

UNDERSTANDING AND ENHANCING THE BELIEFS AND PRACTICES OF PARENT EDUCATORS AND  
THE USE OF CORPORAL PUNISHMENT BY CAREGIVERS

by

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## Author's Statement Page

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## ABSTRACT

# UNDERSTANDING AND ENHANCING THE BELIEFS AND PRACTICES OF PARENT EDUCATORS AND THE USE OF CORPORAL PUNISHMENT BY CAREGIVERS

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Despite evidence suggesting the ineffectiveness of caregivers' use of corporal punishment (CP), it is still a commonly accepted disciplinary practice. The advice of trusted providers is shown to influence parental attitudes of CP; however, research is limited regarding attitudes and discussion of CP with families from providers, such as home visitors and parent educators.

This research, conducted across two studies, aimed to assess and change CP attitudes, knowledge and practices among home visitor and parent educator providers. The first study collected survey data from Georgia providers, with the goal of filling current gaps in the CP scientific literature. A sample of 64 providers reported unfavorable attitudes on the Attitudes Toward Spanking (ATS) scale ( $M = 2.38, SD = .80$ ), and expected more negative outcomes ( $M = 2.92, SD = .86$ ) from the use of CP than positive outcomes ( $M = 2.2, SD = .81$ ) based on the Expected Outcomes of CP scale.

The second study examined effectiveness of a brief training intervention to equip providers with CP knowledge and skills that can be used in sessions and program delivery with caregivers. Workshop participants ( $N=42$ ) demonstrated significant differences from pre-survey (before the training) to post-survey (after the training) on the ATS scale ( $M_{pre} = 2.11, M_{post} =$

1.77,  $t_{35} = 2.77$ ,  $p < .01$ ) and positive ( $M_{pre} = 2.07$ ,  $M_{post} = 1.70$ ,  $t_{35} = 2.86$ ,  $p < .01$ ) and negative ( $M_{pre} = 2.80$ ,  $M_{post} = 3.60$ ,  $t_{35} = -4.71$ ,  $p < .001$ ) Expected Outcomes of CP scale. On the three-month follow-up survey, the negative expected outcomes score continued to be significantly different from the pre-survey score ( $M_{pre} = 2.89$ ,  $M_{3month} = 3.36$ ,  $t_{35} = -2.70$ ,  $p < .05$ ), but the ATS score and positive expected outcomes score were not significantly different from the pre-survey score. Qualitative analyses from interviews conducted with providers who participated in the workshop revealed that providers encountered barriers to discussing CP with families, the need for skill-oriented training, and the positive impact of the pilot training. These findings underscores the need for a disseminable workshop training that can better equip providers to discuss CP with families.

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## **Chapter I: Introduction and Statement of Purpose**

### **Corporal Punishment**

In 2018, the American Academy of Pediatrics, as well as Prevent Child Abuse America, took a firm stance against the use of physical discipline on children, calling for the abolition of corporal punishment in the United States (CP) (Sege, 2018). Currently, there are 16 states and 3 U.S. territories whose mandated reporter laws make exemptions for CP as long as it causes no bodily injury (Child Welfare Information Gateway, 2019). However, the evidence is clear that CP does in fact, physiologically harm children immediately and throughout their life courses, whether or not a specific level of bodily injury occurs (Gershoff et al., 2016). For instance, research has found that exposure to harsh CP reduced gray matter volume by 14-19% in the prefrontal cortex of a child's brain. When this area of the brain is altered, a child may struggle to regulate their own emotions and behaviors and to interpret the actions of others (Tomoda et al., 2009). Exposure to CP is also related to long-term behavioral outcomes, such as the intergenerational transmission of intimate partner and family violence, both as a victim and perpetrator (Schwartz et al., 2006; Gershoff, 2002).

Recent data suggest that the use of physical forms of discipline among American parents is on the decline (Child Trends, 2015). However, for parents that continue to use CP, it is usually due to expected benefits resulting from CP and perceived social norms. Research indicates that perceived norms and expected outcomes of CP use are strong predictors of parents' attitudes and use of CP (Taylor et al., 2017). CP can also be generational, with those who were physically disciplined as children are more likely as adults to endorse and use CP (MacKenzie et al., 2012). Nationally representative surveys show that on average 49% of parents spanked their child ages



0 to 9 years; however, in southern regions of the U.S., where CP is more socially acceptable, rates were as high as 86% (MacKenzie et al., 2012; Flynn, 1994; Finkelhor et al., 2019). Within the south, studies have identified three subgroups with higher reported usage of CP: families living in poverty, black caregivers, and conservative Protestants (Finkelhor et al., 2019).

Taylor and colleagues found that a strong predictor of parents' positive attitudes toward CP was their perception that the trusted providers they turn to for advice on child discipline, approved of CP (Taylor et al., 2017). Thus, family and child prevention and intervention service providers, such as home visitors and parent educators, are in a unique position to shift the knowledge and attitudes of parents. However, many professionals are trepid when approaching this topic, resulting in missed opportunities to prevent and reduce CP use among parents who may be most at-risk for engaging in this behavior (West et al., 2018).

### **Aims & Theory**

The overall goal of this research is to reduce caregiver's use of CP by equipping direct service providers with knowledge and skills to discuss discipline strategies with parents and caregivers. This study focused on home visitors and parent educators that deliver multi-session parent education programs to caregivers at home or in group settings, which hereafter will collectively be referred to as providers. There were two aims of this project, conducted across two research studies. The first study collected data from providers to fill existing gaps within the literature and to inform the adaptation of a training on CP. Data collected during this phase assessed current levels of resources, knowledge, attitudes, and behaviors of providers in regards to CP. Given providers' training in child development we expected that they already viewed CP unfavorably, but lacked CP specific resources and tools to use with caregivers and

feel uncomfortable discussing CP with caregivers. The information collected informed the adaption of an existing CP training, currently used among medical professionals.

The second study focused on the measurement of knowledge, attitude, and potential behavioral change among providers who participated in the adapted training entitled, "Dear Parent: Discussing Discipline." We hypothesized the training would increase providers' (1) knowledge of consequential outcomes related to CP, (2) unfavorable attitudes towards CP, and (3) confidence (self-efficacy) to initiate conversations on discipline. We also expected to see participants have more frequent and comfortable conversations about CP with caregivers after the training.

**Theory.** These aims are grounded in the social cognitive theory's constructs of outcome expectations, knowledge, and self-efficacy, which have previously been used in behavior change programs related to discipline and client education (Bandura, 2002; Lee Thompson, 2017). Multiple studies have shown the more knowledge a caregiver has on the potential adverse effects of CP, the less likely they are to endorse or use it (Holden et al., 1999; Durrant, 2003; Taylor et al., 2011; Taylor et al., 2017). Brief interventions targeting knowledge of consequential outcomes related to CP and its ineffectiveness have demonstrated the ability to change attitudes to become less favorable among parents and young adults (Holden et al., 2014; Reich et al., 2012; Robinson et al., 2005; Perrin et al., 2017). Caregivers who spank typically do so because they expect their children will become more obedient and mindful of their caregivers (Holden, 1999; Taylor et al., 2011). When a caregiver uses CP, and the child immediately stops the behavior or appears upset over the consequences of their behavior, this reinforces the desired outcomes of CP. Despite the immediate response to CP, a child's

behaviors have been shown to remain constant or worsen with continued CP. The coercion theory states that negative externalizing behaviors seen in children are more likely to occur when reinforced with harsh discipline such as CP, creating a cyclical effect (Scaramella & Leve, 2004; Patterson, 2016). In their early childhood coercion model, Scaramella and Leve (2004) further explain how reactionary parent-child interactions impede the development of social and emotional competence, which evokes harsher parenting and mutually reinforcing behaviors.

To use direct service providers as a mechanism to change the views or practices of caregivers, they must credibly articulate this sensitive information. Role-playing and scenario-based training are frequently used to increase the confidence of providers to effectively communicate difficult messages to clients, as will be done in the proposed intervention (Blake & Blake, 2019; West et al., 2018). By grounding this project in the social cognitive theory, we will build the providers' knowledge base and practice communication skills to increase their self-efficacy to have discussions around CP with families they serve.

**Public Health Significance.** Examining current practices extends the literature on CP and prevention/intervention services that can adequately address this ineffective disciplinary practice. Additionally, this work could identify many avenues of future research by doing the first review of providers' (e.g., home visitors and parent educators) attitudes and training practices regarding CP. This study has the potential to fill in identified gaps within the literature: (1) how current parenting prevention and intervention curricula directly address CP, (2) how program providers are trained to explicitly discuss this sensitive topic with caregivers, (3) providers' attitudes on CP, and (4) perceived barriers in addressing CP with caregivers.

It should not be assumed that since home visiting and parent education programs have been found to reduce and prevent child abuse (Avellar & Supplee, 2013), that these outcomes automatically translate to the reduction of CP. There is limited information on these types of programs' impact on the continued use of moderate CP by the caregiver. In addition to discussing alternative or positive discipline practices, it is imperative to directly address CP if we hope to motivate positive behavioral change and norms among caregivers. Scientific evidence must be used in tandem with trusted professionals to deliver an appropriate and culturally relevant message to caregivers. Evaluating this pilot training's impact on providers could lead to cost-effective ways to embed CP reduction methods within appropriate and pre-existing programs.

## Chapter II: Literature Review

### Violence Against Children

Decades of research have resulted in strong evidence, confirming the detrimental effects of CP (Gershoff et al., 2018). Commonly referred to as physical discipline, spanking, or a variety of other graphic descriptors such as whapping or belting, CP is defined as hitting a child using an open hand or object with the desire to modify a child's behavior (Strauss, 2000). Although discipline is a natural part of child-rearing, complexities deriving from cultural norms, personal experiences, and beliefs make it challenging to discuss, let alone address directly with programming (Holden, 1999; Bornstein, 2012; Gershoff et al., 2010). Given that children's earliest interactions with caretakers and loved ones set trajectories towards their future social and emotional competence, educational attainment, and financial stability, identifying best practices to address CP is warranted.

Experts, lawmakers, and society have gone to great lengths to address violence against children. However, there is an apparent contradiction when it comes to policies, practices, and attitudes that have allowed caregivers to use corporal punishment (CP) on their children. International entities such as the United Nations found that CP violates the Convention on the Rights of the Child in 2007 and nationally, the American Academy of Pediatrics and Prevent Child Abuse America called for the abolition of CP in 2018 (United Nations, 2007; Prevent Child Abuse America, 2018). Sweden was the first country to reconcile its unequivocal opposition to violence against children and the use of CP by prohibiting its use among caregivers, followed by numerous other countries (e.g., Finland, Norway, Austria, and Ukraine) (Durrant, Rose-Krasnor & Broberg, 2003). This collective mobilization has yet to be adopted within the United States, as

it has by 58 other nations. Furthermore, the U.S. is 1 in only three industrial countries to allow it within schools, although individual states have the autonomy to ban CP in their school systems. The 19 states that permit CP use in schools, which are clustered in the Southeast and extend into the Midwest, are also areas with higher rates of reported CP acceptance and use by caregivers (Gershoff & Font, 2016).

No U.S. state has prohibited caregivers from using CP as a disciplinary method. However, definitions and policies around physical abuse and CP vary by state. For instance, Virginia's Department of Social Services defines physical abuse as "any act which, regardless of intent, results in a non-accidental physical injury. Inflicted physical injury most often represents unreasonably severe CP. This may happen when the parent is frustrated or angry" (Commonwealth of Virginia Department of Social Services, 2019). This definition places CP on the continuum of violence against children and includes harsh CP as abuse. In contrast, Georgia's mandated reporter policies outline physical abuse as "physical injury or death inflicted upon a child by a caretaker thereof by other than accidental means; provided, however, that physical forms of discipline may be used as long as there is no physical injury to the child." While both policies categorize physical injury as abuse, Virginia's description negatively frames CP while Georgia's code affirms its practice. Many state laws do not mention physical discipline, others allow physical discipline as long as it doesn't result in bodily injury, and Idaho's code confirms "the right of the parent to use reasonable corporal punishment." South Carolina and Arkansas' state code permits transient marks such as mild to moderate bruising. Lastly, Oklahoma's code explicitly lists spanking, switching, or paddling are not to be considered abusive physical discipline (Child Welfare Information Gateway, 2019). While it is

illegal for an adult to strike another adult and even for foster parents to use CP, all state codes endorse CP by a parent, even if by omission (GA Division of Family and Children Services, 2015).

### **Corporal Punishment as a Disciplinary Practice**

**Scope of the Problem.** Over the past few decades, social norms have gradually changed to view CP less favorably, and rates of CP have declined. However, in 2014, 76% of U.S. men and 65% of women believed it was "sometimes necessary to discipline a child with a good, hard spanking," compared to 84% of men and 82% of women in 1986 (Child Trends Databook, 2015). A 2012 study found 80% of 11,000 parents survey in a nationally representative sample had at one time or another spanked their child, and 27% had within one-week of the survey (Gershoff, 2012). Using the 2014 National Survey of Children Exposed to Violence, Finkelhor and colleagues reported only 37% of parents use spanking, indicating a continued reduction in the use of CP. In terms of how CP is influenced by child age, 49% of parents reported CP use with children ages 0 to 9 as compared to 23% of parents with children ages 10 to 17. There are mixed findings when it comes to child gender; some studies reported no difference in the use of CP between girls and boys, while others found boys to be spanked more often (Berthelon et al.,2020; Holden 1999; Finkelhor et al., 2019).

Although the nationally representative data present a downward trend in the use of CP, it is essential to note that within families potentially at-risk for child abuse or neglect, the use of CP is considerably greater. Higher rates of spanking were found among 4-year-olds, Southern families (59% compared to 40% in the Northeast and West), and among Black families (59% compared to 46% in White and 48% in Hispanic families) (Finkelhor et al., 2019). Previous studies reported similar findings by demographic characteristics, but in regards to race

MacKenzie and colleagues (2012) went one step further to control for factors that inequitably impact Black families. When adjusting for poverty and maternal support and depression, they found race was no longer a predictor of spanking, signifying the associative role that the stress of poverty and maternal well-being has on CP (MacKenzie et al., 2012). Lastly, higher parental education and financial stability have been noted as protective factors, lowering the use of CP (Holden Study 2, 1999; Beauchaine et al., 2005; Berthelon et al., 2020; Finkelhor et al., 2019).

In addition to demographic characteristics, a variety of contextual factors are associated with CP. Closely linked aspects of parental stress, such as perceived child temperament and frequency and degree of misbehavior, are associated with CP. Escalation of misconduct, such as talking back, running, or not listening, increases the use of CP (Berthelon et al., 2020; Holden 1999). As previously stated, the coercion theory shows that harsh and negative reinforcement of a child's misbehaviors is likely to propagate those misbehaviors, creating a mutually reinforcing cycle (Patterson, 2016). This pattern extends beyond the parent-child dyad to other peer relationships. Research has shown children who are spanked prefer aggressive conflict resolution strategies with peers compared to those who are not spanked (Simons & Wurtele, 2010). These reactionary behaviors also transmit between generations. A caregiver's own experiences in childhood and expected outcomes associated with spanking, greatly influence their attitudes towards CP, and thus practices (Chung et al., 2009; Strauss et al., 2000). If an individual was spanked as a child, they are more likely to endorse CP and to associate spanking with more positive child behaviors. Furthermore, caregivers, especially under stress, often default to their innate responses, developed during their childhood as a result of harsh parent-child interactions (Schwartz et al., 2006). Another contextual factor shown to increase CP



endorsement is the teachings of some religious communities. Families who are conservative Protestants have higher rates of CP endorsement and use, resulting from differing interpretations of biblical passages such as "do not withhold discipline from a child; if you punish him with the rod, he will not die," *Proverbs 23:13* (Vieth, 2014). Given that approximately 65% of Americans identify themselves as Christians, the need to incorporate and appropriately address religious views when discussing discipline is vital (Pew Research Center, 2019).

**Expected Outcomes and Attitudes.** Not surprisingly, caregivers who spank believe there is an overall benefit to their child. Compared to caregivers who don't or infrequently spank, those who frequently (weekly) use spanking as a disciplinary action believe it will result in desirable short and long-term outcomes in the child and parent-child relationship. Perceived outcomes include an increase in parental respect, instant compliance with the parent's requests, an understanding between right from wrong, feeling of guilt over misbehaviors, and a decrease in future transgressions while increasing appropriate behaviors (Holden, 1999). In a small qualitative study, Southern Black mothers revealed commonly held beliefs regarding CP from their community. They felt it was "an expression of love not harm; it worked to promote child safety and respect; it worked when nothing else worked; and it was essential for teaching important long-term lessons relevant for being out in the world." Undoubtedly, their views are culturally crosscutting, considering the persistently high rates of CP use among parents in the U.S. Despite beliefs that CP improves child behaviors, a study done by Holden (1999) found parents who spank report the same or higher frequencies of misbehaviors by children (Holden, 1999). In a small observational study, Holden and colleagues (2014) additionally found that 73%

of children misbehaved again within 10 minutes of receiving a spanking (Holden, Williamson & Holland, 2014).

Further, decades of research have resulted in a substantial body of literature that consistently links moderate spanking with negative outcomes across study designs, populations, and settings (Gershoff, 2002; Gershoff & Grogan-Kaylor, 2016). For instance, a 2016 meta-analysis by Gershoff and Grogan-Kaylor examined rigorous studies' effect sizes to determine outcomes attributable to "moderate" spanking. Moderate spanking was defined as "the use of physical force with the intention of causing a child to experience pain but not injury for the purposes of correction or control of the child's behavior" but does not include any discipline that would "knowingly cause severe injury to the child" (Gershoff & Grogan-Kaylor, 2016). The meta-analysis found 13 significant childhood outcomes linked to spanking, out of 17 reviewed. Significant consequences included aggression, antisocial behavior, poor parent-child relationship, impaired cognitive ability (lowering verbal skills and receptive vocabulary), decreased self-esteem, and physical abuse from parents (Berthelon et al., 2009; MacKenzie et al., 2012; Gershoff & Grogan-Kaylor, 2016). The largest effect size was the increased risk for physical abuse, which displayed a dose-response relationship. Negative consequences seen in adulthood included antisocial behavior, mental health issues, lower cognitive performance, and positive attitudes towards spanking. This is the most recent and rigorous meta-analysis with a mean effect size of  $d = .33$  (95% CI [.29, .38]) determined from 160,927 unique children included (Gershoff & Grogan-Kaylor, 2016).

Although this study focused on moderate spanking, it is important to note that moderate spanking has been shown to predict harsher forms of punishment and to have similar

outcomes as abuse (Straus, 2001; Fréchette et al., 2015; Gershoff & Grogan-Kaylor, 2016; Afifi et al., 2017). In a longitudinal study by Landsford and colleagues (2012), mild to moderate spanking in one year was found to be a risk factor for harsh spanking in the following year. As noted above, Gershoff and Grogan-Kaylor (2016) found moderate spanking and physical abuse to be associated with detrimental outcomes in similar ways; the mean magnitude effect of moderate spanking is 65% that of physical abuse when it comes to detrimental childhood outcomes. Adverse childhood experiences (ACEs), like child physical abuse, are related to poor health and well-being outcomes throughout life (Felitti et al., 1998). Additionally, adults who were spanked as children have increased odds of suicide attempts, moderate to heavy drinking and substance abuse, and to be a victim of as well as the perpetrator of domestic violence (Afifi et al., 2017; Schwartz et al., 2006).

Stress hormones, such as cortisol, act as an intermediary mechanism between childhood spanking and poor health outcomes by biologically altering the way a child's brain develops. Bugental and colleagues (2003) compared maternal use of moderate CP and toddlers' hormonal reactivity to stress. Opposed to toddlers who weren't spanked, they found those who were spanked exhibited higher levels of cortisol in reaction to stressful situations (e.g., when a parent leaves their child for a short duration with someone unknown to the toddler) (Bugental et al., 2003; Bugental et al., 2010). Moreover, the biological impact of harsh spanking, denoted by lasting marks on the child, has been associated with a 14-19% reduction of gray matter volume in the prefrontal cortex of a child's brain (Tomoda et al., 2009). This evidence establishes the link between CP and biological effects that explains the consequences experienced more commonly by those who are spanked. Given the collective evidence regarding CP, it should be

considered an ACE and prevented along with other forms of violence against children (Afifi et al., 2017).

### **Interventions to Reduce Corporal Punishment**

**Brief CP Educational Interventions Targeting Parents.** Although decades of research have produced consistent evidence demonstrating CP as ineffective and potentially harmful, there is decidedly less research on interventions to address the attitudes towards or practices of CP. Considering individual attitudes have been cited as the strongest predictor of disciplinary practices, this is a frequent target for CP interventions (Holden et al., 2014; Chung et al., 2009). Research examining attitudes towards spanking suggests that introducing new empirical information on spanking's ineffectiveness or consequential outcomes can shift attitudes (Holden et al., 2014; Reich et al., 2012; Robinson et al., 2005; Perrin et al., 2017).

A variety of brief educational interventions have provided participants with CP information to review and then summarize critical points on the ineffectiveness and potential harms resulting from this type of discipline. Robinson and colleagues (2005) asked college students working toward their Masters in Education to synthesize research related to CP and include their thoughts on whether CP seemed to be useful or ineffective in an assigned paper. It was also noted that participants were all current teachers. Students randomized into the control group received a standard writing assignment not related to child discipline. A significant but modest decrease was found in CP endorsement among the intervention students compared to the control group students (Cohen's  $d = .43$ ). Comparable effects were found by Holden and colleagues (2014) implementing an educational intervention among non-parents and parents. Non-parent participants were recruited from a college student listserv and

randomly assigned to take an active or passive online learning module. Both conditions reviewed the same research articles that presented 12 problems associated with CP. Throughout the online module, the active group ( $n = 53$ ) had to indicate how closely CP was associated with negative outcomes. In contrast, the passive group ( $n=65$ ) was asked to review the articles with no engagement. Although there was a significant decrease in favorable attitudes toward CP from pre to post-test in the active group ( $d= .40$ ), there was no significant difference between the conditions given the similarities of assignments between groups. The study was repeated with parents of 2 to 8-year-old recruited from a college alumni listserv and Amazon's Mechanical Turk website. This time, the researchers had the randomized control group ( $n=257$ ) read research findings on the effects of daycare instead of the same materials as the intervention group ( $n=263$ ). Results indicated a significant decline in attitudes toward CP from pre to post-test in the intervention group ( $d= .40$ ) that was not observed in the control group.

Among conservative Christian college students ( $n=121$ ), Perrin and colleagues (2017) demonstrated that adding a religious component that provided a progressive interpretation of biblical passages was more effective than presenting empirical information alone. They examined attitudes towards spanking four weeks before and right after a brief educational intervention. The intervention included group sessions lasting about 40 minutes, where participants read provided materials, were able to ask additional questions to a facilitator, and were asked to give oral summaries. The students were randomly split into three research groups where they were presented with only one of the following: 1) empirical material on the ineffectiveness and negative outcomes related to CP, 2) the empirical materials and progressive

views on biblical passages about discipline, or 3) a summary on the benefits of daycare as a control condition. While the control group showed no difference in attitudes, both intervention groups showed a significant decrease in favorable attitudes. The most considerable change in attitudes was found in the group that reviewed both empirical materials and progressive religious narrative ( $M_{pre} = 41.23$ ;  $M_{post} = 33.29$ ), demonstrating the need to include contextually relevant materials when addressing attitudes towards CP.

Reich and colleagues used baby books, in a randomized design, to embed discouraging information about CP. New mothers were recruited during their third trimester in an urban area obstetric office. Those who consented were asked to complete a baseline questionnaire and then given six baby books that corresponded with the six well-child visits recommended for the first year life ( $n = 167$ ). Data were collected at 7 points in time, beginning in the participant's third trimester up until the infant was 18-months old. The intervention group, whose baby books discussed child development and CP, had less favorable attitudes towards CP compared to mothers in the control group, who received baby books that only discussed child development ( $d = .67$ ). They also found effects were strongest among Black mothers and mothers with lower education levels, although the books were not ethnically nor culturally specific (Reich et al., 2012).

Another approach that has been tested is a video-based 20-minute program called *Play Nicely*. This randomized study targeted attitudes of CP among parents ( $n = 96$ ) recruited from a preschool and pediatric clinic. Post-intervention results suggested a significant decrease in favorable attitudes of CP in the intervention group compared to the control group, who were

shown a video on child development ( $d = .44$ ). However, the effect had diminished at the four-month follow-up assessment ( $d = .27$ ) (Scholer et al., 2010).

Lastly, Holland and Holden (2014) piloted a one-time motivational psycho-education session that included 43 mothers with children aged 3 to 5, who were randomly assigned to receive the intervention or waitlist. The mothers, who were recruited from childcare centers, were assessed for attitudes toward CP at baseline, post-intervention, and 1-month follow-up. The sessions, averaging 64-minutes, focused on CP and consisted of engaging, educating, and evoking techniques. Results showed a considerably larger effect size compared to other studies ( $d = .97$ ) in the one-month follow-up between treatment and control groups. However, there was no significant difference between groups in reported use of CP at the one-month follow-up assessment. This could indicate that additional behavioral support is needed by the mothers to produce actual changes in CP use, or that their use of CP at the baseline was moderate to low. Overall, the research summarizing brief educational interventions for young adults and parents has indicated small to moderate favorable effects seen immediately after the intervention and for limited follow-up durations.

**Using Providers to Influence Parent Attitude or Behavior.** Using research-based educational materials has not been enough to broadly change discipline practices within the U.S. Outside of a parent's own childhood experiences, a parent's endorsement of CP is highest when they perceive that a trusted provider approves of CP. (Taylor et al., 2011). Within the South, nearly half of surveyed caregivers said they primarily looked to pediatricians for advice on child discipline; other trusted professionals included psychologists, religious leaders, and parent educators (Taylor et al., 2011). About 75% of U.S. pediatricians from a national survey

viewed CP unfavorably and considered it harmful (Taylor et al., 2018). Another study examining CP attitudes of randomly surveyed members of the American Psychological Association found that 83% viewed CP negatively (Miller-Perrin & Rush, 2018). Moreover, brief interventions directed at clinical providers' abilities to prevent violence and CP have shown promise to influence a parent's attitudes and reduce the use of CP (Dynes et al., 2020; Gershoff et al., 2018; Knox et al., 2011).

As a trusted source of parenting advice, these home visiting and parent education providers have demonstrated success in changing parenting behaviors, particularly among vulnerable families, across many implementation variations (Kirkpatrick et al., 2007; Self-Brown et al., 2014; Lahti et al., 2019). In 2017, over 300,000 families received more than 3.5 million home visits from an evidence-based program (National Home Visiting Resource Center, 2018). Evidence-based programs have met empirical standards of evidence as determined by the Home Visiting Evidence of Effectiveness Program and the California Evidence-Based Clearinghouse (California Evidence-Based Clearinghouse, 2020). These credentialing bodies also designate more home visiting and parent education programs as emerging/promising, which are evidence-informed but have yet to meet all the standards to become evidence-based. Home visiting and parent education programs generally cover parent-child interactions, educational exploration of the child, health, and safety modules that are meant to prevent and reduce child abuse and neglect while promoting well-being.

These programs are nationally recognized interventions used to prevent and reduce child abuse and neglect, but few related studies specifically report any change in outcome regarding CP. In one study, researchers explored the home visiting program Incredible Years'



ability to reduce parental spanking. The program's focus on lowering behavioral issues in children resulted in a decrease in harsh parenting, with an effect size  $d = .64$  ( $p < .001$ ) one year after the program ended (Beauchaine et al., 2005). Broader educational programs (e.g., Head Start, domestic violence prevention programs) directed at parents have shown modest but promising results to reduce CP through their use of parent educators (Nicholson et al., 2000; Gershoff et al., 2016; Grogan-Kaylor et al., 2019). More research is warranted to better understand how home visiting and parent education programs can decrease the use of moderate CP (Chaffin et al., 2012; Matone et al., 2018).

To effectively relay concepts that may conflict with the parents' beliefs, providers require additional training and skills that go beyond just knowledge of CP. Evidence suggests that providers have difficulty discussing and desire training to address sensitive issues their families are experiencing, such as substance abuse, mental health, domestic violence, and poor parenting (Michalopoulos et al., 2015; Monteiro, 2016; Gill et al., 2007). Strong communication skills are necessary to build trust and motivate behavior change with families (Frankel, 2001). A cluster-randomized trial demonstrated short-term success in-home visitors' attitudes, confidence, and observed skills for communication. During the post-training assessment, home visitors showed more favorable attitudes towards discussing parenting risks but not in addressing parenting behaviors with parents, relative to the control group (West et al., 2018). The intervention covered "communication skills for difficult conversations with families" and "promoting positive parenting," along with other subjects but did not explicitly mention anything related to CP.

## **Purpose of Current Study**

Despite the wealth of empirical evidence against the use of CP by caregivers, it is still a commonly used and accepted disciplinary practice (Finkelhor et al., 2019). The advice of trusted providers is shown to influence parental attitudes of CP, a critical factor in changing behavior (Taylor et al., 2011). However, there is limited research regarding attitudes towards CP from providers such as home visitors and parent educators. Taylor and colleagues (2017) surveyed the full membership list of the American Professional Society on the Abuse of Children (APSAC), which is comprised of professionals working in the field of child welfare and well-being. Most respondents were counselors or physicians, but only about 13% of respondents were child welfare workers, which was not filtered down further to determine how many respondents were home visitors or parent educators. Over 75% of surveyed APSAC members viewed CP unfavorably, however, they perceived that their colleagues had a slightly more favorable view. Additionally, 76% felt prepared to advise parents on discipline strategies but only 25% believed others in their field were very or extremely well-trained to provide such advice. This is an interesting discrepancy that perhaps speaks to internalized beliefs versus observed behaviors. The majority of current studies exploring the attitudes and beliefs of professionals working with families focus on pediatricians and psychologists (Taylor et al., 2018; Miller-Perrin et al., 2018). Moreover, there is little collectively reported on home visitor's and parent educators' approach to addressing CP with families, although providers have expressed a need to receive further training to discuss sensitive subjects such as CP (West et al., 2018). Furthermore, home visitors and parent educators typically serve families who are more likely to use CP, and therefore,

understanding their beliefs and practices is essential for advancing efforts to reduce the use of CP.

This study had two objectives, the first of which was to fill in knowledge gaps by assessing home visitors' and parent educators' (1) knowledge, (2) attitudes, (3) behaviors and practices, and (4) training/resources available to them in regards to CP. The first objective was met by analyzing data collected from providers through an online questionnaire. Given the abundance of evidence against CP, we expected that participants already viewed CP unfavorably and were reasonably knowledgeable on outcomes related to CP, but lacked CP specific resources and tools for use with caregivers, and feel uncomfortable discussing CP with caregivers.

Secondly, we sought to evaluate the efficacy of a pilot training entitled, "Dear Parent: Discussing Discipline," to increase (1) knowledge of consequential outcomes related to CP, (2) unfavorable attitudes towards CP, and (3) the confidence (self-efficacy) to initiate conversations on discipline with parents. We expected participants to have greater confidence to initiate discussions as well as have more frequent conversations about CP with caregivers than at baseline. Ultimately, we hope the results of this study will be used to advance provider practices and for the development of further skill-based training needed to reduce the use of CP.

## Chapter III: Methods

### Study One

In the first component of this research, study one, self-reported data were collected from home visitors and parent educators through an online survey that assessed (1) knowledge, (2) attitudes, (3) behaviors, and (4) training/resources available to them with regards to CP. Participants were invited to participate in the ten minute survey by email using two identified state-level professional networks' email distribution platforms. The distribution lists encompass the majority of home visitors and parent educators across the state, approximately 370 individual providers. Since the online survey asked about sensitive topics such as beliefs on spanking, the survey did not require respondents to answer each question as required responses are shown to increase dropout rates. As a result, response rates varied by question (Décieux et al., 2015). Respondents did not receive an incentive for completing the survey. The procedures were approved by Georgia State University's Institutional Review Board.

**Participants.** This study focused on home visitors and parent educators included within Georgia's Home Visiting Institute, housed at the Department of Public Health, and the Georgia Family Support Network, which is part of the Prevention and Community Support Section of the Division of Family and Children Services. Specific participant (N=64) characteristics can be seen in Table 2. In 2018, over 1,400 families were served by one of Georgia's evidence-based home visiting programs and another 750 by evidence-informed programs. While there is no standard educational degree requirement to become a provider, each program entails specific training protocols to become certified in that model. Among families served by these programs, over 70% were living below the federal poverty line, 53% were unemployed, and 38% had no high

school diploma or GED, all of which are associated with higher rates of CP use. English (71%) and Spanish (21%) were the predominant languages spoken by families, and the majority of the families were Black (52%) or White (40%) (Georgia Department of Public Health, 2019).

## **Measures**

The online survey asked respondents to answer a series of questions about their attitudes and knowledge of spanking and their professional experiences with spanking. For the purposes of this study, we defined spanking as "hitting a child with a hand or an object with the intention of causing pain, but not injury, for the purposes of correction or control of the child's behavior," in accordance with similar surveys that assessed medical providers' attitudes toward spanking (Taylor et al., 2018; Miller-Perrin & Rush, 2018). This definition was stated in the survey as a header for relevant sections.

As seen in Table 1, the online questionnaire was divided into five sections: (1) demographic information, (2) assessment of current resources, (3) attitudes toward spanking, (4) expected outcomes of CP, and (5) perceived ability and behaviors in addressing CP with families.

**Demographics.** To gather demographic information, we asked for the respondent's ethnicity, sex, age, education level, current professional role, length of experience in the field, and which region of the United States they most closely identify.

**Assessment of Current Resources.** This section included questions to collect information on any training or materials that providers have access to for themselves or use with their clients about CP.

**Attitude Toward Spanking.** This outcome was measured using the abridged, 4-question, Attitudes Toward Spanking (ATS) scale, which is commonly used within the literature and has reported reliability scores ranging between  $\alpha = 0.79$  and  $0.81$  (Holden, Miller, & Harris, 1999; Taylor et al., 2011; Taylor, Fleckman, & Lee, 2017). The scale includes the following questions: "Spanking is a normal part of parenting," "Sometimes the only way to get a child to behave is with a spank," "When all is said and done, spanking is harmful," and "Overall, spanking is a bad disciplinary technique." Responses were collected on a 5-point Likert scale (1 being *strongly disagree*, up to 5 which was *strongly agree*), and two questions were reverse coded. Higher overall scores represent more positive attitudes towards spanking.

**Expected Outcomes of Corporal Punishment.** This outcome was measured by using the positive and negative subscales of the Outcomes of CP scale (Holden, 1999; Durrant et al., 2003; Taylor et al., 2018). The positive and negative subscales measure the degree to which an individual expects negative outcomes to be associated with the use of CP and how much an individual expects positive outcomes are related to CP. Questions are scored on a 5-point Likert scale (1= never to 5= always). This section of questions begins with "How often do you think that spanking a child leads to..." followed by eight positive outcomes and six adverse outcomes. The eight positive outcomes included in the scale are (1) having better behavior in the short term, (2) having better behavior in the long term, (3) being more respectful of parents, (4) learning correct behavior, (5) having a better relationship with the parent, (6) having a decreased chance of delinquency, (7) having a decreased chance of incarceration, and (8) having a better sense of self-control. The six adverse outcomes included are (1) being physically injured, (2) being more aggressive, (3) being physically abused, (4) having poorer cognitive

abilities, (5) having poorer mental health, and (6) having poorer physical health. The positive and negative outcomes are averaged across each subscales, final scores range from one to five. Scores closer to five indicates the respondent thinks that positive or negative outcome is more likely to occur as a result of using CP and for scores closer to 1, less likely to occur.

**Perceived Ability to Discuss CP and Behavior:** To measure this outcome, respondents were asked if they had effective strategies to address CP and if providers had an obligation to intervene when they knew CP was occurring. To assess their behaviors, respondents were asked how often within the past 6-months they had seen or were aware that families they work with were using CP. If they had any knowledge of CP occurring, they were then asked if and how they intervened.

## **Study Two**

Study two adapted and assessed the effectiveness of a pilot training to increase providers' (1) knowledge of consequential outcomes related to CP, (2) unfavorable attitudes towards CP, and (3) self-efficacy to discuss discipline with parents. Participants were invited to partake in the training through the same email distribution channels as in study one with the stipulation they must agree to attend the full four-hour training over the course of two days. The pilot training was evaluated through online pre-, post-, and three-month follow-up surveys, linked by participant through a sequencing code entered by the individual. Additional data were collected through semi-structured qualitative interviews with participants following the training.

Participants did not receive any incentive for attending the training but were compensated \$10 for completing the three-month follow-up survey and \$15 for participating in

the qualitative interviews. The procedures were approved by Georgia State University's Institutional Review Board.

**Intervention Adaptation and Implementation.** The training curriculum is based on the "No Hit Zone" training and presentations initially developed by the Up Institute, with input from a diverse team of experts and partners including Stacie LeBlanc, J.D., the Up Institute, Prevent Child Abuse Georgia, Children's Healthcare of Atlanta, and the National SafeCare Training and Research Center (Gershoff et al., 2018). The survey results from study one were used to inform the adaptation of the training materials by examining the gaps in current resources and practices. New training discussion scenarios and resources were also developed based on the responses collected in study one. The pilot training covered consequences of CP, social norms, alternative discipline methods, effective communication skills, role-play scenarios, and also provided attendees with a variety of resources. Additional logistic adaptations were made to deliver this training virtually given the need to limit physical contact during the COVID-19 pandemic. To avoid "zoom fatigue", the training was broken-up over two days, consisting of two hour sessions each day and a small reflective exercise participants did in-between days. Each training class size was also capped at 30 people to maintain active engagement and allow for meaningful feedback to participants. Two complete virtual sessions were facilitated by Prevent Child Abuse Georgia and the Up Institute.

**Participants.** Study two included home visitors and parent educators who deliver multi-session parent education programs to caregivers at home or in group settings in Georgia. There were 21 individuals who attended the first session and 30 attended the second for a total of 51 training participants. Specific participant characteristics can be seen in Table 5.



## Measures

**Quantitative.** The surveys included the same measures used in study one with some modifications, see Table 1, and again allowed participants to skip questions. The pre-training survey collected the same information obtained in study one. The post-training survey included the ATS scale, Outcomes of CP Scale, questions to evaluate training satisfaction and usefulness, and their perceived ability, willingness, and plan to discuss CP with families. The three-month follow-up survey replicated the post-training survey with additional questions to gauge change in behavior.

**Qualitative.** During the virtual training and in follow-up emails, attendees were asked to volunteer for a semi-structured interview, occurring within one month after the training. Seven participants volunteered during the training and the research coordinator reached out to other selected participants who did not express as much enthusiasm during the training to ensure different perspectives were represented. Sampling decisions made during the data collection process have been previously used in qualitative research to increase the variation in the sample (Roy et al., 2015). Volunteers were accepted until 20% of the sample had volunteered, for a total of 10 participants. A research coordinator conducted the interviews to assess participant satisfaction with the pilot training and further explore their views on CP and intentions to discuss CP with caregivers. Questions included: (1) Prior to the training, what did you generally include when discussing discipline with families? (2) Among families you work with, what are some of the attitudes and practices in regards to CP? (3) Can you discuss any barriers you had in discussing CP with families and if the training addressed any of those? (4) In what ways did participating in the training increase your knowledge or ability to discuss CP with

families if at all? (5) What aspects of the training did you find the most valuable or what parts would you change? (6) Did you share any of what you have learned or the resources provided with colleagues or have you changed any organizational practices due to the training? Using a semi-structured interview format, the interviewer asked additional questions where appropriate to collect more in-depth information. The ten semi-structured interviews took place over zoom and were transcribed automatically then reviewed by the lead research coordinator in comparison to the audio recording to ensure accuracy. Each interview lasted between 15 to 30 minutes and individuals were compensated \$15 for their participation in the interview.

### **Data Analysis**

Quantitative data were analyzed using SPSS software (version 27). Study one's findings predominantly included descriptive statistics that summarized participant responses. One-way ANOVAs and independent t-tests were used to determine any significant relationship between demographic variables and scored scale measures.

In study two, one-way ANOVAs and independent t-tests were used to determine any significant relationship between demographic variables and scored scale measures collected in the pre-survey. The mean difference between times was calculated using paired sample t-tests for the primary outcomes of interest, the ATS scale and outcomes of CP subscales. Changes in behavior were reported descriptively. A significant ( $\alpha=.05$ ) effect of the intervention group was used to determine any differential change for the adapted training program.

Qualitative data were examined through a deductive thematic analysis using Nvivo software (version 12) (Lofland et al., 2004). Three research coordinators independently read

and coded each transcript then came together to assemble one master set of codes that represented questions asked during the interview and other themes that arose. Researchers then separately applied the master codes to each transcript, meeting weekly to discuss any discrepancies that could be addressed until the team reached over 80% agreement on coding (McHugh, 2012).

**Table 1**

*Summary of Study 1 and 2 Data Collection Plan*

<b>WHO</b>	<b>All Georgia Home Visiting/ Parent Educator Network</b>	<b>Participants of Training</b>			
<b>WHAT</b>	<b>Preliminary Survey-</b> guide material development	Pre-Training Survey	Post-Training Survey	3-Month Post-Training follow up survey	Phone Interview
<b>HOW</b>	<b>Emailed Blast</b> Qualtrics Survey	Online Qualtrics- linked through sequencing code			Record & Transcribe
<b>Data</b>	1. Demographics 2. Any current curriculum used to discuss discipline 3. <b>Scale:</b> Attitudes Toward Spanking 4. <b>Scale:</b> Outcomes of CP 5. <b>Perceived Ability &amp; Behavior:</b> If/how they address it	1. Demographics 2. Any current curriculum used to discuss discipline 3. <b>Scale:</b> Attitudes Toward Spanking 4. <b>Scale:</b> Outcomes of CP 5. <b>Perceived Ability &amp; Behavior:</b> If/how they address it	1. <b>Scale:</b> Attitudes Toward Spanking 2. <b>Scale:</b> Outcomes of CP 3. Questions specific to training & change in self-efficacy to discuss discipline	1. <b>Scale:</b> Attitudes Toward Spanking 2. <b>Scale:</b> Outcomes of CP 3. Questions specific to <b>training</b> & change in self-efficacy to discuss discipline 4. <b>Perceived Ability &amp; Behavior:</b> Any use of skills from training	1. Demographics 2. Thoughts toward training (learning style/ length/messages) 3. Resources provided 4. <b>Perceived Ability &amp; Behavior:</b> How they plan or have used it with families

## Chapter IV: Results

### Study One

**Demographics.** Demographic characteristics from study one's sample are shown in Table 2. There were 64 home visitors and parent educators from Georgia, with an average of 14.7-years of experience ( $SD = 9.25$ ), who responded to the survey. All respondents were

female and nearly 80% regionally identified with the Southeast. The majority of respondents were either Black (43.8%) or White (43.8%) followed by Hispanic (9.4%). Lastly, 64% were over 40-years-old and about 72% had at least a bachelor's degree.

**Table 2**

*Demographic Characteristics of Study One's Survey, N=64*

<b>Characteristics</b>	<b>n</b>	<b>%</b>	
<b>Gender</b>			
Female	64	100	
<b>Race</b>			
White	28	43.8	
Black	28	43.8	
Hispanic	6	9.4	
Asian	1	1.6	
Other	1	1.6	
<b>Age in Years</b>			
20 to 40	23	36.0	
41 to 65	41	64.0	
<b>Region of US<sup>a</sup></b>			
Southeast	51	79.7	
Southwest	6	9.4	
Midwestern	1	1.6	
Northwest	2	3.1	
Northeast	4	6.3	
<b>Education Level</b>			
High School/GED	2	3.1	
Some College	19	25	
Bachelor's Degree	29	50	
Graduate Degree	14	21.9	
	<b>Mean</b>	<b>SD</b>	<b>Range</b>
<b>Years of Experience</b>	14.7	9.3	<1 – 45 years

<sup>a</sup> Represents the region of the US that the respondent most closely identifies with, all respondents resided in Georgia during the completion of the survey.

**Assessment of Current Resources.** About 80% of respondents reported that they strongly or somewhat agreed the parent education curriculum they use provided adequate materials/resources on spanking and 87% strongly or somewhat agreed feeling comfortable

discussing spanking with families. Furthermore, 61% reported the curriculum they use in family intervention delivery described alternatives to CP and also described the negative outcomes associated to spanking. Only 32% of respondents reported the parent education curriculum they use addressed religious or cultural norms regarding spanking. Moreover, only 28% reported that their agency had a written policy against the use of CP.

**Attitudes and Expected Outcomes of CP.** Surveyed providers largely reported unfavorable attitudes toward CP ( $M = 2.38$ ,  $SD = .80$ ), 60% strongly disagreed or disagreed with CP, about 33% were neutral and 6.7% strongly agreed or agreed with the use of CP. Attitudes toward spanking did not significantly differ by demographic characteristics of the respondents.

Overall, respondents expected more negative outcomes from the use of CP than positive outcomes. There were 22.8% of respondents that thought CP was associated with negative outcomes always or most of the time, 40.4% about half the time, and 36.8% rarely or never. Approximately 9% of respondents expected positive outcomes from CP all or most of the time, 22.8% about half the time, and 68.4% rarely or never. Positive expected outcomes of CP in White respondents ( $M = 1.76$ ,  $SD = .49$ ) significantly differed from Hispanic respondents ( $M = 2.67$ ,  $SD = .92$ ,  $p = .037$ ) as well as Black respondents ( $M = 2.53$ ,  $SD = .86$ ,  $p < .01$ ). This finding shows that Hispanic and Black respondents believe the use of CP leads to positive outcomes, such as parental respect or a decrease in child misbehaviors, more frequently than White respondents. Expected outcomes of CP did not significantly differ by any other demographic characteristic.

**Table 3***Georgia Providers' Attitude Toward Spanking and Expected Outcomes of CP, N=64*

Measures	n	$\alpha$	Range	Mean	SD	Strongly Disagree/ Disagree	Neither Agree nor Disagree	Strongly Agree/ Agree
<sup>a</sup> ATS Score	60	.64	3.25	2.38	.80	60%	33.3%	6.7%
<sup>b</sup> Expected Outcomes						Never/ Seldom	Half of the Time	Always/Most of the Time
Positive Outcomes	57	.89	3.25	2.21	.81	68.4%	22.8%	8.8%
Negative Outcomes	57	.88	3.83	2.92	.86	36.8%	40.4%	22.8%

<sup>a</sup> The Attitude Toward Spanking (ATS) scale is scored on a range between 1 and 5, 1 meaning unfavorable and 5 meaning very favorable attitudes toward spanking.

<sup>b</sup> The Positive Outcomes and Negative Outcomes of CP are subscales of the Expected Outcomes of CP scale, each range between 1 and 5. Scores closer to 5 show the respondent expects that particular outcomes is associated with CP and scores closer to 1 shows that they do not.

From the ATS scale, as noted in Table 4, over 20% agreed that spanking was a normal part of parenting and another 40% neither agreed nor disagreed with this statement. Additionally, 56.7% of respondents thought that spanking was harmful to children.

**Table 4***Attitudes Toward Spanking Questions and Responses, N=64*

Statement	n	Strongly Disagree/ Disagree (%)	Neither Agree nor Disagree (%)	Strongly Agree/ Agree (%)
Spanking is a normal part of parenting	59	45.8%	30.5%	23.7%
Overall spanking is a bad disciplinary technique	60	18.3%	21.7%	60.0%
Sometimes, the only way to get a child to behave is with a spanking	60	75.0%	18.3%	6.7%
Spanking is harmful	60	18.3%	25.0%	56.7%

**Perceived Ability to Discuss CP and Behavior.** Providers were also asked how often they addressed CP they were aware of with families they served within the past six months. Out of those who reported knowing a caregiver was using CP (n=32), only 37.5% of providers said they always addressed the use of CP with that caregiver, 25% did most of the time, 21.9% did sometimes, and 15.6% reported they never addressed it. Providers stated some of the following reasons for not addressing CP with a caregiver: not wanting to embarrass the caregiver; fear of further upsetting the caregiver; it is a caregiver's right to use CP; or they didn't know what to say.

### Study Two: Quantitative Results

**Demographics.** Demographic characteristics of the study sample (N=51) from the pilot training are shown in Table 5. The majority of participants were female (96.1%), regionally identified with the Southeast (82%), and had on average 12.9 years of experience ( $SD = 8.0$ ). Over half were Protestant (54%) and over the age of 40 (58.8%). Most of the participants were either White (40%) or Black (40%) followed by Hispanic (14%), and all other races accounted for 6% of the sample. There were 21.6% of participants who had graduate level degrees and another 41.2% with a Bachelor's degree; the remaining had either some college (29.4%) or a high school diploma/GED (8%).

**Table 5**

*Demographic Characteristics of Study Two Participants, N= 51*

<b>Characteristics</b>	<b>n</b>	<b>%</b>
<b>Gender</b>		
Female	49	96.1
Male	2	3.9
<b>Race</b>		
White	20	40.0

Black	20	40.0	
Hispanic	7	14.0	
Other	3	6.0	
<b>Age in Years</b>			
40 years and under	21	41.2	
41 years and over	30	58.8	
<b><sup>a</sup>Region of US</b>			
Southeast	41	82.0	
Southwest	3	6.0	
Midwestern	3	6.0	
Northwest	1	2.0	
Northeast	2	4.0	
<b>Education Level</b>			
High School/GED	4	8.0	
Some College	15	29.4	
Bachelor's Degree	21	41.2	
Graduate Degree	11	21.6	
<b>Religion</b>			
Protestant	27	54.0	
Catholic	3	6.0	
Agnostic	2	4.0	
Other	8	16.0	
Prefer Not to Answer	10	20.0	
	<b>Mean</b>	<b>SD</b>	<b>Range</b>
<b>Years of Experience</b>	12.9	8.0	<1 – 33 years

<sup>a</sup> Represents the region of the US that the respondent most closely identifies with, all respondents resided in Georgia during the completion of the survey.

Preliminary analyses were performed to determine any significant differences in the ATS and positive and negative outcome of CP scores by demographic characteristic. No significant differences were observed. Of note, mean differences in participants' ATS varied by race and religion. Black and Hispanic participants had similar scores for attitudes toward spanking ( $M = 2.49$ ,  $SD = .96$  and  $M = 2.43$ ,  $SD = .72$  respectively) and White participants had slightly less favorable attitudes toward spanking ( $M = 2.06$ ,  $SD = .78$ ). Additionally, Protestant participants



had the most favorable attitudes towards spanking which aligns with previous studies (Child Trends, 2015).

**Attitudes and Expected Outcomes of CP.** To further analyze results, only data were used for participants who completed the training pre-survey and at least one of the two post-training surveys. No significant differences were found on survey outcomes between those who were included and not included in further analysis. A paired samples t-test demonstrated similar trends were found across the pre-, post-, and three-month follow-up surveys for the ATS and positive and negative expected outcomes of CP scales. The greatest changes were seen between the pre and post-survey means and slightly smaller mean changes were sustained between the pre- and three-month follow-up. The ATS and positive and negative expected outcomes of CP scales all showed a significant differences in the pre-survey compared to the post-survey, seen in Table 6. Participants' attitudes toward spanking became significantly less favorable ( $M_{pre} = 2.11$ ,  $M_{post} = 1.77$ ) immediately following the training ( $t_{35} = 2.77$ ,  $p < .01$ ). In the three-month follow-up survey, the ATS mean scores had slightly increased compared to the post-survey but still showed overall less favorable attitudes toward spanking than before the training.

Results from the positive outcomes of CP scores showed a significant difference ( $t_{35} = 2.86$ ,  $p < .01$ ) between the pre- and post-surveys ( $M_{pre} = 2.07$ ,  $M_{post} = 1.70$ ), signifying that participants expected more positive outcomes of CP prior to the training than immediately after the training. A significant difference was not found for positive outcomes between the pre-survey and three-month survey, suggesting that although there is knowledge change immediately post training, those changes do not sustain. The negative outcomes of CP scores

indicated a significant difference ( $t_{35} = -4.71, p < .001$ ) between the pre- and post-surveys ( $M_{pre} = 2.80, M_{post} = 3.60$ ) and were also significantly ( $t_{35} = -2.70, p < .05$ ) maintained from pre-survey to the three-month follow-up survey ( $M_{pre} = 2.89, M_{post} = 3.36$ ). The increase in mean scores shows the sample expected more negative outcomes resulting from CP at the post and three-month follow-up survey than prior to the training. When asked in the post-survey if their knowledge of consequential outcomes related to spanking increased as a result of the training, 92% of participants agreed or strongly agreed.

**Table 6**

*Mean Comparisons of Scales Between Pre-, Post-, and Three-Month Surveys, N=42*

<sup>a</sup> Measures	Pre	Post	t-test	Pre	3-Month	t-test
	M (SD)	M (SD)		M (SD)	M (SD)	
Attitude Toward Spanking	2.11(.84)	1.77(.85)	2.77**	2.00(.83)	1.84(.75)	1.14
Positive Expected Outcomes	2.08(.67)	1.70(.77)	2.86**	2.00(.56)	1.82(.74)	1.42
Negative Expected Outcomes	2.80(1.02)	3.60(1.11)	-4.71***	2.89(1.02)	3.36(1.06)	-2.70*

<sup>a</sup> Scales are scored on a range between 1 and 5. For the ATS scale, 1 is less and 5 is more favorable attitudes toward spanking. For the Expected Outcomes of CP subscales, scores closer to 5 show a greater expectation of that positive or negative outcome and scores closer to 1 indicate that outcome is less expected.

\*Significantly differed from the pre-test measure at  $p < .05$

\*\*Significantly differed from the pre-test measure at  $p < .01$

\*\*\*Significantly differed from the pre-test measure at  $p < .001$

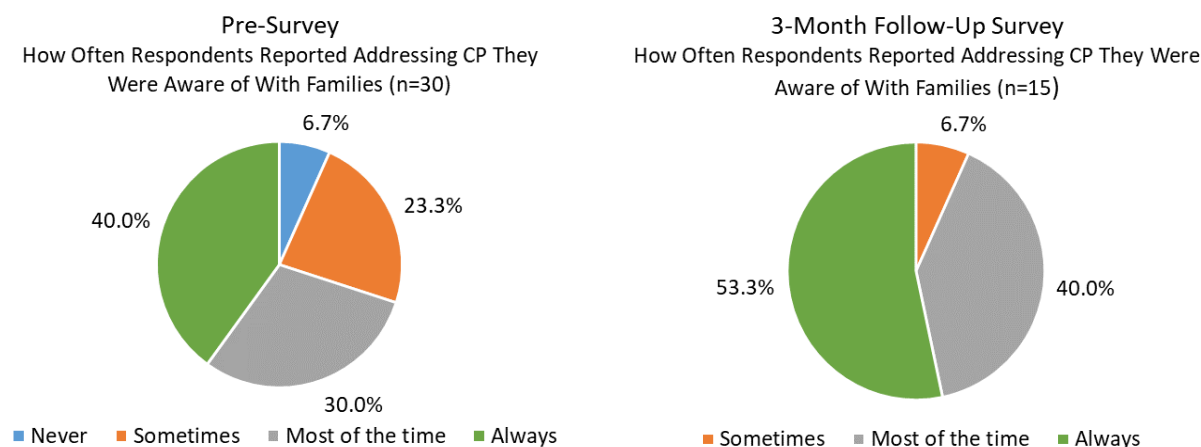
**Perceived Ability to Discuss CP and Behavior.** Prior to the training, 23% of participants strongly agreed they had effective strategies they could use to guide discussions on CP with caregivers which increased to 81% immediately following the training and 65% at the three-month follow-up survey. In the pre-survey, 30% of participants strongly agreed that they had an obligation to intervene if a family they served was spanking or hitting their children compared

to 76% and 74% in the post-survey and three-month follow-up survey respectively. Additionally, 86% agreed or strongly agreed that they felt more likely to discuss the use of CP with families as a result of the training, indicating a positive increase in the self-efficacy to discuss CP with families.

Although behavior change was not an immediate objective of this research study, data were collected to gauge if providers addressed CP more after the training. A descriptive analysis shows that participants reported more consistently addressing CP that was occurring among caregivers they served three-months after the training compared to before the training, as shown in Figure 1. In the three-month follow-up survey, 53.3% of respondents indicated they always addressed CP they knew about compared to 40% prior to the training.

**Figure 1**

*How Often Participants Reported Addressing CP They Were Aware of Prior to the Training (n=30) Compared to 3-Months After the Training (n=15)*



In the three-month follow-up survey (n=33), participants were asked what actions they had taken as a result of attending the training: 45% shared materials/resources from the training with caregivers; 79% shared what they had learned from the training with caregivers;

73% talked about what they had learned with co-workers or friends/family; and 12% were working with their organization to have written policies and practices against the use of CP.

### **Study Two: Qualitative results**

Ten attendees from the pilot training also participated in semi-structured qualitative interviews, with professional experience ranging from 1 to 22 years. Themes that emerged from the analysis included (1) barriers to discussing CP with families (2) the need for skill-oriented training and (3) the impact of the pilot training.

**Barriers to Discussing CP with Families.** Across the board, individuals felt that “bringing it [CP] up is awkward because people tend to have strong opinions.” Participants stressed the sensitivity of the subject and many felt they lacked knowledge or skills to effectively address CP prior to the training. The most frequently cited barrier was the ability to address religious views of CP that caregivers held. One participant said that they “got that [parents bringing up religion], every time in the parenting classes, that was kind of the wall.” Another provider agreed that “even if a person isn't religious they'll throw that out there, spare the rod, spoil the child, and it's in the Bible.” Participants were eager for resources on “knowing how to talk around that” so that they weren't “going against someone's religion” by discouraging CP and could maintain trust in the provider-caregiver relationship.

Discussing CP in general was seen to be risky to the provider-caregiver relationship. One provider added that they did not feel they were encouraged to directly discuss CP by their program by saying “they don't want parent educators telling parents ‘don't spank your child,’ because then they might, you know, not want to participate anymore.” Grandparents and other family members also have an influential role in attitudes toward and use of CP that could result

in barriers to addressing CP with the caregiver. For example, one participant said, “Grandma says do it and Grandma’s behind you telling the parent ‘don't listen to that lady, books don't mean anything.’ So, you know, family members that are very pro spanking and so the families have a resistance.”

Overall, providers experienced numerous barriers in addressing CP based on the caregiver’s personal beliefs or social norms. Additionally, a lack of knowledge to effectively address CP led to further discomfort or hesitancy in addressing this sensitive topic. Ultimately, this resistance also seemed greatly intertwined with worry about maintaining a positive provider-client relationship.

**The Need for Specific and Skill-Oriented Training.** The interviewees’ had various levels of training and resources to equip them to discuss CP with families. Three of the interviewees reported they had never had any training on CP nor did their curriculum/program materials directly cover it. These providers used curricula or materials that “talk about positive strategies, different techniques and different things that you can do with discipline, but I don't think it goes into the harmful aspect of spanking.” Another four providers had materials that briefly discussed the harms of spanking or had experience in various trainings where “it's been referenced that spanking can be harmful, but it hasn't been the main focus.” This left only 30% of interviewees who reported receiving more in-depth training in regards to “how CP can affect brain development,” “various reasons people spank,” or “faith-based curriculum” prior to the study workshop.

Although the majority of providers had some exposure or access to information on CP, they inconsistently discussed CP with families due to the barriers described above. One home

visiting supervisor said that some of their staff “would just talk about corporal punishment if they were asked, or if it came up in the curriculum,” but they weren’t sure “how many actually talked about it, you know, consistently.” Moreover, the providers reported the majority of trainings they previously attended hadn’t been “so specific about different strategies” or go into “actual application” when it came to discussing CP with families.

The providers interviewed were seemingly eager for additional resources, and one said that materials provided in the pilot training “helps the comfort level for home visitors specifically when they have something they can hand out to go over, like where the curriculum may have gaps.” Rather than learning “trial by fire” or along the way, one parent educator expressed the need for providers, especially earlier in their career, to have more in-depth and skill-based training to discuss CP with families:

*“I wish I would have had it (the pilot training) 11 years ago. It was very helpful. I mean, there's a lot of stuff in it that I learned along the way. If I would have had it earlier in my parent education career, I think I could have made more difference to some of these families that were using corporal punishment.”*

**Impact of the Training.** The training included information and skill-building activities to specifically address sensitive topics related to CP, such as religion and cultural background, as well as information on the impact of CP from research. The interviewees who reported religion as a barrier also discussed how the pilot training increased their self-efficacy to address this topic with families. One provider said the “faith information made an impact on me and I know it made an impact on one of our staff as well, just being able to have that information to share when it's coming from a faith motivated response.” They felt the pilot training was able to help

providers discuss CP in a way such that “they're not going against the parent’s faith or not trying to argue with them. But having that knowledge and being able to have a way that opens conversations with families and not feel like they're judging them, just makes it easier for them to have those conversations with families.”

In addition to reporting increased knowledge and skills, 40% reported they had already used what they learned with families they serve. One parent educator stated, “Taking the class gave some language that I had not had before. That same day as the training, I think I had a parenting class that afternoon so we talked about that language specifically.” The parent educator went on further to state it had already made an impact on the parents, “The whole brain damage thing came out a couple of times during our post-class evaluations of the sessions that I taught with the new material.” Furthermore, about half of the interviewees shared information from the pilot training within their organization, professional networks, and even with friends or family. One provider said the pilot training was helpful in “opening up that conversation to give people that space to reflect and think about it.”

When interviewees were asked if the pilot training helped them overcome any barriers in addressing CP with families, one responded, “I do feel much more empowered to talk to families about corporal punishment now. Before, I just didn't feel like I had any knowledge to do it.”

Additionally, even though many attendees said they “already knew corporal punishment was bad”, or knew the harms of CP, they still gained “some specific language that allowed me to make a stronger argument that corporal punishment is not a good idea.” They felt that the pilot training “increased their confidence to be able to talk with families more frequently about

it.” A consistent response from the providers was an appreciation of the training offering strategies for discussing CP with families in a non-accusatory way that can allow for parent openness to a mind shift regarding the use of CP.

## **Chapter V: Discussion and Conclusion**

The purpose of this project, conducted across two studies, was to assess and improve the attitudes, knowledge and practices of providers in regards to CP. The first study collected data from providers to fill existing gaps within the literature and the second study examined the effectiveness of a pilot training intended to better equip direct service providers with knowledge and skills to discuss CP with caregivers.

Previous studies have focused on the attitudes toward spanking of other family-serving professionals, but this is the first exploratory study to examine the ATS and expected outcomes of CP of home visitors and parent educators. The close relationship that home visitors and parent educators have with families, sometimes for many years, make their profession very influential in the lives of young families. Results from this study provide insight into the views and practices of providers regarding CP and can be used to improve provider resources or skill-based trainings.

### **Study One: Assessing Provider Attitudes, Knowledge, and Practices**

The aim of study one was to assess home visitors' and parent educators' (1) knowledge, (2) attitudes, (3) behaviors and practices, and (4) training/resources available to them in regards to CP. As expected, the target population, whose profession requires training and knowledge of child development already had significant knowledge regarding the detrimental



outcomes associated with CP and unfavorable attitudes toward CP. However, respondents from study one reported more favorable attitudes toward CP ( $M = 2.38$ ) than in national surveys of other family-serving professionals such as pediatricians ( $M = 1.86$ ) (Taylor et al., 2018) and members of the American Professional Society on the Abuse of Children (APSAC) ( $M = 1.86$ ) (Taylor et al., 2017). Study one's sample also expected more positive outcomes and less negative outcomes to be associated with CP than in the national sample of pediatricians and APSAC members. This is consistent with other findings that show the Southeast, even professionals working to protect the lives of children, have more favorable attitudes toward CP (Child Trends, 2015).

Findings from study one demonstrated that providers' current curricula used in session delivery and prior training tended to focus largely on positive discipline while providing some information on the impact of CP, but seldom covered more sensitive issues concerning CP. In study one, 61% of respondents reported their curriculum described the negative outcomes associated to CP but only 32% reported their curriculum covered religious or cultural norms regarding spanking, which can create barriers to discussing CP, particularly in the Southeast. Lastly, only 43% of providers in study one reported always addressing CP with a caregiver when they had knowledge it was occurring.

### **Study Two: Impact of Pilot Training**

Using the results of study one, the pilot training was customized to focus on addressing sensitive topics regarding CP, such as religious views and cultural norms, and use various practice activities to improve communications skills when addressing CP with families.

The objective of study two was to evaluate the efficacy of the adapted pilot training, "Dear Parent: Discussing Discipline," to increase (1) knowledge of consequential outcomes related to CP, (2) unfavorable attitudes towards CP, and (3) the provider self-efficacy to initiate conversations on discipline with parents. The results demonstrate that the pilot training produced positive changes in participant knowledge, attitude, self-efficacy, and behavior that were largely maintained through the three-month follow-up survey. For the ATS and positive and negative outcomes of CP scales, the greatest changes were seen between pre and post-survey means and slightly smaller mean changes were sustained between the pre and three-month follow-up, for all but the ATS scale.

It is noteworthy that researchers did not expect large changes in participants' ATS or expected outcomes of CP considering the finding from study one, which revealed providers already had unfavorable ATS and were knowledgeable on positive and negative outcomes of CP. However, significant changes were indicated, and even the modest changes seen in study two are important in comparison to national samples of other family-serving professionals. Prior to the pilot training, participants reported more favorable attitudes toward spanking ( $M = 2.11$ ) as compared to national surveys of other family-serving professionals such as pediatricians and APSAC members ( $M = 1.86$ ). After the training, in the post and three-month follow-up survey, participants' attitudes toward spanking ( $M = 1.77$  and  $M = 1.84$ , respectively) became less favorable than the national averages of other family-serving professionals (Taylor et al., 2018; Taylor et al., 2017).

Even more encouraging are the increases found in provider self-efficacy and the frequency with which providers discussed CP with families after completing the training. These

findings are imperative because converting knowledge and role play training into behavior change is the ultimate goal of any skill-oriented training. Despite the brief follow-up time of the post and 3-month surveys, and the limited in-person interaction due to COVID-19, participants reported discussing CP with families more often than they had prior, using information from the training in other ways. At the three-month follow-up, 53.3% responded they always addressed CP when they knew it was occurring compared to 40% prior to the training, and 79% reported discussing what they had learned from the training with a caregiver. Qualitative data offered even more insight and case examples for how these changes were enacted. For example, one provider described how the parents were positively impacted after the provider included new information into their parent education class as a result of attending the pilot training. Another provider felt empowered to discuss CP as a result of the training, whereas they didn't have much knowledge on it before. The qualitative data further justify the implementation of skill-based training focusing on CP. Of the ten interviewed, 70% reported they had not received any in-depth training specific to discussing CP with families. This is not completely commensurate with what providers reported in the survey, but perhaps prior to the workshop, people were more confident that they had been trained, and once the workshop had occurred they realized they had never received skill based learning with as much depth on this topic. Prior to the training, providers reported experiencing some degree of barriers to discussing CP, but afterwards, they were confident in the skills gained to discuss CP with families. Participants also frequently stated the desire for supplementary strategies (responding to common reasons caregivers spank using effective messaging) to discuss CP with families and practice in applying those skills. Interviewees noted that pilot training helped fill gaps in their knowledge or

curriculum, and provided specific language they could use to address CP with caregivers. While similar interventions have focused on knowledge of progressive religious aspects of CP or improving communication skills between providers and families, this training is unique in its approach to improve the communication skills of providers to discuss particularly sensitive topics concerning CP (Perrin, Miller-Perrin & Song, 2017; West et al., 2018). Participants felt the resources and practice discussing sensitive issues were impactful in helping them overcome barriers to communicating with families. Since the use of CP can be rooted in a caregiver's religious views or family tradition, some providers stated they were hesitant to discuss CP, fearing it could negatively impact their relationship with the family. According to the qualitative analysis, the pilot training better equipped providers to discuss CP in a way that was non-judgmental and didn't go "against the parent's faith," making conversations easier and less risky to the provider-caregiver relationship.

### **Limitations**

There are several limitations to the current study that could be improved upon in future research. First, the sampling size and methods limit the generalizability of reported results. The sample size was relatively small, limited to providers in Georgia, and self-selected to participate in the pilot training. Studies that build upon this work should randomize participants into training or comparison groups to produce more robust findings, and attempt to include more participants from more dispersed geographic locations. Second, participants in the qualitative interview were voluntary, introducing self-selection bias into the results. Third, the baseline scores of the main outcomes of interest did not leave much room for change (ceiling effect). Furthermore the same group who was invited to take the survey in study one was also invited

to participate in the pilot training, which had a very similar pre-survey. Exposure to the survey multiple times could have biased the results of the pre-survey or post-survey although we found no significant difference in outcomes of interest in study one's surveys and study two's pre-survey. Future research on this skill-oriented training should focus on measures to better gauge behavior change in providers or any impact on the families they serve. For instance, collecting observational data of provider sessions with family that would allow for coding of CP discussions would be helpful to increase the confidence of the generalizability of the workshop training.

Due to COVID-19, this training had to be thoughtfully adapted to be delivered virtually, paying special attention to practice scenarios, role playing, and allotting time for feedback. Delivering this training virtually versus in-person could have impacted the results, however, similar training among healthcare providers has been shown to be as effective virtually as in-person at increasing communication skills, knowledge and self-confidence (Quail et al., 2016).

### **Conclusion and Next Steps**

The findings of this study clearly demonstrates the need for additional training and the ability of such a skill-oriented training to better equip providers to discuss CP with families. Building on this work by collecting nationally representative data from home visitors and parent educators could greatly inform the many organizations and agencies who work with or are implementing parent education programs. The results of this exploratory study focus on home visitors and parent educators, but have also shown promise to impact caregivers, which is the ultimate goal of this work. Future research on this provider focused training should be expanded to include the impact on the caregivers they serve. This training could also be

adapted and delivered to a variety of family-serving professionals, easily embedded in the initial or supplemental training home visitors receive, or in conjunction with other initiative such as No Hit Zones, policies and practices to eliminate the use of CP within agency settings such as hospitals (Gershoff et al., 2018; LeBlanc et al., 2019)

Despite the growing evidence against the use of CP, directly discussing CP with caregivers is still a daunting task given the sensitivity of the issue and social norms throughout the nation. This study has demonstrated that the implementation of skill-oriented training to discussing CP for providers is needed and a potentially effective way to reduce a caregiver's use of CP. Furthermore, the initial success of the virtual format used in the pilot training allows this intervention to be easily scaled-up and cost-effective, making for simple dissemination.

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