A Home Based Behaviour Management Program and Children's Dinner Time Behaviour Problems

By Gregory Smith and Dennis Ford

Gregory Smith is a therapist with the Home Based Intervention Program of Adelaide Central Mission Child Care Services.

Dr. Dennis Ford is consultant psychologist for Adelaide Central Mission Child Care Services.

Parents in two families were experiencing difficulties in the management of their children's behaviour. One particular time of difficulty was at dinner. The specific interventions to decrease this dinnertime difficulty, and the general outline of a behavioural home based approach used with both families are described. Levels of appropriate behaviour increased markedly in both families.

Defining the Problem

In families in which the children are exhibiting behaviour problems, a common time of conflict can be dinnertime. This disruption over mealtimes can be the most annoying source of conflict, a climax to a tiring and frustrating day for a number of mothers.

It can be particularly exasperating for the "harassed" mother who is tired after looking after the children, to have cooked a wholesome meal, only to find the children too "active" or disruptive to sit down and eat it. Having bought, organised and cooked the dinner for her children, the mother may then find herself chasing the children to eat it.

Fortunately, many mealtime disturbances are among the most easily resolved of conflicts.

The following outline is of a home based intervention program used with two different families in which one major problem was the children's behaviour at dinner. The intervention program took place in the home and dealt with parent/child interaction and child behaviour.

In both cases mealtime was a problem, and the early focus on this specific area of conflict enabled the parents to rapidly experience success in managing their children's behaviour. This experience of success was helpful for the parents' confidence and further motivation to work for change in other areas of difficulty.

Three areas shall be focussed upon in the following paper:

1) the general approach taken in the home-based program.
2) the specific intervention regarding mealtime behaviour.
3) other changes in the lives and outlooks of the parents subsequent to the interventions.

General Approach

The intervention program used is home-based in that the therapist actually works with the family in the home. The therapist often works in the home at times when the parents may be experiencing most difficulty. This enables the therapist not only to offer support to the family but to act as a model for how to handle situations of concern to the family.

After an initial interview in the therapist's office to determine suitability of the family for the program and to explain the general procedures of intervention, contact is made in the home.

Before intervention the therapist spends time as an observer in the home to observe patterns of parent/child interaction. This is followed by a baseline period (typically one week) in which the family collect data relevant to the focus of treatment with minimal therapist contact.

The intervention itself is based in a behavioural approach, but is varied with each family to be maximally effective for each family's particular situation. It is essentially a skills training program. It has advantages over group instruction or other office based intervention in that it allows:

1) Modeling in the home in the specific situation of difficulty
2) Monitoring and corrective feedback to be given on the spot
3) Support to be given directly during stressful periods
4) Removal of the difficulties inherent in generalising from a group or office situation to the home situation.

Basic inputs typically include:

1) A strong emphasis on positive reinforcement i.e. notice and act when the child is being good to strengthen his appropriate behaviour
2) Training in techniques to weaken the strength of misbehaviour, (e.g. response cost, extinction, time-out).
3) How to define and record behaviour for change
4) Discussion of parental expectation of the child (e.g. is what the parent wants appropriate for the child's age?)
5) Training in communication skills.

Working in the home allows other issues which affect the parent/child relationships (e.g. parental resentments, conflicting parental style, marital problems, depression, home management) to be seen and whether be dealt with by the therapist or be referred to a suitable agency.

The Families:

The composition of the two families was as follows:

Family A: Single mother with three boys, aged 6, 3½ and 2 years.

Family B: Mother and father with two boys aged 3½ years and 19 months.

The presenting problems of Family A were non-compliance, defiance and tantrums exhibited by all children.

The presenting problems of Family B were for the 3½ year old: "hyperactivity", non-compliance, sulking and shouting.

Both families referred to dinnertime behaviour as a particular area of conflict, with the children in Family A described as "refusing to eat" at dinnertime.

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Figure 1. Family A

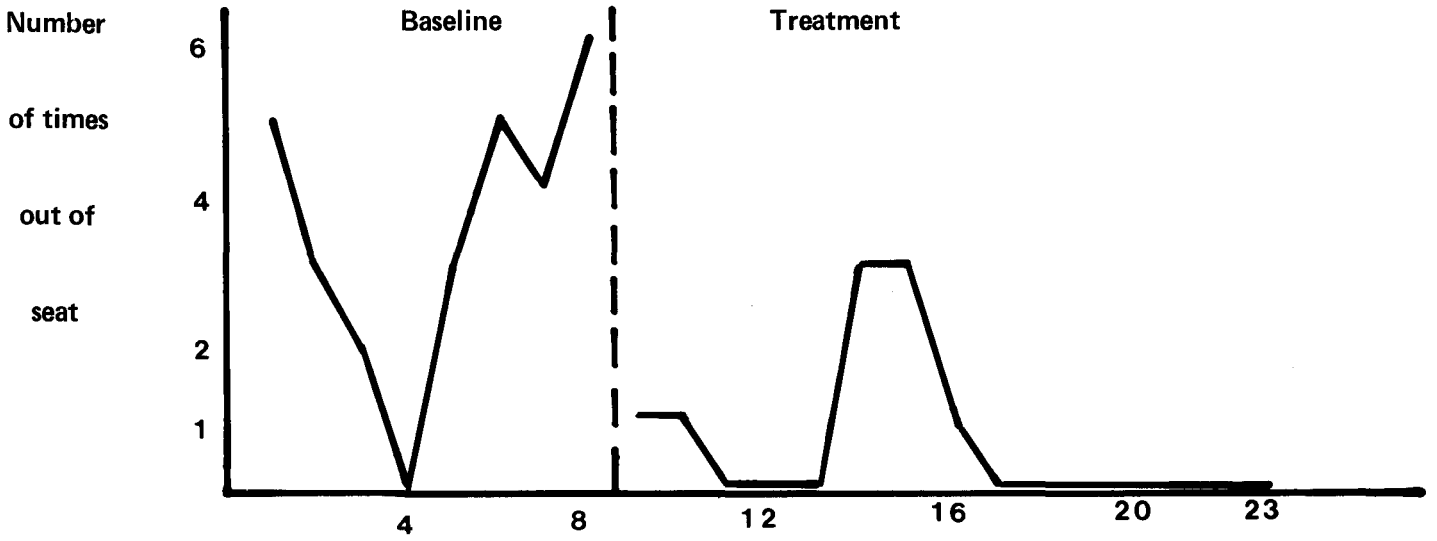
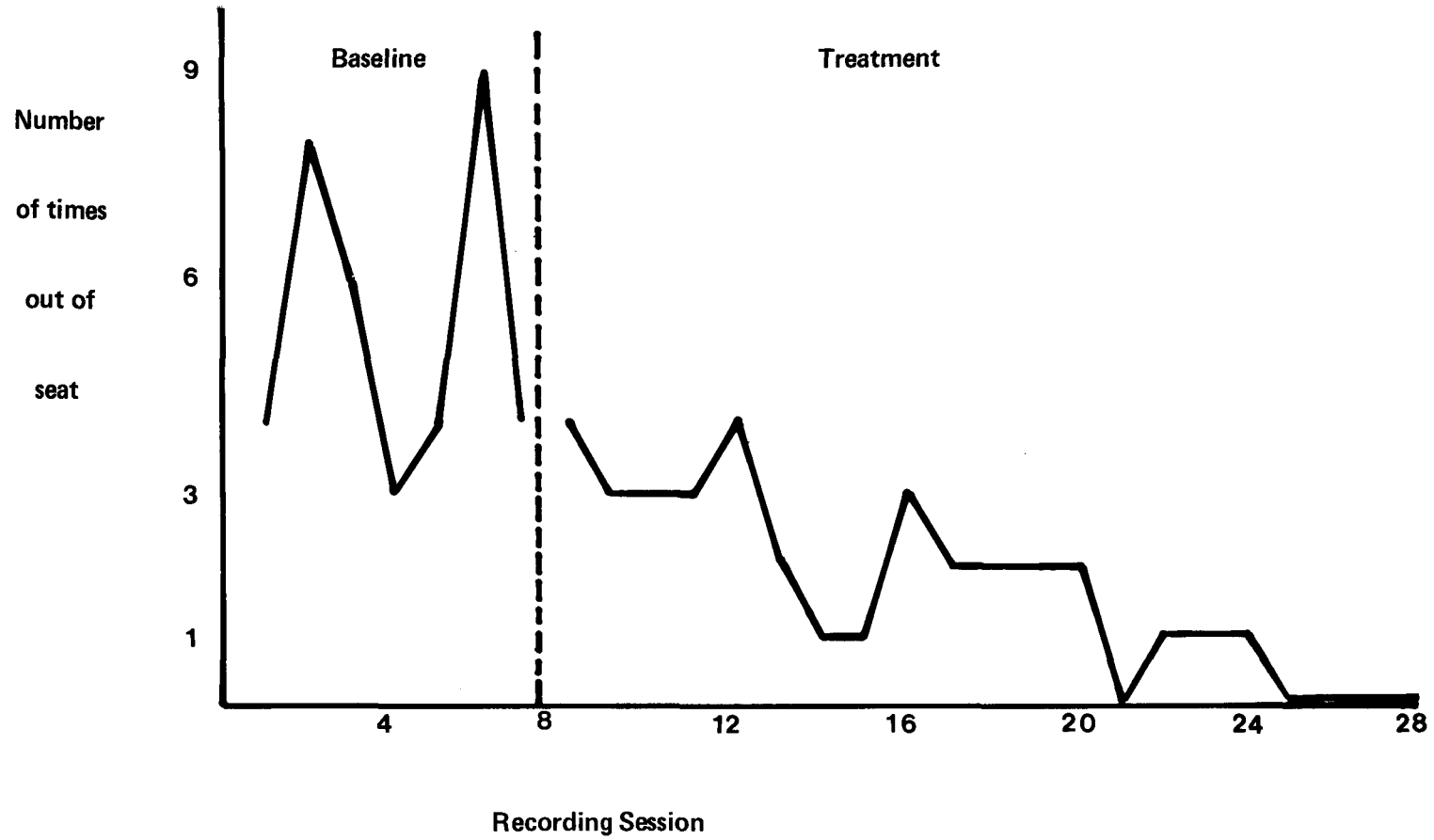


Figure 2 Family B



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Intervention For Dinnertime Problems:

In both families it was noticed that the children received little attention while at the table or when eating appropriately. It was also noticed that the children did receive attention when they left the table or refused to eat. This attention was in the form of threats, warning, repeated instructions, physically guiding a child back to the table or eye contact (often glaring).

The present intervention used the following steps:

1) Turning off the television in an adjoining room so as to minimise distractions
2) Reaffirming the rule (existing in both houses) that for a certain time before dinner no snacks would be given to the children
3) In Family B, preparing the kitchen area so that knives, and other instruments with which a child may hurt himself or cause most damage were put out of sight. (They had expressed concern that their child may hurt himself if left unsupervised).
4) Having the parents sit down with the children
5) Having parents give the children positive attention when they were sitting and eating appropriately. Such attention could be statements about what the children were doing or conversation about school or outings, etc.
6) Ignoring completely any behaviour of the child while out of his seat and ignoring completely any behaviour or speech of the children regarding refusing to eat. (It was necessary to emphasise that ignoring included not looking at the child, no "telling off", no instructions to return to the table).
7) In Family A, the issuing of dessert and a soft drink were contingent upon most of the main meal being eaten. This rule had often been used inconsistently in the past, and was formalised for this program. It was not stated that *all* the main meal need be eaten as some allowance would be made for individual dislike, of certain foods, e.g. a particular vegetable in a stew.

Steps 5 and 6 constitute the use of differential reinforcement whereby appropriate behaviour is reinforced (by positive attention) and inappropriate behaviour is treated by an extinction process (ignoring).

The number of times the children left the table during a baseline period and during the intervention period are shown in Figures One and Two for Families A and B respectively. In Figure One (Family A) the number of times out of seat is for all three children collectively. In Figure Two (Family B) the number of times out of seat is for the 3½ year old boy only.

In Family A a further problem was the children's refusing to eat. After the use of the steps listed above, the mother reported that this was no longer a problem.

During and after the specific work with the mealtime difficulties further input was given to both families relevant to child management. This included further information on positive reinforcement, ignoring and Time-Out, as well as input on communication skills.

In both families levels of inappropriate child behaviour decreased and appropraite behaviour increased, as reported by the parents and observed by the therapist. Parents perceived themselves as having greater control over their children's behaviour and as being happier in their relationships with their children.

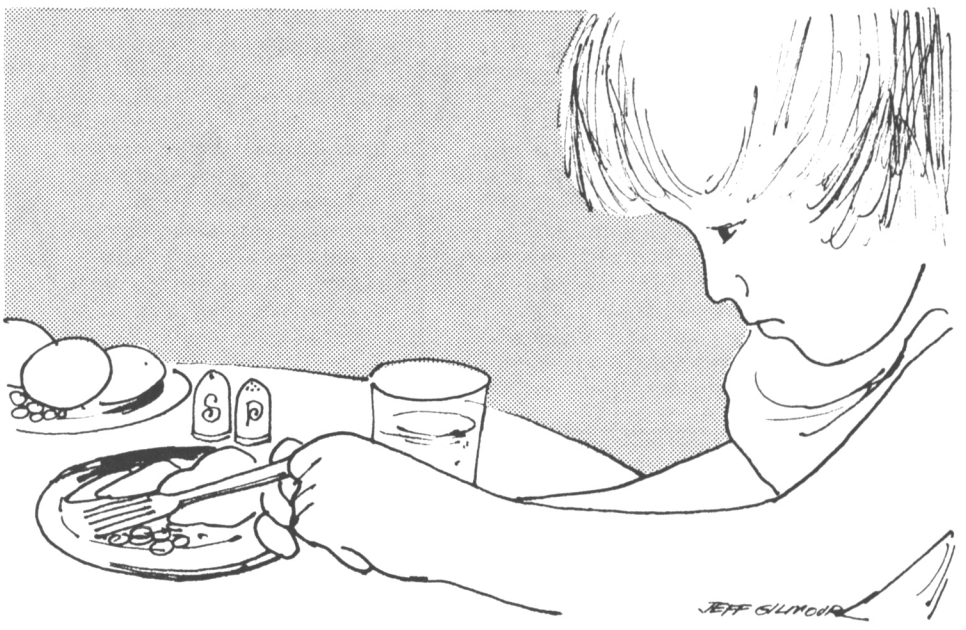
Subsequent and Additional Changes

In Family A, once the mother could see and experience more control over her relationships with her children (she felt she was no longer under their control, but effective in influencing their behaviour), she could look more effectively at other issues in her life. Mrs A had been depressed, had felt resentful of the children as controlling and limiting her life and was feeling dissatisfied and often resentful in her relationship with a close male friend. Having taken more control in one area of her life, Mrs A discussed other areas with the therapist. She made arrangements to have the 3½ year old child attend kindergarten and to allow herself to do more things which she found satisfying. On the therapist's suggestion she compiled a list of activities which were reinforcing to her. She made more time to do those things; e.g. painting at home, writing poetry, visiting friends. She also began to feel more confident about discussing with her boyfriend those issues about which she had previously felt resentful and had felt unable to discuss. She appeared more energetic, happier, more confident and less depressed. These changes were reported not only by the therapist, but by an independent observer (a student, who acted as an observer) and a community aide, independent of the intervention programs, who had acted as a counsellor with Mrs A for several months. These changes appeared consistent over one, two and four week follow-ups and Mrs A reported dealing appropriately with other difficulties (e.g. a school problem for her eldest boy) as they arose.

At the conclusion of work with Family B, mealtime behaviour was appropriate, the parents expressed personal satisfaction about the 3½ year old child's behaviour and reported friends and relatives as commenting on the child's "change in behaviour". He was also observed to be able to concentrate for longer periods of time (e.g. observed to play with toy cars for one hour), and he was reported by the kindergarten he attended as playing more appropriately with other children. These changes were observed to be maintained at two and four week follow-ups.

Summary

In both families the inappropriate dinnertime behaviour was greatly reduced. The success in dealing with this specific area of difficulty was seen as rewarding for parents and helpful in maintaining motivation to change other problem behaviours of their children. Both families experienced and maintained a decrease of unacceptable behaviours and an increase of desirable behaviours by the children. Experience of more control by the mother of the children in family A led to her exerting more control in other areas of her life. Thus in both families the home based intervention was seen to be appropriate and effective. ●



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