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A short-term evaluation of a hospital no hit zone policy to increase bystander intervention in cases of parent-to-child violence

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ABSTRACT

This study used a pre/post design to evaluate the implementation of a hospital-wide No Hit Zone (NHZ) bystander intervention around parent-to-child hitting. A total of 2326 staff completed the pre-NHZ survey and received training about the NHZ policy; 623 staff completed the post-test survey 10 months later. A group of 225 parents participated in the pre-NHZ survey and a second group of 180 participated in the post-NHZ survey, also 10 months later. Compared to staff in the pre-NHZ group, staff in the post-NHZ group had more negative attitudes about spanking and more positive attitudes about intervention when parents hit children in the hospital. Few differences were found among the parent pre- and post-groups. This study demonstrated that NHZs are a feasible way to inform and train hospital staff in ways to intervene during incidents of parent-to-child hitting to promote a safe and healthy medical environment.

1. Introduction

Physical abuse of children leads to long-term physical and mental health problems (Francis, Nikulina, & Widom, 2015) and is illegal in all 50 U.S. states (Child Welfare Information Gateway, 2016a). Prevention of physical abuse is a key public health goal (Fortson, Klevens, Merrick, Gilbert, & Alexander, 2016). Use of even legal forms of parent-to-child hitting, often referred to as physical punishment or spanking, is a consistent predictor of whether parents will physically abuse their children (Gershoff & Grogan-Kaylor, 2016; Lee, Grogan-Kaylor, & Berger, 2014). (Note: the terms “parent-to-child hitting,” physical punishment, and spanking are used interchangeably throughout this paper.) Acknowledging this connection, the Centers for Disease Control and Prevention have identified decreasing parents' use of physical punishment as a promising strategy for reducing physical abuse of children (Fortson et al., 2016).

Beyond its connection to physical abuse, there is ample evidence that physical punishment itself is harmful to children. Physical punishment has been linked consistently with a range of negative outcomes for children, including mental health problems, behavior problems, and lower cognitive ability (Gershoff & Grogan-Kaylor, 2016). A childhood history of spanking has been associated with the same mental and physical health outcomes in adulthood as other adverse childhood experiences such as physical or sexual abuse (Afifi et al., 2017). Reducing or eliminating physical punishment can thus reduce the risk for detrimental outcomes and reduce the risk that children experience physical abuse.

Parent-to-child hitting typically happens at home but sometimes occurs in public settings where bystanders are present. This paper presents an evaluation of a promising strategy for reducing parent-to-child hitting in public settings known as No Hit Zones (NHZs). NHZs take a bystander intervention approach to reducing violence against children by empowering professionals trusted by parents, namely medical center staff, to intervene and educate when they witness parent-to-child hitting.

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1.1. Darley and Latané's theory of bystander behavior

Understanding why some bystanders behave prosocially and others do not has been the focus of research for several decades and has provided the foundation for a range of intervention efforts. Interest in promoting intervention by bystanders who witness some form of emergency such as violence being committed against someone, began with Darley and Latané's (1968) classic study of individuals' responses to strangers in distress. Based on a series of experimental studies, Latané and Darley (1970) argued that four conditions must be met in order for a bystander to actually engage in helping behavior, namely that the bystander must notice something is happening, interpret the situation as an emergency, feel responsibility to intervene, and know how to intervene effectively, either directly or indirectly. They observed that some bystanders seemed to meet the first three conditions, and felt distress and concern for the victim, but did not take action because they did not know what to do. Thus, inaction may not equate with apathy but rather reflect a lack of adequate information about how to intervene.

Banyard, Plante, and Moynihan (2004) have condensed Latané and Darley's (1970) four steps into three criteria for successful bystander interventions around violence in relationships, namely: (1) change participants' norms about the importance of taking action when violence is witnessed, (2) ask participants to make a commitment to intervene, and (3) provide training so that participants develop necessary skills to intervene successfully. The NHZ intervention is designed in accordance with these three criteria.

1.2. Bystander behavior in cases of child abuse

Child abuse is often seen or heard by neighbors. In a statewide survey of adults in Kentucky, 9% were aware that some of their neighbors were abusing their children (Paquin & Ford, 1996). If this number is extrapolated across the United States, it implies that millions of adults are aware of child abuse and have the potential to intervene. Although bystander-based interventions have been used successfully to reduce dating violence, sexual violence, and stalking (Coker et al., 2016; Coker et al., 2017), only a handful of researchers have applied the theory of bystander behavior in order to understand what motivates bystander intervention in case of child abuse.

Davis (1991) interviewed 37 bystanders who had intervened when they witnessed a parent hitting a child in a public setting such as a store or a doctor's office. All directly confronted the parent perpetrator by approaching them and typically by speaking to them. In some cases parents protested that it was none of the bystanders' business. Only a few bystanders called authorities to report the parents' hitting behavior. The majority of the bystanders said their motivation was concern about the welfare of the children.

Consistent with Darley and Latané's theory, Christy and Voigt (1994) found that individuals who "had witnessed a child being abused or possibly being abused in public" (p. 826) and subsequently intervened said they did so because they felt a responsibility to stop the abuse and they were clear about how to intervene. The majority of those who did *not* intervene were just as upset as the interveners with the parents' behaviors, but they did not know what they should do.

An analysis of calls to report child abuse in the Netherlands (Hoefnagels & Zwikker, 2001) found that community members constituted the highest proportion of bystanders who reported abuse. All of the reporters of abuse noticed something concerning, such as something worrisome that the victim child said or seeing the abuse directly. Fully 60% were certain that abuse was occurring. This study further supports the application of Latané and Darley's theory in child protection cases.

1.3. Medical centers as ideal settings to reduce parent-to-child hitting

There are several reasons that medical centers can be effective settings for the reduction of child abuse and parent-to-child hitting more generally. First, medical professionals are important influences on parents' attitudes about and use of physical punishment. When parents are asked whom they trust for advice on discipline, they rate doctors and medical professionals as highly trustworthy (Taylor, Moeller, Hamvas, & Rice, 2013), so much so that parents' perceptions of these professionals' approval or disapproval of physical punishment predict their own approval of physical punishment (Taylor, McKasson, Hoy, & Dejong, 2017).

A second reason is that parent-to-child hitting is common in medical settings. A survey of staff from two medical centers found that 50% of physicians, 25% of nurses, 27% of other direct-care staff, and 17% of non-direct care staff had witnessed at least one incident of parent-to-child hitting in the previous year (Font et al., 2016). However, many staff are unsure whether or how they should intervene. In that same study, two thirds of direct-care staff took action when they saw parent-to-child hitting, but only 38% of non-direct care staff did so (Font et al., 2016). These findings make clear that medical center staff are often bystanders of parent-to-child hitting but not all intervene.

Third, medical centers are important settings to reduce parent-to-child hitting because witnessing violence can be upsetting and stressful (Kennedy & Ceballo, 2014). Exposure to violence in a medical setting will be especially upsetting to any patients with a history of violence victimization and particularly to those who are in the hospital for injuries sustained from being a victim of violence. Because staff are tasked with promoting the health, healing, and safety of all patients, they have an obligation to prevent all forms of potential violence exposure by their patients.

A final reason for intervention in medical settings is that intervening in cases of parent-to-child hitting is increasingly seen as a professional and ethical obligation for medical staff. Several major medical professional organizations have urged their members to prevent parent-to-child hitting, including spanking, in all settings. Specifically, the American Academy of Pediatrics (1998, 2014), the Canadian Paediatric Society (2016), the National Association of Pediatric Nurse Practitioners (2011), and the American Academy of Child and Adolescent Psychiatry (2012) have each advised their members to discourage parents from spanking and to promote disciplinary alternatives. All medical staff are also mandated reporters of suspected child abuse or neglect (Child Welfare Information Gateway, 2016b). A bystander intervention for parent-to-child hitting takes this responsibility one step further by asking staff to prevent abuse if they witness a situation likely to escalate and to capitalize on parents' trust by taking the opportunity to educate them about the harms of hitting children and what they can do instead.

There is thus a need to educate medical center staff about the harms of physical punishment, the circumstances in which they should intervene, and the ways in which they can intervene effectively. The No Hit Zone initiative was created to accomplish these goals.

1.4. The No Hit Zone bystander intervention

A No Hit Zone (NHZ) is a universal policy instituted in a setting involving families, such as a medical center, that establishes zero tolerance of hitting of any kind, including parents hitting their children for any reason. The main goal of NHZs is to promote a safe and healthy environment for patients, families, and staff within the medical center (Frazier, Liu, & Dauk, 2014). A secondary goal is to encourage parents to use non-violent forms of discipline instead of hitting (see: www.thisisanohitzone.org). Cismaru (2013) recommends that bystander interventions for child abuse communicate clearly that no child should be hit, that discipline does not need to include physical punishment, that bystanders should always intervene, and that there are clear and effective ways to intervene. An NHZ is thus an example of a bystander-based approach to child abuse prevention in that its goals are to change norms about whether to intervene and to inform potential bystanders