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To Spank or Not to Spank

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Compensation Program (NVICP) and, in our opinion, does not create a known ascertainment bias. In addition, similarities in the presentation and clinical/pathological findings of central nervous system illness (encephalopathy) after both natural measles and measles vaccine demonstrate biologic plausibility that measles vaccine might cause encephalopathy.

With regard to the "ultimate irrelevance of biologic plausibility to the Compensation Board," we agree in part. Pediatricians practicing during the 1980s may well remember the vaccine causation controversy surrounding DTP immunization that led to a liability crisis and, ultimately, enactment of the NVICP. Congress set up the Vaccine Injury Table (VIT) to avoid disagreements over causation by making temporal association an important eligibility element for listed conditions. Although biologic plausibility is an important standard for assessing causation in medicine, it is less important in law. In the case of the NVICP, the statute provided for a "legal presumption of causation," if encephalopathy onset occurred 0 to 15 days after measles immunization. (The time interval on the VIT was changed subsequently to 5 to 15 days to better reflect the expected time period of viral replication.) On the other hand, claims alleging "table" conditions with onset outside the time interval, or conditions not listed on the VIT, gain eligibility for compensation only after scientific evidence of causation is proven.

Dr Sepkowitz concludes with the opinion that "this investigation is yet another attempt to establish an adverse event from a vaccine. . .and by ignoring or minimizing years of descriptive epidemiology on reactions." Epidemiology is limited in its ability to allow conclusions on extremely rare events such as encephalopathy following measles vaccine and is essentially quiet on this issue.

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To Spank or Not to Spank

To the Editor.—

The new discipline policy, "Guidance for Effective Discipline,"[1] of the American Academy of Pediatrics (AAP) is seriously flawed. Despite an excellent discussion of parental nurturance and positive reinforcement strategies, the policy statement is ill-founded and unrealistic in its account of corrective strategies, especially in its critique of disciplinary spanking.

To develop an unbiased, scientific analysis of the current research on corporal punishment, the AAP co-sponsored a consensus conference 3 years ago in which I participated. A 13-point consensus statement was drafted by the conference panel of experts. Concerning the use of corporal punishment by parents, the panel could not find sufficient data to proscribe the use of spanking with children between the ages of 24 months and preadolescence. A literature review presented at the conference actually found stronger evidence for beneficial than detrimental effects of spanking with 2- to 6-year-old children.[2] The co-chairs of the conference concluded, "Given a relatively ''healthy' family life in a supportive environment, spanking in and of itself is not detrimental to a child or predictive of later problems."[3]

The new AAP discipline policy statement largely ignores the consensus conference statement and, instead, selectively plucks from the conference proceedings several allegations of the avowed spanking opponents, without acknowledging the presentations of other participants. Eleven of the 13 citations in the policy statement to support its unconditional antispanking position in the "supplemental information" section concern presentations of antispanking participants at the consensus conference, not original research.

To support its antispanking position, the policy relies on weak, nonfocused research and ignores solid data to the contrary. For example, the policy claims that spanking leads to aggression, though the best studies indicate a neutral to positive effect of spanking on childhood aggression.[4] Two years ago, Gunnoe published a study finding that the use of spanking with 4- to 7-year-olds was associated with reduced antisocial behavior, and noted that "for most children, claims that spanking teaches aggression seem unfounded."[5] By contrast, the policy relies on sociological studies by Graziano and Straus which did not muster sufficient approval of the consensus panel to influence the final consensus statement.

In addition to its troubling data selection and review biases, the new policy unnecessarily handicaps parents of young children. The only corrective methods condoned in the policy are time-out, infrequent verbal reprimand, and privilege removal, with time-out being the primary method acceptable for young children. Time-out is described as being effective only if "used consistently . . . not excessively, and with strategies for managing escape behavior." Its correct implementation may even require "special education with a professional." What about the parent who, for various reasons, may be unable to implement time-out correctly? For the average toddler, who can require correction every 6 to 8 minutes,[6] how can a parent avoid overusing time-out when other methods are not allowed? The consensus panel concluded that *reliance* on any one corrective method will diminish its effectiveness.[7] Following the new policy's guidelines with young children could lead to precisely such ineffective overuse of time-out. Parents need more disciplinary options, not fewer, to deal with the many different behavioral situations and child temperaments.

It is troubling that our Academy would espouse an "all or none" blanket condemnation of spanking founded on selective and biased citations of the research. Making this the primary theme of the policy statement cripples the effectiveness of the policy as a whole. Such Academy positions purportedly based on science will in the long run harm the credibility of the Academy. We need to do a better job building on the review of the consensus panel published in *Pediatrics* in October 1996, rather than ignoring it.

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To the Editor.—

The recent "Guidance for Effective Discipline" published by the American Academy of Pediatrics (AAP)[1] is outstanding in its overview of discipline and on several specific issues (eg, time-out), but it is prematurely one-sided in its preference for time-out versus disciplinary reasoning and its position on nonabusive

spanking. By failing to represent the range of research-based conclusions on these two issues, it explicitly opposes most leading textbooks in child development,[2–5] the only systematic review of the literature on child outcomes of nonabusive spanking,[6] and the disciplinary responses that mothers actually use for two-thirds of the misbehavior incidents of 2- and 3-year-olds.[7,8]

The first one-sidedness concerns two distinct scientific literatures on parental discipline—child psychological and clinical behavioral. By ignoring child psychologists' preference for disciplinary reasoning[9–11] and by siding almost solely with behavioral clinicians' preference for time-out, the AAP discipline statement directly contradicts most leading textbooks in child developmental psychology.[2–5] It also ignores important work integrating the two perspectives, including research showing that disciplinary responses combining reasoning with punishment are especially effective, even for children as young as 10 to 29 months old.[7,8,11–13]

On the second controversy, the AAP discipline statement ignores 12 of the 13 consensus statements of the 1996 conference on corporal punishment[14] and the only systematic review of child outcomes of nonabusive spanking.[6] Most citations in the 1998 AAP discipline statement refer to presentations of the absolutist antispanking advocates at the 1996 conference, even though none of those cited points was reflected in the 1996 conference consensus statements[14] or even in its post-conference "qualifying statements."[15] Thus, the AAP discipline statement incorporates an absolutist antispanking rebuttal to the more centrist 1996 consensus conference.

Due to such one-sidedness, the AAP discipline statement explicitly opposes mothers' actual disciplinary responses to 67% of the misbehavior incidents of 2- and 3-year-olds,[7,8] including all the ones that were most effective at delaying subsequent recurrences of similar misbehavior, eg, a combination of reasoning and nonphysical punishment.[7]

The one-sidedness on these two issues is somewhat understandable, because clinicians who treat disruptive children see parents misusing reasoning and spanking as well as other discipline responses. It is easy for such professionals to let their hearts get ahead of their heads, thus ignoring the range of relevant scientific evidence.

On one of these issues (spanking), the famous psychologist Hans Eysenck made the following important points to the British Psychological Society 5 years ago: "Our sole justification for being taken seriously in the field of social policy is precisely that our advice is based on rigorous research evidence; if it is not, we are no different from the usual run of lay commentators making contradictory suggestions. Psychiatrists arguing vociferously on opposite sides in court have brought the profession into disrepute; we should avoid similar disasters. . . . When the evidence is in, we should certainly speak up; to do so when the evidence is uncertain, confused and contradictory is not in the best interest of psychology as a science."[16] The Academy should heed such sound advice, for the welfare of the Academy as well as the families and children it serves.

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In Reply.—

The letters by Drs Trumbull and Larzelere raise concerns about the recent AAP policy statement "Guidance for Effective Discipline."[1] Trumbull and Larzelere are concerned that the statement is "unrealistic" because most parents spank their children and that it does not reflect the AAP-sponsored consensus conference.[2] It is because most parents spank that such a policy statement is needed. Trumbull raises concerns that this statement removes options for families; that besides time-out "other methods are not allowed." It is with a goal of long-term change that the Academy statement "recommends that parents be encouraged and assisted in the development of alternative methods other than spanking for dealing with undesired behavior."[1] Certainly teaching parents a variety of strategies is encouraged in the statement but only a few could be elaborated. In fact nine references were provided for articles discussing techniques other than time-out. Dr Larzelere is to be commended for his unique naturalistic research on discipline of 2- to 3-year-olds and the effectiveness of including reasoning.[3] The AAP statement does not ignore the literature as he asserts but specifically notes factors that improve effectiveness of discipline including "clarity on the part of the parent and child as to what the problems behavior is," "delivering instruction and correction calmly and with empathy," and "providing a reason." The AAP is not a police body that disallows child-rearing techniques. It is a body that strives to bring information to its membership when the health and well-being of children can be improved by this knowledge, especially when a practice is common and in need of change. Pediatricians are respected, at least by the AAP, for their ability to incorporate new knowledge and apply it through their own clinical skills with their particular populations.

We are gratified that these critiques recognize the broad focus of the AAP statement, which discusses discipline as a system with parental nurturance and positive reinforcement as the two most important of the three basic components. Spanking was only one area addressed but stands out as one in need of change because of its ineffectiveness, side effects, and the frequency of its misuse. Trumbull and Larzelere assert that the AAP-sponsored consensus conference on corporal punishment "found stronger evidence for beneficial than detrimental effects of spanking 2- to 6-year-old children." The studies being cited included a total of 164 children in 8 studies, excluding the 1 child case study. Of these, 127 received two spanks as a backup to time-out only when needed. The main author of the studies of these 127 (Roberts) also found that spanking was no more effective than briefly placing the child behind a barrier when needed as a backup to time-out.[1] Only in Larzelere's 38 subjects were spankings given by parents as a primary punishment, which is how families most commonly use it. In a subsequent study replicating Larzelere's, Sather[5] found that the positive effect of punishment on reducing fighting recurrence, which Larzelere uses to defend the general use of spanking, occurred whether corporal or noncorporal backup was used. Thus, there were zero studies presented at the consensus meeting or in Larzelere's own unique review of the literature that found spanking to be more effective than other methods. Certainly using

time-out is often difficult and requires many repetitions and a great deal of self-control on the part of the parent; that is the nature of learning in children and of raising them. We shouldn't underestimate parents' (or pediatricians') ability to change just because it is difficult.

A critical but perhaps subtle aspect of the consensus report has to do with the age of the child who might be spanked. The consensus conclusions clearly state that "currently available data indicate that corporal punishment, as previously defined (spanking), when compared with other methods of punishment, of older children and adolescents is not effective and is associated with increased risk for dysfunction and aggression later in life." Trumbull, Larzelere, and almost all other professionals who endorse spanking of preschoolers are ignoring the fact that parents do not stop this practice as the child ages even though clear detrimental effects are evident by age 7. Straus has found that 60% of 12-year-olds, 40% of 14-year-olds, and 25% of 17-year-olds are still spanked by their parents (on average 8 times a year for the 13- to 14-year-olds).[6] This figure is derived from two large surveys of 1146 and 3229 parents based on spankings reported by only one parent and thus probably understate actual use. Spanking may be difficult to stop in part because its use makes less painful techniques less effective. Thus, even if spanking were not detrimental in toddlers and preschoolers, its use should be avoided from the youngest age and other methods substituted to establish effective means that can be continued as the child matures.

AAP policy statements are based on findings from many kinds of research studies that are not always comparable and generally not designed to direct pediatric practices. The conclusions needed to guide practice must come from expert opinion about data different from that required for a research program. The AAP sets out goals towards which pediatricians should strive. Just as for civil rights in America, sometimes society, in this case pediatric society, has to espouse something unpopular before the data is complete (or can ever be) to lead in raising consciousness.

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AAP Committee on Psychosocial Aspects of Child and Family Health

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Following is a reply/rebuttal from Dr Trumbull.

In Reply.—

Dr Wolraich quotes from the consensus committee findings published in the October 1996 supplement to *Pediatrics.* To this quotation, "currently available data. . .", he has added "(spanking)" after the term corporal punishment.

As an active participant at the conference, I specifically recall the reason we added the qualifying phrase "as previously defined" after the term corporal punishment. The committee took great pains to distinguish the terms "spanking" and "corporal punishment." Spanking is a subset of corporal punishment. The latter covers all forms of physical punishment including abusive practices like punching, face-slapping, kicking, scalding, etc. Spanking is defined as physically noninjurious, intended to modify behavior, and administered to extremities or buttocks.[1]

No study of corporal punishment with older children (ages 7 to 12 years) and adolescents finding detrimental effects explicitly limited its use to the nonabusive forms defined as "spanking" at the conference. Therefore, the consensus statement only warns of detrimental effects of corporal punishment (broadly defined). There were studies of corporal punishment, limited to "spanking," that showed no detrimental effects on older children.[2] For this reason, the committee specifically qualified the term "corporal punishment" with the phrase "as previously defined" to bring this important point to the reader's attention.

The term "spanking" in parentheses should be deleted from the quotation in Dr Wolraich's letter because it is inaccurate, misleading, and directly contradicts the intent of the quoted statement.

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Effectiveness of RSV-IVIG in Premature Infants: Success in the Home

To the Editor.—

The efficacy and cost-effectiveness of respiratory syncytial virus immune globulin (RSV-IVIG) (RespiGam; MedImmune Inc, Gaithersburg, MD) as prophylaxis has been examined and challenged in many arenas. A letter to the editor, published in the February 1998 edition of *Pediatrics,* submitted data from the Children's Hospital and Health Center, San Diego and Sharp Mary Birch Women's Hospital neonatal intensive care unit. Their data described very poor compliance with subsequent RespiGam infusions and questionable benefit. SpectraCare's experience in the home care setting shows, quite distinctly, an increase in parental compliance, efficacy, and cost-effectiveness of respiratory syncytial virus (RSV) prophylaxis with RespiGam.

During the 1997–1998 RSV season (October 1997 to April 1998), 228 doses of RespiGam were administered by SpectraCare Home Health, Louisville agency, to 60 infants deemed eligible by the ordering neonatologist or pediatrician. The infants met Food and Drug Administration and American Academy of Pediatrics guidelines for inclusion in a RSV prophylaxis program. The vast majority of our infants, 83%, were referred by the Neonatal Follow-up Program of the University of Louisville School of Medicine. The remaining patients were referred to SpectraCare's program by other neonatologists and pediatricians in the Louisville metropolitan area.

Compliance with full-season prophylaxis, cost-effectiveness, decreased stressors on parents, and nursing expertise were all factors the physicians considered when choosing to administer RespiGam in the home. The 1997–1998 season was the second complete season of RSV prophylaxis for SpectraCare's Pediatric Program. All infants received their first dose in a hospital setting, either inpatient or outpatient, to assure no adverse reaction to the drug. Subsequently, our specialty pediatric home care nurses traveled the states of Kentucky and Indiana to administer remaining RespiGam doses to infants in their home environments. The nurses established intravenous (IV) access, infused the RespiGam, and remained in the home throughout and 30 minutes after each infusion. Our nurses averaged 1.98 access attempts per dose, with a 58% first attempt success rate.

Our patient population was comprised of 56.14% infants of 28 weeks and younger gestation and 40.34% from 29 to 32 weeks' gestation. Ages of the children included: 68.42% were 0 to 6 months of age and 21.05% were 7 to 12 months of age at season's onset. Of the total population, 12.5% were on home oxygen. Of the doses received, 45.62% had 1 to 3 doses and 54.39% had 4 to 6 doses administered by SpectraCare in their homes.

A majority of patients, 89.4%, completed the season's doses. Of the 10% in the incomplete group, 7% were attributable to diagnosis with active RSV, at which point the neonatologist chose to forego further doses. The other 3% were incomplete because of venous access difficulty. These cases occurred in March, and the physician chose to omit the last dose because the children had received 4 doses and upon assessment were doing well. These children remained RSV-free on followup post-RSV season.

Within the total patient population, only 3% experienced a RespiGam-related reaction during their home infusions. The recorded reactions were comprised of rash and fever. All were successfully treated with oral Tylenol and Benadryl, and the RespiGam infusion was completed.

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