่วนบุคคลทั้งทางร่างกายและจิตใจ ซึ่งเป็นผลหรืออาจจะเป็นผลให้เกิดความทุกข์ทรมาน ทั้งทางร่างกายและจิตใจของผู้ถูกรักษา แบ่งออกเป็น

“ความรุนแรงต่อร่างกาย” หมายถึง การใช้กำลังและ/หรืออุปกรณ์ใดๆ เป็นอาวุธคุกคามหรือทำร้าย เช่น ขว้างปา ทุ่มของใส่ ผลัก กระทบก เขย่า ใช้มือฟาด ตบ ทูบตี ตะต่อย และใช้มีดหรือปืนเข้าทำร้าย เป็นต้น ส่งผลให้ผู้ถูกรักษาได้รับบาดเจ็บต่อร่างกาย หรืออาจถึงแก่ชีวิต

“ความรุนแรงต่อจิตใจ” หมายถึง การกระทำใดๆ ซึ่งมีผลทำให้ผู้ถูกรักษาได้รับความเสียหาย เสียสิทธิ และเสรีภาพ เช่น การพูดจาดูถูกด่าทอ ข่มขู่ ตะคอกใส่ มองด้วยความเหยียดหยามไม่ให้เกียรติ ตลอดจนจำกัดและกีดกันสิทธิเสรีภาพทั้งในที่สาธารณะและในการดำเนินชีวิตส่วนตัว เป็นต้น

ข้อความ	เห็นด้วย อย่างยิ่ง	เห็นด้วย	ไม่เห็น ด้วย	ไม่เห็น ด้วยอย่าง ยิ่ง
1. การใช้ความรุนแรงเป็นทางเลือกหนึ่งในการแก้ปัญหา				
2. ฉันมักไม่สบายใจ ที่ได้ข่าวเกี่ยวกับนักเรียนใช้ความรุนแรง				
32. การใช้ความรุนแรงในการแก้ปัญหา ก่อให้เกิดผลเสียต่อตัวฉัน ครอบครัว สถาบันการศึกษา และสังคม				
33. พ่อแม่ของฉันไม่ได้ว่ากล่าวอะไร เมื่อฉันใช้ความรุนแรงในการแก้ปัญหา เพราะมันเป็นสิทธิของฉัน				

แบบสอบถาม เรื่องแบบวัดทักษะการจัดการความรุนแรงในวัยรุ่น

แบบสอบถามชุดนี้ ประกอบด้วยข้อคำถามที่เกี่ยวข้องกับทักษะในการจัดการความรุนแรงในวัยรุ่น ที่เกี่ยวข้องกับการแก้ปัญหา ทักษะการจัดการกับอารมณ์ และความเครียด ทักษะการสื่อสาร และการสร้างสัมพันธภาพระหว่างบุคคล โดยให้นักเรียนอ่านคำถาม และคำตอบอย่างละเอียด ทำความเข้าใจ แล้วจึงตอบคำถาม คำถามทุกข้อจะถูกนำไปรวบรวมวิเคราะห์เพื่อหาแนวทางในการศึกษาการเสริมสร้างทักษะในการจัดการความรุนแรงของนักเรียน

และเพื่อให้ผลการวิจัยเกิดประโยชน์สูงสุด ขอให้นักเรียนตอบคำถามทุกข้อตามความเป็นจริงมากที่สุด ข้อมูลที่ได้จากการตอบแบบสอบถามจะเก็บไว้เป็นความลับ และไม่มีผลต่อการเรียนของนักเรียนแต่อย่างใด แบบ สอบถามทั้งหมดแบ่งเป็น 3 ตอน ดังต่อไปนี้

ตอนที่ 1 ทักษะการแก้ปัญหา

ตอนที่ 2 ทักษะการจัดการกับอารมณ์ และความเครียด

ตอนที่ 3 ทักษะการสื่อสาร และการสร้างสัมพันธภาพระหว่างบุคคล

ตอนที่ 1 ทักษะการแก้ปัญหา (*Problems Solving Skills*)

คำถาม	จริง	ค่อนข้างจริง	ไม่จริง
1. ฉันชอบมองปัญหาหลายๆแง่มุม			
2. ฉันสามารถแก้ปัญหาเฉพาะหน้าได้ดี			
12. ฉันชอบรับการตัดสินใจในแนวทางการแก้ไขปัญหานั้นเลือก แม้ว่าจะเป็นวิธีการที่ไม่ดีที่สุดก็ตาม			

ตอนที่ 2 ทักษะการจัดการกับอารมณ์ และความเครียด (Coping with Emotion and Stress)

คำถาม	จริง	ค่อนข้างจริง	ไม่จริง
1. ฉันเป็นคนใจเย็นไม่ค่อยโกรธใคร ง่ายๆ			
2. คนอื่นมักบอกว่าเป็นคนเก็บ อารมณ์ได้ดี			
19. เมื่อมีคนตวาดฉันด้วยเสียงดัง ฉันจะ ตวาดกลับทันที			

ตอนที่ 3 ทักษะการสื่อสาร และการสร้างสัมพันธภาพระหว่างบุคคล
(Interpersonal Relationship Skills)

คำถาม	จริง	ค่อนข้างจริง	ไม่จริง
1. ฉันมักกังวลเมื่อต้องไปพบปะกับคนที่ รู้จักมาก่อน			
2. ฉันไม่กล้าบอกความต้องการของฉันให้ ผู้อื่นรู้			
13. การใช้คำพูดที่สุภาพ และ เหมาะสม กับ บุคคล เวลา และสถานที่ เป็นสิ่งสำคัญ			

แบบสอบถามความรับผิดชอบต่อสังคม

แบบสอบถามฉบับนี้สร้างขึ้นเพื่อสอบถามความคิดเห็นต่อความรับผิดชอบต่อสังคม ข้อคิดเห็นที่ได้จากคำตอบของนักเรียน จะเป็นประโยชน์ในการศึกษาเป็นอย่างยิ่ง คำตอบแต่ละข้อของนักเรียนจะไม่มีข้อใดถูก ข้อใดผิด เพราะคำตอบของแต่ละคนตอบตามความคิดเห็นของตนเอง อาจจะแตกต่างกันได้ จึงใคร่ขอร้องให้นักเรียนตอบตามสภาพความเป็นจริงทุกข้อ ผู้วิจัยขอขอบคุณนักเรียนทุกคนที่ให้ความร่วมมือในการตอบ

คำชี้แจงในการตอบแบบสอบถาม

1. แบบสอบถามมีทั้งหมด 47 ข้อ แต่ละข้อจะเป็นการสอบถาม ความคิดเห็นในความรับผิดชอบต่อสังคม
2. วิธีตอบแบบสอบถาม ให้นักเรียนระลึกถึงเหตุการณ์ว่า นักเรียนมีความคิดเห็นอย่างไร แล้วให้กาเครื่องหมาย / ลงในคำตอบท้ายข้อความที่ตรงกับความคิดเห็นที่สุดข้อละหนึ่งคำตอบ ขอให้ตอบทุกข้อ

ความคิดเห็นของนักเรียน	จริงที่สุด	จริง	เกือบจะจริง	ไม่จริง
(00) ฉันคิดว่าเพื่อนที่ไม่มีความรับผิดชอบต่อการทำงานกลุ่ม เป็นบุคคลที่สมควรถูกตำหนิ		/		
(00) ความรับผิดชอบต่อสังคมเป็นการหน้าที่ ที่ทุกคนควรต้องปฏิบัติอย่างเคร่งครัด			/	

หลักเกณฑ์ในการตอบแบบสอบถามมีดังนี้

- จริงที่สุด หมายถึง นักเรียนเห็นว่าข้อความนั้นเป็นความจริงมาก
 จริง หมายถึง นักเรียนเห็นว่าข้อความนั้นจริง
 เกือบจะจริง หมายถึง นักเรียนไม่แน่ใจว่า ข้อความนั้นเป็นจริง
 ไม่จริง หมายถึง นักเรียนเห็นว่าข้อความนั้นไม่จริง

ข้อความ	จริง ที่สุด	จริง	เกือบจะ จริง	ไม่จริง
<i>ความรับผิดชอบต่อน้ำที่พลเมือง</i>				
1. เมื่อนั้นได้รับมอบหมายให้ทำงาน หรือ รับปาก จะทำอะไรให้ใครนั้นจะทำให้เสร็จเรียบร้อย				
2. เมื่อนั้นทำความผิดหรือทำของเสียหาย นั้น พยายามปิดบังเพื่อไม่ให้คนอื่นทราบ				
<i>ด้านความรับผิดชอบต่อครอบครัว</i>				
11. เมื่อมีการแบ่งหน้าที่กันทำงานบ้าน นั้น มักละเลยไม่ปฏิบัติหรือจะปฏิบัติต่อเมื่อ มีคนเตือน				
12. เมื่อนั้นเห็นของใช้ในบ้านวางเกะกะ นั้น จะช่วยจัดให้เรียบร้อยไม่ว่าในบ้านนั้นจะ มีหรือไม่มีคนรับใช้ก็ตาม				

ข้อความ	จริง ที่สุด	จริง	เกือบจะ จริง	ไม่จริง
<p>ความรับผิดชอบต่อโรงเรียน ครู อาจารย์</p> <p>24. เมื่อเรียนวิชาใดไม่เข้าใจ ฉันจะพยายาม ทำความเข้าใจโดยการอ่านทบทวน ถาม ครู เพื่อน จนเข้าใจดี</p>				
<p>25. ฉันทำการบ้านที่ครูสั่งเสร็จทันเวลา แม้ว่า ครูจะตรวจหรือไม่ตรวจก็ตาม</p>				
<p> </p> <p> </p> <p> </p> <p> </p>				
<p>ด้านความรับผิดชอบต่อเพื่อน</p> <p>36. เมื่อยืมของผู้อื่นมา ฉันจะรีบส่งคืนให้ตาม กำหนดที่รับปากไว้</p>				
<p>37. เมื่อได้รับมอบหมายจากเพื่อนในกลุ่ม ให้ เตรียมอุปกรณ์บางอย่างมา ฉันมักจะลืม นำมา</p>				
<p> </p> <p> </p> <p> </p>				
<p>47. ฉันเห็นว่าถ้ารับปากจะทำอะไรให้เพื่อนแล้ว ฉันต้องทำให้เสร็จเรียบร้อยทุกครั้ง</p>				

แบบสังเกตและบันทึกพฤติกรรมการปฏิบัติตัวของนักเรียน
(O-ABS)

ชื่อผู้ปกครอง ผู้สังเกต.....

ผู้ถูกสังเกตคือ.....ชั้นปีที่.....ปีการศึกษา..... ภาคเรียนที่.....

โรงเรียน.....

พฤติกรรม ประกอบด้วยพฤติกรรมที่แสดงออกทางกาย และพฤติกรรมที่แสดงออกทาง
วาจา ในการวิจัยครั้งนี้ได้ให้คำจำกัดความ ไว้ดังนี้

พฤติกรรมที่บันทึก คือ พฤติกรรมที่นักเรียนทำให้บุคคลได้รับบาดเจ็บ ได้รับความเสียหายทางร่างกาย หรือจิตใจ และ/หรือ เป็นพฤติกรรมทำลายสิ่งของซึ่งแบ่งออกเป็น สอง ลักษณะคือ

พฤติกรรมที่แสดงออกทางกาย หมายถึง พฤติกรรมที่นักเรียนทำให้บุคคลได้รับบาดเจ็บเสียหายทางร่างกายหรือจิตใจ ซึ่งการทำให้ได้รับความเสียหายทางจิตใจนั้น อาจเป็นการกระทำให้อับอายหรือใช้อำนาจบังคับจิตใจ รวมทั้งพฤติกรรมทำลายสิ่งของ ซึ่งยกเว้นการกระทำตามหน้าที่หรืออุบัติเหตุ

พฤติกรรมที่แสดงออกทางวาจา หมายถึง พฤติกรรมที่นักเรียนแสดงออกทางการพูด การใช้วาจา ที่ทำให้บุคคลได้รับความเสียหายทางด้านร่างกาย จิตใจ

การบันทึก : การบันทึก X เมื่อมีพฤติกรรมอย่างใดอย่างหนึ่งที่ระบุเกิดขึ้นในช่วงการสังเกต

การบันทึก O เมื่อ ไม่มีพฤติกรรมที่ระบุเกิดขึ้นเลย

พฤติกรรม	จำนวนครั้งของการสังเกตและบันทึก การเกิดพฤติกรรม							
	1	2	3	4	5	6	7	8
พฤติกรรมที่แสดงออกทางกาย								
- การทำร้ายร่างกาย โดยการตี ต่อย								
- การทำลายสิ่งของ เช่นการฉีกสมุด, การเขียนลงบน โต๊ะ หรือสมุดของผู้อื่น								
- การใช้ภาษาท่าทางคำทอผู้อื่น เช่นการยกนิ้วกลาง หรือท่าทางเลียนแบบ ข้อบกพร่องของผู้อื่น								
- การทำหน้าทำตาใส่ อย่างไม่เป็นมิตร								
บันทึก (ผู้สังเกตสามารถบันทึกพฤติกรรมที่แสดงออกในทางลบทางร่างกาย หรือจิตใจ และ/หรือ ทำลายสิ่งของ ที่พบขณะสังเกตได้)								

พฤติกรรม	จำนวนครั้งของการสังเกตและบันทึก การเกิดพฤติกรรม							
	1	2	3	4	5	6	7	8
พฤติกรรมที่แสดงออกทางวาจา								
- การกล่าวตำหนิผู้อื่น								
- การพูดขี้วู								
- การกล่าวคำหยาบคาย								
- การใช้คำพูดคุกคาม ข่มขู่								
บันทึก (ผู้สังเกตสามารถบันทึกพฤติกรรมที่แสดงออกในทางลบทางร่างกาย หรือจิตใจ และ/หรือ ทำลายสิ่งของ ที่พบขณะสังเกตได้)								

.....(ลงชื่อ)

วันที่.....เดือน.....พ.ศ.....

แบบประเมินความพึงพอใจ ต่อประสิทธิผลของ
โปรแกรม การจัดการความรุนแรง ในวัยรุ่น : ระยะที่ 1 (Estimative Phase)

ข้อความ	5	4	3	2	1
	มาก	ค่อนข้าง มาก	ปาน กลาง	ค่อนข้าง น้อย	น้อย
1. การป้องกันการใช้ความรุนแรงมีความหมายต่อตัวฉัน					
2. ฉันเรียนรู้ความหมาย และลักษณะของความรุนแรง					
3. ฉันได้เรียนรู้สาเหตุของการเกิดความรุนแรง					
4. ฉันได้เรียนรู้สัญญาณเตือนที่นำไปสู่ความรุนแรง					
5. ฉันได้เรียนรู้ผลกระทบของการใช้ความรุนแรง					
6. ฉันได้เรียนรู้การจัดการความรุนแรง					
7. ฉันได้ปรับเปลี่ยนทัศนคติในทางลบต่อการใช้ความรุนแรง					
8. ฉันได้เรียนรู้ภาวะอารมณ์และความรู้สึกของตนเอง และผู้อื่น					
9. ฉันได้ตระหนักในอารมณ์และความรู้สึกที่แสดงออก					
10. ฉันได้ปฏิบัติการเพื่อควบคุมอารมณ์และความเครียดของ ตัวเอง					
11. ฉันมีทางเลือก และแนวทางการจัดการอารมณ์ความรู้สึกที่จะ นำไปสู่การใช้ความรุนแรง					
12. ฉันพึงพอใจกับการเข้าร่วมโปรแกรม					

ข้อคิดเห็นและข้อเสนอแนะอื่นๆ

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แบบประเมินความพึงพอใจ ต่อประสิทธิผลของ
การจัดการความรุนแรง ในวัยรุ่น : ระยะเวลาที่ 2 (Transitive Phase)

ข้อความ	5	4	3	2	1
	มาก	ค่อนข้าง มาก	ปาน กลาง	ค่อนข้าง น้อย	น้อย
1. ฉันได้ประเมินตนเอง ในการป้องกันการใช้ความรุนแรง					
2. ฉันได้เรียนรู้ประสบการณ์เกี่ยวกับการสร้างสัมพันธภาพ ที่ดีกับผู้อื่น					
3. ฉันได้เรียนรู้วิธีการสื่อสารเพื่อหลีกเลี่ยงการนำไปสู่การ ใช้ความรุนแรง					
4. ฉันได้เลือกวิธีการปฏิบัติ และมีแนวทางในการจัดการ สถานการณ์ที่มีโอกาสนำไปสู่ความรุนแรง					
5. ฉันดูแลตนเอง ที่จะแสดงออกโดยไม่ใช้ความรุนแรง					
6. ฉันได้พัฒนาความคิดใหม่ในการดูแลตนเองเพื่อป้องกัน การใช้ความรุนแรง					
7. ฉันได้พัฒนาทักษะใหม่ในการดูแลตนเอง เพื่อป้องกัน การใช้ความรุนแรง					
8. ฉันได้เรียนรู้แนวทางการแก้ไขปัญหาที่เกิดขึ้นในชีวิต อย่างเหมาะสม					
9. ฉันได้ปฏิบัติการแก้ไขปัญหาที่เกิดขึ้นด้วยตัวฉันเอง					
10. ฉันได้ปฏิบัติการแก้ไขปัญหาอย่างได้ผลในสถานการณ์ จริงโดยไม่ใช้ความรุนแรง					
11. ฉันได้ปรับเปลี่ยนทัศนคติ ต่อการใช้ความรุนแรงว่าเป็น สิ่งที่ไม่ควรกระทำ					
12. ฉันพึงพอใจกับการเข้าร่วมโปรแกรม					

ข้อคิดเห็นและข้อเสนอแนะอื่นๆ

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แบบประเมินความพึงพอใจ ต่อประสิทธิผลของ
การจัดการความรุนแรง ในวัยรุ่น : ระยะเวลาที่ 3 (Productive Phase)

ข้อความ	5	4	3	2	1
	มาก	ค่อนข้าง ข้าง มาก	ปาน กลาง	ค่อนข้าง ข้าง น้อย	น้อย
1. ฉันประเมินตนเอง เพื่อการป้องกันการแสดงออก ที่นำไปสู่ความรุนแรง					
2. ฉันสามารถบอกผลของการปฏิบัติว่าเหมาะสม หรือไม่เหมาะสม ควรปฏิบัติ หรือ ไม่ควรปฏิบัติ					
3. ฉันมีแนวทางการปฏิบัติของตัวเองในสถานการณ์ รุนแรงที่เกิดขึ้นรอบตัว					
4. ฉันได้เรียนรู้ผลกระทบที่เกิดจากการใช้ความรุนแรง					
5. ฉันสามารถสรุปข้อคิดเห็นจากผลที่เกิดตามมา ภายหลังการใช้ความรุนแรงได้					
6. ฉันเห็นคุณค่าในการปฏิบัติอย่างเหมาะสม ต่อตนเอง และผู้อื่น					
7. ฉันได้สร้างสรรค์พฤติกรรมใหม่ กับการจัดการความ รุนแรง					
8. ฉันได้คงพฤติกรรมที่ดีไว้ได้อย่างต่อเนื่อง					
9. ฉันได้เรียนรู้ทักษะในการแก้ปัญหา เพื่อป้องกันการ ใช้ความรุนแรง					
10. ฉันตระหนักในความรับผิดชอบที่มีต่อตนเอง และ ผู้อื่น					
11. ฉันได้พัฒนาความรับผิดชอบที่มีต่อสังคม					
12. การเข้าร่วมโปรแกรมก่อให้เกิดประโยชน์ต่อตัวฉัน					

ข้อคิดเห็นและข้อเสนอแนะอื่นๆ

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Manual

คู่มือ การจัดการความรุนแรง ในวัยรุ่น



Violence
Violence

Prevention
Prevention

วิณีกาญจน์ คงสุวรรณ

คณะพยาบาลศาสตร์ มหาวิทยาลัยสงขลานครินทร์

รายนามที่ปรึกษา

รองศาสตราจารย์ ดร.วันดี สุทธิรังษี

ผู้ช่วยศาสตราจารย์ ดร. แสงอรุณ อิศระมาลัย

Prof.Dr.Sandra J.Weiss

รายนามผู้ทรงคุณวุฒิ

นพ.สมัย ศิริทองถาวร

ดร.กฤษณา วุฒิสินธ์

คุณ เสาวลักษณ์ ลังกาพันธ์

คุณ ดุจเดือน ชินเจริญทรัพย์

อาจารย์ อภรณ์ เม่งอำพัน

อาจารย์ อนงค์วรรณ เมฆเจริญวิวัฒนา

คำนำ

ปัจจุบันปัญหาการใช้ความรุนแรงในวัยรุ่น เป็นปัญหาที่สำคัญเป็นอันดับต้นของประเทศไทย และมีแนวโน้มที่จะเพิ่มจำนวนมากขึ้น ที่สำคัญคือ นับวันจะยิ่งทวีความรุนแรง และมีรูปแบบที่หลากหลายมากขึ้น ก่อให้เกิดผลกระทบทั้งทางตรง และทางอ้อม ทั้งต่อตนเอง บุคคลรอบข้าง และสังคมโดยรวมอย่างปฏิเสธไม่ได้

พื้นฐานที่สำคัญสำหรับการดูแลเด็ก ในช่วงวัยรุ่นนั้น คงต้องเป็นความร่วมมือกันของสถาบันครอบครัว และสถาบันการศึกษา ที่จะอบรมสั่งสอน กล่อมเกลา เลี้ยงดูเด็กให้เป็นคนดี และมีพฤติกรรมที่เหมาะสม การส่งเสริมเด็กให้มีการพัฒนาทั้งทางด้านสติปัญญา จิตใจ อารมณ์ สังคม และจิตวิญญาณนั้น เป็นสิ่งที่ต้องดูแลควบคู่กันไป เพื่อที่จะสร้างเสริมให้เด็ก มีแนวทางในการจัดการกับปัญหา ที่เกิดขึ้นได้อย่างเหมาะสม และมีประสิทธิภาพ เด็บโตเป็นผู้ใหญ่ที่มีความสมบูรณ์ และมีความรับผิดชอบต่อสังคมต่อไป

รูปแบบการดูแลตนเองเพื่อจัดการความรุนแรง ที่ได้พัฒนาขึ้นนี้มีเป้าหมายให้นักเรียนวัยรุ่น ได้ตระหนักถึงความสำคัญของการดูแลสุขภาพกาย และสุขภาพจิตตนเอง ในการป้องกันการใช้ความรุนแรง โดยการใช้กิจกรรมที่เป็นการส่งเสริมสุขภาพจิตและการป้องกันการเกิดปัญหาทางจิตอย่างมีประสิทธิภาพ เพื่อที่จะส่งเสริมให้นักเรียนเกิดการเรียนรู้การป้องกันปัญหาดังกล่าวด้วยตัวเอง โดยได้รับการพัฒนา

ความรู้ และความสามารถ ตลอดถึงการมีการปรับเปลี่ยนทัศนคติที่มีต่อการใช้ความรุนแรง มีทักษะในการจัดการปัญหาที่เกิดขึ้นโดยการคิดพิจารณา ตัดสินใจ ด้วยความตั้งใจที่จะปฏิบัติในแนวทางที่เกิดขึ้นจากการได้เรียนรู้ และการส่งเสริมความสามารถในการดูแลตนเอง เมื่อเผชิญกับสถานการณ์ที่อาจจะนำไปสู่ความเครียด เรียนรู้ที่จะสร้างสัมพันธ์ภาพที่ดีต่อผู้อื่น และการมีความรับผิดชอบต่อสังคม มีการแสดงพฤติกรรมเหมาะสม ที่สามารถที่จะช่วยลดแนวโน้มในการใช้ความรุนแรงได้ อีกทั้งยังเป็นการปลูกฝังพื้นฐานของการเป็นผู้มีสุขภาพจิตที่ดี และมีความพร้อมในการพัฒนาการทางด้านจิตใจ อารมณ์ และสังคมเมื่อเข้าสู่วัยผู้ใหญ่ ต่อไป

เนื้อหาในคู่มือเล่มนี้เป็นเพียงส่วนหนึ่งที่จะช่วยให้ครูพ่อแม่ และผู้ปกครองได้ใช้เป็นแนวทางในการส่งเสริมการป้องกันการใช้ความรุนแรงของวัยรุ่น เป็นเสมือนแนวทาง ที่จะเพิ่มความเข้าใจในปัญหาดังกล่าว ได้อย่างเหมาะสม และมีประสิทธิภาพ แม้จะมีใช้เป็นที่ครูพ่อแม่ ผู้ปกครองควรรู้ ทั้งหมด หากแต่จะเป็นส่วนหนึ่งที่สำคัญ ที่มีคุณค่าแก่การเรียนรู้ และเลือกสรรนำไปใช้เพื่อเป็นประโยชน์ต่อไป

วิณีกาญจน์ คงสุวรรณ

คู่มือ

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แผน การสนับสนุน และให้ความรู้
เรื่อง การจัดการความรุนแรง ในวัยรุ่น



วิณีกาญจน์ คงสุวรรณ
นักศึกษาปริญญาเอก คณะพยาบาลศาสตร์
มหาวิทยาลัยสงขลานครินทร์

แผนการสนับสนุน และให้ความรู้ ที่ 1

หน่วยที่ 1 การจัดการกับอารมณ์และความเครียด กับการป้องกัน การใช้ความรุนแรง

กิจกรรมที่ 1 แผนที่แห่งตน (Self-Map)

จำนวน 50-60 นาที

สำหรับ นักเรียนมัธยมศึกษาปีที่ 1

สาระสำคัญของกิจกรรม คือ การเพิ่มความรู้สึगतงบวกเกี่ยวกับตนเอง การตระหนักในความแตกต่างของอารมณ์และความรู้สึกของบุคคลรอบข้าง เป็นการเพิ่มความเข้าใจในแนวทางในการจัดการอารมณ์ในทางลบ และการเพิ่มแนวทางเลือกเพื่อจัดการกับสถานการณ์ที่เป็นสาเหตุของการทำให้เกิดความเครียดที่อาจนำไปสู่การใช้ความรุนแรงได้

วัตถุประสงค์	เนื้อหา	กิจกรรมการสนับสนุน และให้ความรู้	อุปกรณ์ และ สื่อ	ภาระงาน	การ ประเมินผล
<p>1. เพื่อพิจารณาความรู้สึกลงในทางบวกของตนเอง</p> <p>2. เพื่ออธิบายความรู้สึกลงในทางบวกของตนเองในแต่ละองค์ประกอบในแผนภูมิ</p>	<p>-ทัศนคติ ต่อการใช้ความรุนแรง</p> <p>-ความรู้สึกลงในทางบวกคืออะไร?</p> <p>-คู่มือครูหน้า 11-14</p> <p>-คู่มือนักเรียน หน้า 7-10</p>	<ol style="list-style-type: none"> 1. ผู้สอนอธิบายรายละเอียดเกี่ยวกับความสำคัญของความรู้สึกลงในทางบวกเกี่ยวกับตนเองว่าความรู้สึกทางบวกคืออะไร? มีความสำคัญอย่างไร? และเมื่อเรามีความรู้สึกทางลบจะส่งผลกระทบต่อตัวเราเองอย่างไร? (10 นาที) 2. ผู้สอนแจกแผนภูมิการมองความเป็นตนเอง (Self-Map) และอธิบายวิธีการดำเนินกิจกรรม (5 นาที) 3. ผู้เรียนคิดวิเคราะห์ และประเมินตนเองในความสามารถที่มีอยู่ในทางบวกเพื่อที่จะเพิ่มความเข้าใจตนเอง และเขียนลงในแผนภูมิ (15 นาที) 4. ผู้สอนสุ่มผู้เรียน 4-5 คน โดยให้ผู้เรียนนำเสนอความรู้สึกทางบวกเกี่ยวกับตนเองในชั้นเรียน (15 นาที) 5. ผู้สอนจะส่งเสริมให้นักเรียนแลกเปลี่ยนประสบการณ์ที่เป็นแผนภูมิการมองความเป็นตนเอง (Self-Map) โดยให้ผู้เรียนจะได้ติดแผนภูมิการมองความเป็นตัวเองลงบนบอร์ด และใช้เวลา ที่ว่างเพื่อเรียนรู้ของเพื่อนแต่ละคน (5 นาที) 	<ol style="list-style-type: none"> 1. แผนที่แห่งตน 2. ใบสรุปเนื้อหา 3. คู่มือนักเรียน <p>กิจกรรมที่ 1</p>	<p>-แบบบันทึกแผนที่แห่งตน</p> <p>-แบบบันทึกประสบการณ์การเรียนรู้</p> <p>กิจกรรมที่ 1</p>	<p>-การนำเสนอผลงาน: แผนที่แห่งตน</p> <p>-การบันทึกประสบการณ์การเรียนรู้</p> <p>กิจกรรมที่ 1</p>

วัตถุประสงค์	เนื้อหา	กิจกรรมการสนับสนุน และให้ความรู้	อุปกรณ์ และ สื่อ	ภาระงาน	การ ประเมินผล
		6. ผู้สอนสรุปกิจกรรมเพื่อที่จะมุ่งเน้นให้เห็นว่าประโยชน์ในการมองตนเองในทางบวก และชี้ให้เห็นว่าบุคคลผู้ซึ่งไม่รู้สึกรักกับตนเองจะมีแนวโน้มที่จะแสดงพฤติกรรมที่ไม่ดีต่อผู้อื่นได้ (10 นาที)			

APPENDIX B

PROTECTION OF HUMAN SUBJECTS' RIGHTS

คำชี้แจงและการพิทักษ์สิทธิผู้เข้าร่วมวิจัย
(สำหรับ นักเรียน)

ดิฉัน นางวินีกาญจน์ คงสุวรรณ นักศึกษาปริญญาเอก สาขาการพยาบาล (นานาชาติ) คณะพยาบาลศาสตร์ มหาวิทยาลัยสงขลานครินทร์ กำลังทำการศึกษาวิทยานิพนธ์ เรื่อง ประสิทธิภาพของโปรแกรมการป้องกันความรุนแรง ต่อความรุนแรง ของวัยรุ่นไทยในโรงเรียนมัธยมศึกษา

การศึกษาครั้งนี้มีวัตถุประสงค์เพื่อ ศึกษาประสิทธิภาพของโปรแกรมการป้องกันความรุนแรง ต่อความรุนแรง ของวัยรุ่นไทยในโรงเรียนมัธยมศึกษา เพื่อเป็นการส่งเสริม และสนับสนุนโรงเรียนต่อการป้องกันการให้ความรุนแรงในนักเรียนวัยรุ่นในระดับมัธยมศึกษา ซึ่งประกอบด้วยผู้เข้าร่วมวิจัยจำนวน 45 คน โดยนักเรียนแต่ละคนจะพบครูเป็นเวลา 12 สัปดาห์ สัปดาห์ละ 1 ครั้ง ครั้งละ 40-50 นาที เพื่อร่วมกันสร้างเสริมแนวทางการดูแลตนเองของนักเรียน ในการป้องกันการให้ความรุนแรง ดิฉันจะขอความร่วมมือในการตอบแบบสอบถามการวิจัยคนละ 3 ครั้ง ได้แก่ ก่อนเข้าร่วมโปรแกรมการวิจัย ระหว่างการเข้าร่วมโปรแกรมการวิจัย และทันทีหลังจากเสร็จสิ้นการเข้าร่วมโปรแกรมการวิจัย ตามลำดับ โดยข้อมูลทั้งหมดจะถูกนำเสนอในภาพรวม

นักเรียนมีสิทธิ์ที่จะตอบรับหรือปฏิเสธการเข้าร่วมวิจัยครั้งนี้ได้ตามความสมัครใจ หากนักเรียนปฏิเสธการเข้าร่วมการวิจัยจะไม่ได้รับผลกระทบใดๆ จากทางโรงเรียน ทั้งนี้ ข้อมูลที่ได้จากนักเรียนจะเป็นประโยชน์อย่างยิ่งต่อการป้องกันการให้ความรุนแรงในนักเรียนวัยรุ่นของประเทศไทย และเพื่อเป็นการส่งเสริมสุขภาพจิตให้วัยรุ่นมีคุณภาพชีวิตที่ดีต่อไป

ขอขอบคุณในความร่วมมือ

(นาง วินีกาญจน์ คงสุวรรณ)

สำหรับนักเรียน

ข้าพเจ้าได้รับคำชี้แจงตามรายละเอียดข้างต้น มีความเข้าใจและยินดีเข้าร่วมการวิจัย

ลงชื่อ.....

วันที่.....เดือน.....พ.ศ.....

คำชี้แจงและการพิทักษ์สิทธิผู้เข้าร่วมวิจัย
(สำหรับ พ่อแม่/ผู้ปกครอง)

ดิฉัน นางวินีกาญจน์ คงสุวรรณ นักศึกษาปริญญาเอก สาขาการพยาบาล (นานาชาติ) คณะพยาบาลศาสตร์ มหาวิทยาลัยสงขลานครินทร์ กำลังทำการศึกษาวิทยานิพนธ์ เรื่อง ประสิทธิผลของโปรแกรมการป้องกันความรุนแรง ต่อความรุนแรง ของวัยรุ่นไทยใน โรงเรียนมัธยมศึกษา

การศึกษาครั้งนี้มีวัตถุประสงค์เพื่อ ศึกษาประสิทธิผลของโปรแกรมการป้องกันความรุนแรง ต่อความรุนแรง ของวัยรุ่นไทยในโรงเรียนมัธยมศึกษา เพื่อเป็นการส่งเสริม และสนับสนุนโรงเรียนต่อการป้องกันการให้ความรุนแรงในนักเรียนวัยรุ่นในระดับมัธยมศึกษา ซึ่งประกอบด้วยผู้เข้าร่วมวิจัยจำนวน 45 คน โดยนักเรียนแต่ละคนจะพบครูเป็นเวลา 12 สัปดาห์ สัปดาห์ละ 1 ครั้ง ครั้งละ 40-50 นาที เพื่อร่วมกันสร้างเสริมแนวทางการดูแลตนเองของนักเรียน เพื่อป้องกันการให้ความรุนแรง ดิฉันจะขอความร่วมมือในการตอบแบบสอบถามการวิจัยคนละ 3 ครั้ง ได้แก่ ก่อนเข้าร่วมโปรแกรมการวิจัย ระหว่างการเข้าร่วมโปรแกรมการวิจัย และทันทีหลังจากเสร็จสิ้นการเข้าร่วมโปรแกรมการวิจัย ตามลำดับ โดยข้อมูลทั้งหมดจะถูกนำเสนอในภาพรวม

ท่านมีสิทธิ์ที่จะตอบรับหรือปฏิเสธการเข้าร่วมวิจัยครั้งนี้ได้ตามความสมัครใจ หากท่านปฏิเสธการสนับสนุนนักเรียน ในการเข้าร่วมการวิจัยจะไม่ได้รับผลกระทบใดๆ จากทางโรงเรียน ทั้งนี้ ข้อมูลที่ได้จากท่าน และนักเรียน จะเป็นประโยชน์อย่างยิ่งต่อนักเรียนในช่วงวัยรุ่น เพื่อเป็นการป้องกันการให้ความรุนแรงที่อาจจะส่งผลกระทบต่อสังคมโดยรวม และเพื่อเป็นการส่งเสริมสุขภาพจิตให้วัยรุ่นมีคุณภาพชีวิตที่ดีต่อไป

ขอขอบคุณในความร่วมมือ

(นาง วินีกาญจน์ คงสุวรรณ)

สำหรับผู้ปกครอง

ข้าพเจ้าได้รับคำชี้แจงตามรายละเอียดข้างต้น มีความเข้าใจและยินดีเข้าร่วมการวิจัย

ลงชื่อ.....

วันที่.....เดือน.....พ.ศ.....

APPENDIX C
LIST OF EXPERTISES

รายนามผู้ทรงคุณวุฒิ ในการตรวจสอบเครื่องมือวิจัย

รูปแบบการป้องกันความรุนแรง ต่อความรุนแรง ของวัยรุ่นไทย ในโรงเรียนมัธยมศึกษา

1. ศาสตราจารย์เกียรติคุณ ดร.สมจิต หนูเจริญกุล
ภาควิชา พยาบาลศาสตร์ คณะแพทยศาสตร์ โรงพยาบาลรามาธิบดี มหาวิทยาลัยมหิดล
2. นายแพทย์สมัย ศิริทองถาวร
ผู้อำนวยการ สถาบันพัฒนาเด็กราชนครินทร์ กรมสุขภาพจิต กระทรวงสาธารณสุข
3. แพทย์หญิงกุสุมาวดี คำเกลี้ยง
จิตแพทย์เด็ก และวัยรุ่น สถาบันสุขภาพจิตเด็ก และวัยรุ่นราชนครินทร์
4. รองศาสตราจารย์ ดร. เมธินันท์ ภิัญญชน
ภาควิชา จิตวิทยา และการแนะแนว คณะศึกษาศาสตร์ มหาวิทยาลัยทักษิณ
5. ดร. กฤษณา วุฒิสินธุ์
วิทยาจารย์ วิทยาลัยการสาธารณสุขสิรินธร จังหวัดอุบลราชธานี
6. ผู้ช่วยศาสตราจารย์ วาสนา แฉล้มเขตร
ภาควิชา สุขภาพจิตและการพยาบาลจิตเวชศาสตร์ คณะพยาบาลศาสตร์ มหาวิทยาลัยมหิดล
7. นางสาวลักษณ์ ลังกาพันธ์
นักจิตวิทยา สถาบันพัฒนาการเด็กราชนครินทร์ กรมสุขภาพจิต กระทรวงสาธารณสุข

รายนามผู้ทรงคุณวุฒิ

ในการตรวจสอบ คู่มือ เรื่อง การจัดการความรุนแรง ของวัยรุ่นไทย ในโรงเรียนมัธยมศึกษา

1. นายแพทย์สมัย ศิริทองถาวร

ผู้อำนวยการ สถาบันพัฒนาเด็กธราชนครินทร์ กรมสุขภาพจิต กระทรวงสาธารณสุข

2. ดร. กฤษณา วุฒิสินธุ์

วิทยากร วิทยาลัยการสาธารณสุขสิรินธร จังหวัดอุบลราชธานี

3. นางสาวลักขณ์ ลังกาพันธ์

นักจิตวิทยา สถาบันพัฒนาการเด็กธราชนครินทร์ กรมสุขภาพจิต กระทรวงสาธารณสุข

4. นางสาวคุจเดือน ชินเจริญทรัพย์

นักจิตวิทยาคลินิก ภาควิชาจิตเวชศาสตร์ คณะแพทยศาสตร์

มหาวิทยาลัยสงขลานครินทร์

5. นางอนงค์วรรณ เมฆเจริญวัฒนา

อาจารย์ โรงเรียนตันหยงมัส จังหวัดนราธิวาส

6. นางสาวอาภรณ์ เม่งอำพัน

อาจารย์ โรงเรียนสงขลาวิทยาคม จังหวัดสงขลา

APPENDIX D
ACTIVITIES IN THE RESEARCH STUDY

VITAE

Name Mrs. Vineekarn Kongsuwan

Student ID 4858003

Educational Attainment

Degree	Name of Institution	Year of Graduation
Cert. Research Methods for Intervention Research	School of Nursing, University of California at San Francisco (UCSF), USA	2007
Cert. Instructional Strategies for Critical Thinking and Clinical Reasoning	School of Nursing, University of Illinois at Chicago (UIC), USA.	2003
M.A. (Counseling Psychology)	Chulalongkorn University, Thailand	1995
Cert. Nurse Specialist (Psychiatric Nursing)	Ministry of Public Health, Thailand	1993
B.N.S. (Nursing and Midwifery)	Songkhla Nursing College, Thailand	1992

Scholarship Awards during Enrollment

1. Predoctoral scholarship, the Commission of Higher Education, Ministry of Education, the Royal Government of Thailand.
2. The dissertation grant, the Faculty of Graduate School, Prince of Songkla University, Thailand.
3. The publication award, Faculty of Nursing, Prince of Songkla University, Thailand.

Work-Position and Address

Instructor, Department of Psychiatric Nursing, Faculty of Nursing, Prince of Songkla University, Hat-Yai, Songkhla, 90110, Thailand.

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List of Publication and Proceedings

Publications

Kongsuwan, V. (2002). The Arts of cognitive with the ways of nursing.

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Kongsuwan, V. (2002). The experience of physicians in village who are

being counselors from a command of a Her Majesty for counseling in community. *Journal of Public Health Thailand, 9*(4), 235-238.

Kongsuwan, V. (2004). The people in province of southern Thailand to

mental health crisis. *Journal of Southern College of Nursing and Publish Health Network (SC-Net), 1*(1), 22-25.

Kongsuwan, V. (2004). Critical thinking on unrest situation in southern border province of Thailand, *Journal of Public Health Thailand, 13(5)*, 31-34.

Kongsuwan, V., Kongsuwan, V. & Sisripan, S. (2009). Belief and self-care experience of postpartum cesarean section among Thai-muslim women. *12th Region Medical Journal, 20 (1.1)*, 91-101.

Proceedings

Kongsuwan, V., Suttharangsee, W., Isaramalai, S. (2006). *Violence: What is its concept and structure, East Asian Forum of Nursing Scholars (EAFONS)*. Poster presentation in the 9th East Asian Forum of Nursing Scholars, 30-31 March 2006, at the Convention Center, Chulabhorn Research Institute, Bangkok, Thailand.

Charoenwong, S., Kongsuwan, V., Tohkani, M. (2007). *Stress and psychological self-care behaviors of the people in the unrest area of Narathiwat province, Thailand*. Oral presentation in the 6th International Conference: Mental Health in the City (1-3 August), Bangkok, Thailand.

Kongsuwan, V., Suttharangsee, W., Isaramalai, S., & Kools, S. (2008). *Perspectives on violence: A Study in a southern province of Thailand*. Oral presentation in the 11th Congress of the ASEAN Federation for Psychiatry and Mental Health (AFPMH), August 26-29, 2008, Bangkok, Thailand.

Kongsuwan, V., Suttharangsee, W., Isaramalai, S., & Kools, S. (2008). *Perspectives of adolescents, peers, parents, and teachers on youth violence*. Oral presentation in the 10th World-Congress on Self-Care and Nursing: Reflecting the Past-Conquering the Future, 26-29 June, Vancouver BC., CANADA.