Corporal Punishment: Rhode Island Physicians' Perceptions, Experience and Education

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ABSTRACT

Corporal punishment (CP) is defined as inflicting pain to redirect an undesired behavior. The objective of the current study is to assess Rhode Island physicians' perceptions, experiences and education regarding CP. Our data may be used to inform future research and education/training for health care providers on how to provide guidance and have conversations surrounding CP. We developed an anonymous survey that assessed the perceptions, experiences and training of Hasbro Children Hospital physicians regarding CP in the medical setting. A total of 58 physicians responded; participants responded that CP was never effective for improving behavior (67.2%) and never recommended CP (98.2%) to patient families. However, most participants reported never received education on CP (67.9%). Our findings highlight that pediatric providers do not find CP an appropriate method of discipline and underscore the need for standardized training and education surrounding this issue.

KEYWORDS: corporal punishment; pediatric physicians; education; patient families; survey

INTRODUCTION

Corporal punishment (CP) is defined as inflicting pain to redirect an undesired behavior, and is still a widely practiced method of discipline in American households.[1,2] CP is defined as punishment in which physical force is used and intended to cause some degree of pain or discomfort. This can include hitting (i.e. smacking, slapping, spanking) children with the hand or with an implement (i.e. a whip, stick, belt, shoe, wooden spoon).[1] CP may also involve kicking, shaking, or throwing children; scratching, pinching, biting, pulling hair, or boxing ears; forcing children to stay in uncomfortable positions; and burning, scalding, or forced ingestion.[1]

Brookings found that 81% of parents believe that spanking is sometimes appropriate and two-thirds of parents have spanked their child.[3] Prior research has identified that CP is associated with negative sequela for children and adolescents[4]; this includes increased aggressiveness[5], heighted risk for physical abuse[5-7], reinforcement that violence or hitting is an appropriate solution to problems[5,6], and decreased learning capacity.[8] While CP that involves hitting, slapping, or pushing may change behavior in the short-term, CP has consequentially been correlated with a myriad of mental health issues for children in the long-term, such as mood disorders, anxiety, personality disorders, and substance use disorders.[6,8-10] In 2018, Rhode Island Kid's Count identified 9 cases of child abuse allegations related to CP, which decreased from 13 cases in 2016.[11]

The American Academy of Pediatrics (AAP) and the American Academy of Child and Adolescent Psychiatrics (AACAP) identify that CP should not be used with children as it is less effective and associated with negative outcomes in both childhood and adulthood.[1,2] A recent 2018 AAP policy statement acknowledges that pediatricians are in the position of providing guidance to parents on effective discipline, and discussing the harmful consequences of CP.[1] In addition, pediatricians should be cognizant of local resources to provide families, including parenting classes/groups and mental health professionals.

Caregivers rely on pediatricians for advice on a variety of parenting matters; a 2012 study involving 500 parents in Louisiana demonstrated that parents were more likely to follow the advice of pediatricians compared with other professionals, and nearly half (48%) indicated that they were most likely to consult their pediatricians for advice on corporal punishment.[12] Pediatricians and other health providers have the opportunity to be a source of advice for caregivers regarding appropriate discipline.[1] However, there is limited literature regarding physicians' education and training on speaking with families about discipline, and how to intervene when these behaviors are seen. Therefore, the objective of the current study is to assess Rhode Island pediatric physicians' perceptions, experiences and education regarding CP. Our data may be used to inform future research and education/training for health care providers on how to provide guidance and have conversations surrounding CP in our community's hospital settings.

METHODS

The Rhode Island Hospital Institutional Review Board approved all procedures. We developed an anonymous survey that assessed the perceptions, experiences and training

of Hasbro Children Hospital pediatric physicians regarding CP in the medical setting. Experienced child abuse pediatricians reviewed the survey for content.

Participation in the study was voluntary and anonymous. The survey was distributed in November 2017 via e-mail to the pediatric department, including chief residents, who were asked to send the survey to their staff members. Staff listed in the Hasbro Children's Hospital staff services and/or the department of pediatrics at Hasbro Children's Hospital were invited to participate. Several reminder e-mails were subsequently distributed at two-week intervals of time.

The survey captured demographic information (e.g. gender, level of training), personal histories (e.g. use of CP with their own children) and professional experiences (e.g. if they have witnessed CP in the hospital) with CP. Moreover, agreeability and likelihood scales were designed to evaluate participants' views on the importance of providing intervention and education regarding CP. Education and training of participants regarding CP was also assessed.

Research Electronic Data Capture (REDCap) software, a free, secure, Web-based application, was used to create and distribute the survey, and collect de-identified and aggregated data.

RESULTS

A total 58 pediatric physicians at Hasbro Children's Hospital completed the survey; their responses are reported in **Table 1**.

Table 1. RI Physician Responses to Corporal Punishment Survey

Demographics	Total n=58
Gender	
Male, n (%)	19 (32.8)
Female	39 (67.2)
Profession	
Physician	37 (63.8)
Resident	15 (25.9)
Fellow	6 (10.3)
Is CP effective?	
Never	39 (67.2)
Rarely	15 (25.9)
I don't know	2 (3.4)
Sometimes	2 (3.4)
Often	0
Did your parents use CP with you?	
Never	11 (19.3)
Rarely	27 (47.4)
I don't know	0
Sometimes	16 (28.1)
Often	3 (5.3)
Have you used CP with your kids?	
Never	26 (63.4)
Rarely	12 (29.3)
I don't know	0
Sometimes	3 (7.3)
Often	0
Should we educate parents about no CP?	
Strongly Agree	30 (51.7)
Agree	22 (37.9)
Neutral	5 (8.6)
Disagree	0
Strongly Disagree	1 (1.7)
Should we educate parents about other methods of discipline?	
Strongly Agree	40 (69)
Agree	14 (24.1)
Neutral	3 (5.2)
Disagree	0
Strongly Disagree	1 (1.7)

Demographics

The mean age was 42.7 years old, and the majority of participants were female (67.2%). Of the 58 physicians who completed the survey, 63.8% were attendings, 25.9% were residents and 10.3% were fellows. Of participant reported specialty, slightly less than half were general pediatrics (42.9%), followed by pediatric psychiatry (19.0%).

Personal Opinions of and Experiences with CP

When asked if CP is effective for improving behavior, the majority reported 'never' (67.2%) or 'rarely' (25.9%). Forty-one participants reported having children; the vast majority reported never or rarely using CP with their children (92.7%). Approximately one-third of participants (33.4%) reported 'sometimes' or 'often' experiencing CP as a child.

Professional Experiences with CP

Most participants (98.2%) never recommended CP to patient families for unruly children.

Using an agreeability scale (strongly disagree → strong agree), the majority reported agreeing/strongly agreeing that one should intervene when an adult is yelling/threatening a child (84.4%), or when an adult hits a child (98.3%). Moreover, participants mostly agreed/strongly agreed that it is important to educate adults about not using CP (89.6%), and educate about other methods of discipline (93.1%).

Using a likelihood scale (not at all → definitely), participants reported somewhat (43.1%) or definitely (41.4%) likely to intervene when an adult threatens a child, and definitely likely to intervene when an adult hits a child (84.5%). Furthermore, a little over half of participants (53.4%) reported being 'definitely' likely to educate parents about CP, and providing education about other methods of discipline (58.6%).

In the last 6 months, 22.4% of participants witnessed an adult hit/slap/spank a child while in the hospital or clinic setting; of these participants, slightly less than half reported never intervening (38.5%).

Education on CP

When asked if they have ever received education on intervening when an adult hits a child, most participants reported

never (67.9%). Moreover, the majority (73.7%) reported never receiving formal education (e.g. lectures, grand rounds) about how to talk to patient families about discipline or specifically CP (68.4%). More participants reported receiving informal education (e.g. bedside teaching) on how to talk to patient families about discipline (63.2%) and CP (42.1%).

DISCUSSION

Research has identified that corporal punishment is both ineffective and harmful to children and adolescents long-term.[5] Although CP use among U.S. parents has been declining during the 21st century, these behaviors still occur not only in the home, but also in hospital or clinic settings. Our study examined Rhode Island pediatric physicians of varying levels of training on their opinions, experiences and education regarding CP. The majority of participants do not agree CP is effective, and believe they should intervene and provide education to families when CP is identified. However, our findings revealed that many RI physicians have not received formal and/or informal education/training on how to intervene when disruptive behaviors are observed, and how to have discussions with families about CP.

Data from a recent 2016 survey found that US pediatricians do not endorse CP; only 6% of 787 pediatricians held positive attitudes toward spanking, and only 2.5% expected positive outcomes from spanking. Respondents did not believe that spanking was the "only way to get the child to behave" (78% disagreed) or that "spanking is a normal part of parenting" (75% disagreed).[13] Similarly, RI pediatric physicians responded that CP was never effective for improving behavior (67.2%) and do not personally use CP in their home environments (92.7%). Research suggests that African Americans, less formally educated parents, Southerners and born-again Christians are more likely to use or find CP acceptable.[14,15] To our knowledge, statistics specifically on gender differences do not exist, but it is possible that the majority of our respondents being female may have influenced perceptions of and experiences with CP.

The AAP recently released a policy statement (2018) firmly against the use of CP, and the call for pediatricians to provide guidance and resources to families.[1] Consistent with AAP guidelines, the overwhelming majority of our participants (98.2%) never recommended CP to patient families for unruly children. Participants also reported feeling that discussions surrounding CP and discipline were important, and that they were likely to have these conversations with patient families. Duncan et al. reviewed periodic surveys of members of the AAP and noted that between 2003 and 2012, pediatricians had increased their discussions of discipline with parents.[16] By 2012, more than half (51%) of the pediatricians surveyed responded that they discussed discipline in 75% to 100% of health supervision visits with parents of children ages 0 through 10 years.[16] Pediatricians and other health care providers have the opportunity to assess safe and appropriate discipline with families.

The new AAP policy statement now addresses the harm of verbal punishment (e.g. shaming, humiliation). Interestingly, our participants reported decreased likelihood and agreeability to intervene when an adult threatens a child in comparison to hitting a child. The UN Children's Fund defined "yelling and other harsh verbal discipline as psychologically aggressive towards children."[17] Research supports that verbal abuse is associated with increased adolescent depression and conduct problems.[18,19] Pediatricians should be aware of this policy update, and provide intervention and education for families regarding yelling and threatening behaviors.

Despite the majority of RI pediatric physicians reporting that intervening and educating families about CP is important, and are likely to do so, many have not received either formal or informal training on what to do when hitting behaviors are witnessed or how to talk about discipline/CP. Therefore, education regarding these issues should be integrated into formalized settings, such as grand rounds, lectures and training for all pediatric physicians and other healthcare providers. Moreover, informal education such as bedside teaching should also be utilized to practice and observe appropriate ways to have these important conversations with families. Education and training for pediatricians can include a variety of techniques, such as motivational interviewing. Moreover, Barkin et al demonstrated that it was possible to teach parents to use time-outs within the constraints of an office visit.[20] It is also important that pediatricians are aware of community resources for more intensive or targeted help to families (**Table 2**). Considering the close link between CP and physical abuse, physician training should also include education on physical abuse to provide prevention to patient families.

Table 2. Rhode Island Resources for Families Regarding Corporal Punishment

Rhode Island Parent Information Network (RIPIN)	(401) 270-0101, https://ripin.org/
Family Care and Community Partnership (FCCP)	(401) 519-2280, https://www.familyserviceri.org/fccp
Early Intervention	(401) 462-5274, http://www.eohhs.ri.gov/Consumer/FamilieswithChildren/EarlyIntervention.aspx
Nurse Family Partnership	https://www.nursefamilypartnership.org/
Incredible Years	(206) 285-7565, http://www.incredibleyears.com/
The Parent Support Network (PSN)	(401)-467-6855, http://www.psnri.org

LIMITATIONS

The current study had several limitations. Pediatric physicians who practice at Hasbro Children's Hospital in Rhode Island completed the survey, and thus, our results may not generalize to all pediatric physicians in our state or medical providers outside our institution and state. In addition, respondents were asked to identify if they have received education concerning CP, but we did not ask about the specifics of their training. As with any survey, an element of recall bias might have resulted from certain survey questions. Furthermore, to our knowledge there are no statistics about gender differences of parents who inflict CP, and therefore we could not examine whether this may have influenced the responses of our participants. Future studies should explore innovative ways of providing education and training to physicians on CP and discipline. Moreover, integrating more formalized policies and guidance around CP in RI hospital settings may decrease these disruptive and harmful behaviors, and provide pediatricians a platform to initiative these important conversations with families.

CONCLUSION

Our findings, in conjunction with prior studies, highlight that pediatric physicians do not find CP an appropriate method of discipline and underscore the need for standardized training and education surrounding this issue. Caregivers often seek information and hold their pediatricians in a position of trust, and pediatricians may even witness hitting/threatening in the hospital setting; however, discussions of discipline may prove challenging. The presented survey should be utilized to inform an education curriculum specifically for medical providers to subsequently aid in improving victim identification efforts, medical assessments and referrals, informing collaboration with a multidisciplinary team, and developing prevention strategies.

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