Use of violent discipline in childhood – perceptions and practices in Family Health Strategy

Uso de disciplina violenta na infância – percepções e práticas na Estratégia Saúde da Família

Uso de la disciplina violenta en la infancia: percepciones y prácticas en la Estrategia de Salud de la Familia

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Abstract

Introduction: The reflection on family violence against children has gained international prominence in last decades, accompanied by policies for abolition of acts of violent discipline, which still remains socially accepted and used by many responsible. Objectives: To know the perceptions and practices within the scope of Family Health Strategy (FHS) in relation to guidance on methods of discipline in two units in the municipality of Rio de Janeiro. Methods: 38 professionals working in daily care of children were approached. The content analysis of reports obtained through semi-structured interviews was carried out and data were organized in two main categories: professional’s perception of child discipline and practices about childhood discipline: are there opportunities for promotion in the FHS? Results: There is still no routine approach to child discipline in any of the studied clinics, nor are activities carried out to prevent abuse. Professionals related their personal experiences (lived in their own childhood and with their children) with actions carried out in their daily practice. Conclusions: Reports suggest that the approach to corporal punishment remains hidden in childcare care, with loss of opportunities to support parents and to promote positive family bonds. Based on significant changes in violence perception, professionals can reframe their beliefs, expanding their actions on the topic.

Keywords: Family health strategy. Child education. Punishment.
INTRODUCTION

Violence is a complex, polysemic phenomenon, which still remains a challenge in the field of health.¹ Children are especially subject to intrafamily violence that occurs in hierarchical and intergenerational relationships, with the resolution of interpersonal conflicts in an aggressive manner. The consequences of these acts vary according to their magnitude, frequency, and especially the stage of emotional, cognitive, and physical development of the child, impacting the construction of their affections, their self-esteem, and their future bonds.²⁻⁴ In the last decades, the fight against violence against children has become a priority for national and international organizations, with the prohibition of degrading treatment and corporal punishment in several countries, including Brazil.⁵⁻⁶ However, these recommendations are not enough to promote behavior changes of parents and caregivers, who continue to believe in corporal punishment as an effective disciplinary strategy.⁷ The choice to use violent discipline is not necessarily carried out with the objective of perpetrating physical aggression, but due to the lack of knowledge of alternative methods of education, and frustration in face of misbehavior can lead to escalating severity of the acts committed.⁸⁻¹⁰

According to the United Nations Children’s Fund (UNICEF), three quarters of children aged two to four years worldwide (300 million) suffer psychological aggression and/or physical punishment, victims especially of their caregivers.⁴ In Brazil, violent educational methods are also widely used, and it is difficult...
to estimate their magnitude with precision, given the still hidden nature of family violence in society and
the difficulties in registering its occurrence.\textsuperscript{11,12} Currently, in the midst of the new coronavirus pandemic, the
accumulated tensions amid fears about the disease, the intense family coexistence resulting from social
isolation, the overload of domestic tasks due to the remote work model, and the lack of employment and
income are already aggravating conflicts and violence in many homes.\textsuperscript{13,14} Studies have been drawing
attention to the increase in cases of violence against women, children, and adolescents, and warning
and protection campaigns have been intensified.\textsuperscript{14,15} Official data from the State Public Ministry point out
that, in the first weekend after the publication of state decrees with social distancing rules, Rio de Janeiro
recorded a 50\% increase in domestic violence cases.\textsuperscript{15}

There have been recommendations and educational programs to guide parents and caregivers about
healthy discipline methods since the late 1980s.\textsuperscript{16,17} Despite this, addressing violence against children is
still not a routine within the scope of health services, as it is considered a stigmatized topic, avoided by
many professionals in their practice.\textsuperscript{12,18,19} Based on the reorientation of Primary Care (PC) in Brazil, the
tools available for parents to care for their children is in the scope of action of Family Health Strategy (FHS)
professionals, and its objective would be to collaborate for healthy growth and development, in addition
to ensuring their rights.\textsuperscript{20} Comprehensive care for children presupposes accountability and the formation
of a bond between professionals and the assisted family, which goes far beyond the biomedical aspects
related to the adequate diet or up-to-date vaccination, including the need to cover topics related to family
dynamics, including disciplinary and relational aspects.\textsuperscript{21}

Considering the expansion of the FHS in the city of Rio de Janeiro, the high levels of violence
in the city and the challenges that this level of care still faces in terms of qualification and retention of
professionals in the teams, it seems opportune to approach the topic in this context. The present study
aimed to know the approach of the family health team in relation to the methods of child discipline used
within the family in two family clinics in the city of Rio de Janeiro.

METHODS

The study had a qualitative approach and relied on the application of interviews with a semi-structured
script, with reference to health professionals working in two family clinics in program area 3.1 in the city
of Rio de Janeiro. The choice of scenario took into account the large demographic concentration, the
existence of areas of social vulnerability and, above all, the wide offer of health services, with emergency
and university units that could facilitate the approach and awareness of cases of violence against children.\textsuperscript{22}

Family clinics were randomly selected among those that had been in operation for more than five
years, with a number equal to or greater than five teams and with a Residency Program in Family and
Community Medicine. All professional categories involved in the daily care of children were invited to
participate in the research (doctors, nurses, community health agents (CHA), and nursing technicians).
Professionals who had less than one year of experience in the units were excluded.

The interviews were guided by a semi-structured script with 13 questions and divided into three
parts: the first sought to outline the profile of the interviewee according to their academic background and
professional performance, and the others dealt with personal and professional perceptions and practices
in relation to the topic. Two analytical categories were previously defined, namely, “FHS professionals’
perception of child discipline” and “practices related to childhood discipline: are there opportunities for
promotion in the FHS?”
In the period between September and October 2019, 38 interviews were carried out, distributed as follows: 15 interviews with CHA; seven with doctors; seven with nursing technicians; and nine with nurses. The final number of participants was determined by the saturation criterion. The meetings were individual and took place during the workday in a reserved room, after the acceptance of the eligible subjects. The speeches were recorded and later transcribed by the main researcher. Each interview lasted approximately 15 minutes, including the time required to present and sign the informed consent.

Content analysis was performed according to the planned stages of organization, coding, categorization, treatment, and interpretation of the results, in parallel with data collection. Initially, the systematization of the initial ideas was carried out, considering the pre-analytic categories related to the research objectives. The fluctuating reading of the material made it possible to identify the reality researched, with subsequent grouping of data through their organization in the respective categories. At this stage, the professionals interviewed were coded, thus maintaining their anonymity. After performing a new reading, it was possible to identify words and excerpts that served as encoders of themes related to pre-analytical categories. The categorization criterion was semantic, and the emergence of new categories or subcategories was not observed.

The project was approved by the Research Ethics Committee of Universidade Estácio de Sá, under Protocol No. 3392836, and by the Research Ethics Committee of the Municipal Health Department of Rio de Janeiro, under Protocol No. 3533203.

RESULTS AND DISCUSSION

The selected units had a total of 107 eligible professionals, including 12 nurses, 23 physicians, 62 CHA, and 10 nursing technicians. It was not possible to capture the experience of nine professionals who were on vacation (7) or leave (2) and two losses occurred because the participants had to interrupt the interview for urgent care. During the collection, there were eight refusals whose reasons involved embarrassment in the face of the recording and difficulty in interrupting their tasks for the interview. Due to the uncertain situation regarding the links with the units and the delays in the payment of salaries, the frequency of professionals was reduced during the period of the interviews and some could not be found (16).

After skimming the transcripts, it was noticed that the speeches obtained in the two studied units were very similar, and the analysis was performed in a grouped manner. Most respondents were female (33) and had children (28), and the mean age was 32 years, ranging from 21 to 55. Most physicians (4) were resident recent graduates without specialization. All nurses interviewed had a degree or were in a postgraduate course or residency in Family Health. None of the CHA or nursing technicians had experience or previous training in this field, in addition to the Introductory Course that is completed upon admission.

The data were categorized into two axes, namely, “Perception of FHS professionals on child discipline” and “Practices about childhood discipline: are there opportunities for promotion in the FHS?”, in line with the research objectives. To avoid identifying the respondents, abbreviations according to their respective professional categories were used.

Perception of Family Health Strategy professionals on child discipline

Although all respondents reported a previous personal history of violent discipline, most found it natural for children to be spanked in certain situations. A certain trivialization and invisibility of violence
was observed when it had educational purposes. Some professionals reported that they tried to change the patterns experienced in childhood, however they admitted that at times they ended up using physical or emotional violence and not seeing alternatives to their violent practices.

*A lot is said about conversations, right, but I think that sometimes a little pat is not an aggression, no, sometimes the child is too much of an imp, then you give them a little flick to get attention, but always talking, explaining what they did wrong and all, to see if they understand.* — NUR 1 A.

* [...] in reality, it is a paradigm shift, I am trying, it is a daily exercise for me and my husband not to repeat these processes. I’ve used spanking already, but with a lot of heartache, nothing compared to what my father did to me or my sister, without a shadow of a doubt. I hit them with my hand and at most a slip.* — NUR 1 B.

* [...] mine, I tried to give more affection than I had, correcting what was wrong, I would ground them, if they did something wrong I would take away a toy, the TV, sometimes it was necessary to spank, to use slippers, hands, a wand of guava sometimes (laughs). When they cross the line I yell, with the little one, she is very naughty, and I don’t have that much patience, so I’m not gonna lie, sometimes I yell, I slap her butt.* — CHA 5 A.

There is a strong “common sense” about early childhood education through violence in childhood, with the use of physical force and degrading punishment, especially when children are “more undisciplined” and “do not respond” to the demands of their parents or caregivers. It seems that learning by force could better shape childrens’ characters, preparing them for the challenges that life is sure to bring. They are social representations that strongly interfere in family behaviors, serving as references transmitted between generations. The culture of corporal punishment is so strongly represented socially that even families that do not believe in its effectiveness tend to use them at some point, and the positive education, seen as an alternative to violent discipline, remains little recognized and sometimes discredited.

Currently, there is ample reflection on the subject and even a certain weakening of the permission of these violent practices, with a wide normative apparatus. Actions aimed at the abolition of all types of violence against children are even set out in the Sustainable Development Goals (SDGs), in addition to having a strong presence in the media. However, it seems that the advances brought by the current debate, as well as by studies and policies, are not enough to transform the ideas and feelings of professionals, who somehow follow the current culture and the social representation of the use of corporal punishment. Their practices remain strongly determined by their own experiences, lived in childhood and as parents. From the perspective of the explanatory ecological model for the occurrence of violence, the previous experience of violence in the family of origin is an important vulnerability factor, and the experiences and maternity/paternity patterns are maintained across generations. Even in the face of new ideals of affective relationships, respect for diversity and recognition of the social role of childhood, the use of authoritarian resources for conflict resolution remains.

Considering the reports regarding the acceptance of corporal punishment and the minimization of its effects on the development of children, it would be difficult to imagine that the teams’ perspective on the subject was different. It seems opportune to reflect on the reasons for this apparent maintenance of opinions, which may be related to gaps in knowledge about the multiple consequences of violence on
Use of violent discipline in childhood and on the possibilities of professional action in promoting good treatment. It is worth mentioning that spaces related to health care present themselves as propitious and opportune places for the detection and approach of situations of violence against children. The abolition of the practice of corporal punishment would need to go through a dialogic and educational process of social reflection, with the active participation of health professionals and other categories that work in closer proximity to children and their caregivers.

Practices about discipline in childhood: are there opportunities for promotion in the Family Health Strategy?

The analysis of the reports clearly showed the absence of activities specifically aimed at addressing corporal punishment. The interviewees referred to performing classic childcare (assessment of growth, development, vaccination) and acting in the face of common childhood ailments as routine, not mentioning guidance on relational or behavioral issues. The factors identified as limiting this practice involved both aspects related to professional training and the short time available for the teams.

The identification, intervention, and follow-up of cases of abuse still raise doubts. The lack of skills and competences on the part of health professionals to deal with situations, the involvement of families, the lack of conceptual standardization of the different types of abuse, and the precarious institutional support interfere in the confrontation of child violence and configure the challenges to be overtaken.
children were witnessed, in cases considered mild or when there was no bond with the user, the discipline
guidance did not occur or was carried out in a punctual and reactive way.

[...] if I know the family, I even say something if I see them being spanked and such, but when I don’t
know them, I don’t usually get involved, no, unless I see the mother “beating” the child, but that’s it.
I’ve never seen it here either. – NUR5 B.

[...] it’s difficult here because it’s a community, trafficking also makes it difficult sometimes for us to
talk, to approach a case that we’re afraid of having some kind of reprisal. Because there are some
people that the family, the husband, are involved in it, I’m not going to take a case like that to a
guardianship council instance because I’m afraid, you know, of exposing myself, then we end up
without many ways out. – CHA 2 B.

Professionals seem to identify some possibilities for promotion actions, highlighting the integrality
of care and exemplifying the school as a unique space for socialization and cultivation of good relational
practices.\textsuperscript{39} Most respondents perceived the importance of equipping parents on aspects of childcare
and suggested some initiatives mainly related to health education. It was observed that the ideas pointed
out were still very far from everyday life and disconnected from the broader concept of health promotion,
including its social determinants, involving autonomy, popular participation, and other sectors beyond
education.\textsuperscript{40} Although the broad concept of health is already clear to the entire team, the attitude of
“guardianship” toward users is still common, with prescriptive attitudes far from deeper and more complex
issues of health promotion, which include knowledge and social context.\textsuperscript{32,41}

Thus, although the FHS is the place where the child is frequently accompanied, constituting a window
of opportunity for adequate guidance for families, little progress has been made in the construction of
prevention, reinforcement, and support practices in the development of non-violent forms of discipline,
which is a gap still found in services in general.\textsuperscript{12,42} Reports show that prenatal care and childcare itself
do not cover actions capable of strengthening relationships between parents and children, promoting
good treatment, strengthening the bond between mother and child, and transforming attitudes capable of
building a healthier family life.\textsuperscript{43-45}

The literature highlights the potential of longitudinality in care as a possibility to get to know the user,
their social context, life habits and health problems, allowing for adequate and resolute interventions.\textsuperscript{46,47}
Comprehensive care for children requires a differentiated look from the professional, and training and
Permanent Health Education (PHE) are highlighted as essential for the prevention, identification, and
confrontation of violence.\textsuperscript{48} PHE has the work process as an object of transformation, based on the critical
reflection of professionals about what is happening in the daily life of the services and seeking solutions
together with the clientele for the problems encountered.\textsuperscript{49} However, many of these initiatives start from
a conception of instrumental education, with emphasis on specific, fragmented, and decontextualized
actions of the daily life of the services, which need to be rethought for better reflection of professionals
about their practices.\textsuperscript{50}

[...] this is a topic that has the possibility of creating some groups here in the clinic and also in the
school from the [Health at School Program] PSE, we can give visibility to this topic in these spaces,
and then use the spaces already in the community and talk about this and other topics that need
visibility, in the elderly group, the dance group, there are many fathers and mothers there, we can use this to discuss this topic. – NUR 3 AV.

[...] I think that in these meetings that we have, maybe we could talk before it happens, in meetings with prevention families, we had Golden August here, where several topics were addressed, weaning, pot training, we could talk about discipline too, the same way we approach feeding, weaning, pot training, and address this issue too, leave the office a little. – NUR 6 JT

[...] I think that one possibility is educational actions, thus, bringing together several mothers, even pregnant women, and then forming a group, starting this discussion... How do you intend to raise your child? How would you act in this situation? What do you understand by punishment? Promote this reflection among them. – DOC 4 JT

CONCLUSION

The results seem to point out that, despite the recognition of children and adolescents as subjects of rights and the implementation of a legal system of protection against all forms of violence, there are still no effective actions within the scope of the FHS aimed at eliminating physical punishment and other forms of violence. Violent discipline, although rationally condemned, remains socially accepted and professionals themselves have difficulty changing their intra-family practice, strongly anchored by social representations. For this reason, it seems of special importance to create systematic opportunities for teams to reflect on the serious consequences of violent discipline, breaking transgenerational cycles that reinforce coercive education as a path to discipline. Professionals need to be encouraged to seek information on the subject, realizing that this corporal punishment is considered violence against children and has serious consequences on their full development. When they see their role as promoters of good treatment, always in partnership with the community served, it may be possible to create powerful local initiatives to reinforce healthy affective relationships, respecting differences and combating the practice of all types of violence.

It is worth noting that, given the complexity of the topic, the FHS (and other health units) have limited action and are dependent on other sectors of the society. Interventions focused solely on changing attitudes about violent discipline seem ineffective. Appropriate prevention and management of cases of child violence must cover the various contexts and family circumstances in which they occur and require joint and integrated actions, involving professionals from different areas working closely with children, society, Guardianship Councils and other protection institutions. Therefore, it is necessary that each social actor recognizes its responsibility in this process and has adequate conditions to act.

Especially in this moment of pandemic, when the vulnerability of children and adolescents is increased and access to the social support network is reduced, it is essential that health professionals are even more aware of their role as promoters of positive educational practices. Activities such as home visits allow professionals to get closer to the reality of users and are opportunities both for the detection of risk situations and for offering guidance to caregivers. It is important that social isolation is modified based on the collaboration of FHS professionals and its integration with other sectors, helping to bring family members closer, reinforcing support networks and educational alternatives in the community where they work.

The study carried out has limitations in terms of the population and small sample size when considering a specific area (section 3.1), which makes it possible to interpret the results found with less...
generalization capacity. However, it is possible that the perceptions and absence of practices aimed at corporal punishment reported here also occur in similar services, located in large urban centers and with an organization similar to that of the FHS. Here is not the place to blame, once again, health professionals for their social responsibility in this matter, but to show that gaps remain in the scope of services. By bringing visibility to the consequences of corporal punishment and the possibilities of using non-violent discipline, it is expected that the proposed reflection will bring developments in the practices of the teams, such as the development of expanded lines of care for children and their families. It is likely that, with significant changes in the perception of what is considered violence in family relationships, professionals can re-signify their beliefs and expand their actions in the community.

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CONFLICT OF INTERESTS

Nothing to declare.

AUTHORS’ CONTRIBUTIONS

SMS: Project administration, Conceptualization, Data curation, Writing – original draft, Writing – review & editing, Investigation, Methodology, Funding acquisition, Resources, Software. ATMSM: Project administration, Formal analysis, Conceptualization, Writing – original draft, Writing – review & editing, Investigation, Methodology, Funding acquisition, Resources, Software, Supervision, Validation, Visualization.

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