Childhood Discipline: Challenges for Clinicians and Parents

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Although childhood discipline is an important issue for parents, this topic is seldom emphasized by family physicians during well-child examinations. Behavior problems are relatively common but frequently under-recognized by physicians. Opportunities to counsel parents about safe, effective methods of discipline are therefore missed. Discipline should be instructive and age-appropriate and should include positive reinforcement for good behavior. Punishment is only one aspect of discipline and, in order to be effective, it must be prompt, consistent, and fair. Time-out is frequently used to correct younger children, but because it is often enforced improperly, it loses its effectiveness. Corporal punishment is a controversial but common form of discipline that is less effective than some other types of punishment. Its use is linked to child and spouse abuse, as well as to future substance use, violent crime, poor self-esteem, and depression. Despite the possible negative effects of corporal punishment, it is still widely accepted in our society. Since discipline plays an important role in the social and emotional development of children, physicians should be trained to discuss this issue with parents during routine well-child examinations. (Am Fam Physician 2002;66:1447-52,1463-4. Copyright© 2002 American Academy of Family Physicians.)

A patient information handout on childhood discipline, written by the author of this article, is provided on page 1463.

Frustrated parents may ask family physicians about discipline techniques that seem ineffective. However, physicians are often uncomfortable discussing discipline, and parents may be reluctant to introduce the subject because they are worried about criticism of their parenting skills. Parents often rely on certain discipline styles because they were disciplined in that manner when they were children. Because discipline techniques influence the social development of children, counseling about this matter is a critical part of physician-parent encounters.

The term "discipline" derives from the Latin word "disciplinare," meaning "to teach."[1] However, the term is most often associated with the concept of punishment, which falls short of the full meaning of the word. Discipline properly involves a multifactorial approach that makes use of models, attitudes, rewards, and punishments to teach and reinforce socially acceptable behavior. Through discipline, children become able to achieve self-control, self-direction, and a sense of caring.[1-4]

Etiology of Misbehavior

Multiple factors may contribute to behavior problems, including lack of adequate discipline.[5] Commonly, children misbehave when they are tired, bored, or hungry.[6] Children often misbehave when they are deprived of adult attention; misbehavior may elicit attention, and parental scolding may unintentionally reinforce the undesired behavior.[3,7]

Children from families marred by divorce, separation, extreme poverty, substance abuse, parental depression, and other mental illness may be at greater risk for behavior disorders.[2] Biologic factors such as certain temperaments and attention-deficit/hyperactivity disorder (ADHD) may predispose children to misbehavior. Several studies suggest that harsh discipline practices actually exacerbate misbehavior, particularly in European-American children and those with ADHD, and in children of school age.[8-10] Perhaps most influential is the role of parents and other adults and children in modeling behavior.

Discipline should be based on expectations that are appropriate for the child's age and should include limits while permitting acceptable alternative choices.

Principles of Discipline

Discipline should be based on expectations that are appropriate for the age of the child (*Table 1*), and it should be used to set reasonable, consistent limits while permitting choices among acceptable alternatives. Discipline teaches moral and social standards, and it should protect children from harm by teaching what is safe while guiding them to respect the rights and property of others.[3,5]

Although verbal explanations may help older children understand their punishment, reasoning is ineffective if children are incapable of understanding the explanation. Children younger than 18 months are typically unable to appreciate the reasons for punishment, and their overwhelming desire to explore their environment makes punishment less effective.[5]

Parents should show a unified front toward discipline.[4] When parents demonstrate opposing attitudes, children learn to exploit those differences. Parental response to misbehavior must be consistent and should provide immediate, inevitable consequences so that the child appreciates the cause-and-effect relationship.

Rules should be few but clear and, to improve compliance, they should be appropriate for the child's age.[5] Punishment should be a logical or natural consequence of the misbehavior.[6] For example, if a child marks on the wall with a crayon, an appropriate punishment would be to withhold crayons for a period of time; if the child refuses a meal, withholding dessert will be the natural consequence.

Although parents are the ultimate authorities, it is often appropriate for them to be flexible and to negotiate, particularly with older children. By involving children in decision-making regarding punishment, moral judgment is enhanced, and autonomy is reinforced.[3]

TABLE 1
Age-Appropriate Techniques for Childhood Discipline

Intervention	*Infant*	*Toddler*	*School-age*	*Adolescent*
Positive reinforcement	+	+	+	+
Redirecting	+	+	+	0
Verbal instruction/ explanation	0	Ltd	+	+
Time-out	0	+	+	0
Establishment of rules	0	0	+	+
Grounding	0	0	+	+
Withholding privileges	0	0	+	+

0 = Little or no effectiveness; + = effective/recommended; Ltd = limited, may work in certain situations or with more mature toddlers.

Positive Reinforcement

Positive reinforcement is crucial to discipline. One of the most powerful forms of positive reinforcement is parental attention, which should focus on good behavior rather than undesirable behavior. Unfortunately, undesirable behavior more frequently gains parental attention.[1] Parents must identify appropriate behaviors and give frequent feedback, rewarding good behavior immediately so that the child can associate the reward with the good behavior.[7] Rewards can range from smiles, words of praise, and other signs of

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affection to special activities, extra privileges, and material items.[5] A token economy system is effective with many children. In this technique, the child earns rewards (such as stars) for desired behaviors and loses the rewards for undesirable behavior. The rewards can be cashed in for prizes after a specified time.[11]

Parental attention is a powerful form of positive reinforcement and should be directed at good behavior rather than undesirable behavior.

Punishment

Punishment is sometimes a necessary element of discipline, but to be an effective tool it must be coupled with rewards for good behavior. Punishment should be used for teaching, not for revenge. Parents should not punish accidents or behaviors that are part of normal development (such as thumb-sucking or toilet-training accidents in toddlers), and they should avoid teasing, shaming, or nagging.[5]

Extinction

"Extinction" is a form of discipline that eliminates inadvertent positive reinforcement for unacceptable behavior.[1] Ignoring the behavior of toddlers who whine or have tantrums eliminates the positive reinforcement of a response to that behavior.

"Time-out" is the most commonly practiced (and often badly managed) form of extinction. Time-out must involve removing the child from the problem situation. The child should be sent to a corner or instructed to sit in a room with no toys or television. The environment should be neutral, boring, nonfrightening, and safe.

Time-out works well for children from 18 months up to five or six years of age, and it is particularly useful for the correction of temper tantrums, whining, yelling, fighting, and aggression.[5] Effective time-out requires that the child be ignored, and the session should end only when the child has been calm and quiet for at least 15 seconds.[3,12] Time-out should last for a specified time, usually one minute per year of life (to a maximum of five minutes) without interaction.[1,3]

Time-out works best if the child receives regular attention ("time-in") otherwise. The child must appreciate the change from the routine, and the contrast is critical. If a parent claims that time-out does not work, the physician should ask how the parent spends time-in.[12] Time-out is rarely effective immediately but is highly effective over the long term. The most common reason for failure of time-out is the parents' inability to cope with their own distress and to ignore the child's pleading and bargaining.[1]

Withholding privileges is another form of extinction that is more appropriate for older children and adolescents. It requires the removal of a valued privilege, such as television viewing or visits with friends.[1,5] This technique works best if it is used infrequently.

Verbal Punishment

Scolding expresses disapproval, with the intention of eliminating a behavior. This method can be transiently effective if used sparingly; however, when used frequently it can provoke anxiety and encourage the child to ignore the parent. It also may reinforce undesirable behavior by providing attention to the child.[1] Verbal disapproval, when used alone, has been shown to increase noncompliance, and shouted commands often result in excitatory effects in preschoolers.[3] Verbal punishment should never be used during time-out, since it reduces the effectiveness of time-out.

Corporal Punishment

Corporal punishment remains a common but controversial form of discipline. Corporal punishment involves inflicting physical pain, usually in the form of spanking. Acceptable spanking has been limited traditionally to the use of an open hand on the buttocks or

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extremity with the intention of modifying behavior without causing injury.[1]

More than 90 percent of American families use spanking as a form of discipline for toddlers and, according to the National Family Violence Surveys, more than one half use spanking during the early teens.[13,14] Corporal punishment is used more frequently in boys than in girls, especially in impoverished families. Other studies confirm harsher discipline practices among low-income parents, particularly those who experience more family stress.[15]

Physical punishment is also common among socioeconomically mid-level, intact, well-educated families. One study[16] has shown that among this group, only 17 percent of families claim to have never used physical punishment, and 25 percent use it more than a few times weekly.

Although spanking may be effective initially because of its shock value, it is less effective over the long term than extinction and becomes less effective with each use, sometimes even leading to escalation of punishment.[1] Spanking also loses its effectiveness if it is characterized by rage or if signs of rejecting the child follow it.[4] Spanking is inappropriate in children younger than 18 months, because they are too young to appreciate the connection between the behavior and the punishment. Furthermore, corporal punishment used in very young children has a greater likelihood of physical injury.[1]

At no time is it acceptable to strike a child with an object, use enough force to leave marks, pull hair, jerk arms, or shake a child. Physical punishment delivered in anger with the intent to cause pain is never appropriate.[1] The distinction between corporal punishment and child abuse may be subjective, but the identification of abuse is important.

Opponents of corporal punishment argue that frequent physical punishment interferes with the teaching of nonviolent modes of conflict resolution.[13] Because spanking models aggressive behavior and inflicts pain, it may teach the lesson that, in some situations, it is acceptable to inflict pain on others.[1,17]

Studies have shown an association between corporal punishment received as a child and anger that persists into adulthood, increasing the likelihood that those persons will use physical punishment with their own children or physically assault a partner.[13] The use of spanking in older children is associated with higher rates of childhood physical aggression, substance abuse, crime, and violence, and it has been linked to poor self-esteem, depression, and low educational achievement.[13,14] Harsh discipline has also resulted in lowered intelligence among low-birth-weight girls.[18]

Despite the potential negative effects of corporal punishment, it is still widely accepted. One report[19] indicates that 19 percent of mothers believe it is acceptable to spank a child who is less than one year old, and 74 percent believe it is appropriate to spank children one to three years of age. Among physicians, 59 percent of pediatricians and 70 percent of family physicians support the use of corporal punishment, although approval is greatest when it is used to correct dangerous behavior.[20]

Discussing Discipline with Parents

Up to 90 percent of pediatricians but only 52 percent of family physicians discuss discipline as part of anticipatory guidance for parents.[20] Forty percent of parents attending a pediatric primary care clinic endorsed the use of corporal punishment, but the topic was discussed during only 18 percent of the visits.[21] This disparity may be partly due to lack of physician training in this subject.

Because discipline is not routinely discussed, physicians do a poor job of predicting parental concern about behavior issues. In one study,[16] physicians recognized only 11 percent

of mothers who experienced emotional distress over this issue, and they identified only 27 percent of cases where mothers reported using physically abusive levels of violence in the home. Parents often do not discuss discipline with their physician for fear of being accused of abuse.[1,21] Reluctance to discuss this issue may also be cultural because many parents rely on family, neighborhood, and religious resources for advice about discipline.[1,21]

Physicians may encourage discussion simply by asking parents, "How do you get your child to mind you?" An open-ended question may be less threatening than specific questions about discipline techniques.

When discussing discipline with parents, physicians should remain nonjudgmental but clear about what is effective and safe. The physician should try to understand the parents' point of view and show empathy, while allowing the family to individualize a plan. It may be helpful to discuss methods that have been tried in the past and have not been shown to be effective. After determining whether techniques are used properly or consistently, the use of effective discipline techniques should be reinforced.

Discussion about discipline should begin early (during well-child visits), before parents begin experiencing difficulties, and follow-up discussions should occur during later visits. Teaching strategies should include discussion about alternatives to corporal punishment, anger-control skills, children's normal need for independence, and advice about how to deal with authority conflicts.[16]

Patient education materials may be helpful. Some parents may need referral to support groups, parenting programs, or counselors.[1,21]

Some physicians may prefer working with parents individually, while others prefer working with parents in small groups. *Table 2*[22,23] gives guidelines for billing for these services, even when they are performed outside of well-child examinations.

Because discipline is a significant factor in the social and emotional development of children, greater effort should be made by physicians to include discussions about discipline as a routine part of a preventive health program for children. Until childhood discipline becomes an integral part of medical training, however, continued neglect of this important issue is likely.

TABLE 2
Billing Codes for Counseling About Childhood Behavior

Common ICD-9 codes[22]

Health supervision of infant/child: V20.2, routine infant or child health check (including developmental testing, immunizations, vision and hearing screening)

Parent-child problems: V61.20, counseling for parent-child problem, unspecified (including concern about behavior of child, parent-child conflicts)

Common CPT codes[23]

Preventive medicine counseling	Individual	Group
15 minutes	99401	N/A
30 minutes	99402	99411
45 minutes	99403	N/A
60 minutes	99404	99412

ICD = International Classification of Diseases; CPT = Current Procedural Terminology; N/A = not available.

Information from references 22 and 23.

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