

Benefits of Family Meals for Children With Special Therapeutic and Behavioral Needs

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MeSH TERMS

- children with disabilities
- family
- family health
- meals
- social behavior
- social skills

Frequency of family meals (FMs) is associated with favorable child outcomes; however, no study to date has examined the relationship between frequency of FMs and outcomes for children with disabilities. Data from the 2007 National Survey of Children's Health for children with disabilities ($N = 4,336$) were used. Logistic regression for each dependent variable was completed using frequency of FMs and covariates of age, gender, race, family structure, and poverty level. Each day per week increase in the frequency of FMs increased the likelihood for positive social skills (odds ratio [OR] = 1.09, 95% confidence interval [CI] [1.01, 1.19]) and engagement in school (OR = 1.09, 95% CI [1.02, 1.16]). Frequency of FMs was not associated with problematic social behaviors or parental aggravation with child. Our findings suggest that children with disabilities whose families participate in frequent FMs have a greater likelihood of positive social and family health outcomes.

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Family meals (FMs), a regularly occurring occupation for families, have been positively associated with a variety of child outcomes, including academic skills, language development, and physical health (Fiese & Schwartz, 2008). Engagement in the ritual of eating together, a stabilizing occupation for families, is associated with increased consumption of healthy foods and a lower likelihood of unhealthy weight (Videon & Manning, 2003). Children who partake in regular FMs often experience responsive caregiver communication patterns and display less problematic behaviors (Fiese, Foley, & Spagnola, 2006; Martin-Biggers et al., 2014). Exposure to extended dialogue during mealtime, particularly in the preschool years, has been associated with improved vocabulary and reading scores in school-age children (Eisenberg, Olson, Neumark-Sztainer, Story, & Bearinger, 2004).

Although many studies associate frequent FMs with positive outcomes for children and families, no studies have specifically addressed the effects of frequent FMs for children with disabilities. Research

has shown that children with disabilities demonstrate difficulties with social skills (Tse, Hamiwka, Sherman, & Wirrell, 2007), problematic school engagement (Rock, 2005), and challenging social behaviors (Case-Smith, 2013). Therefore, an exploration of the relationship between frequent FMs and outcomes for children with disabilities and their families is warranted. The purpose of this study was to examine the association between frequency of FMs and positive social behaviors and academic engagement for children with disabilities.

Method

Data Collection

This study used data from the 2007 National Survey of Children's Health (NSCH), which is described in Blumberg et al. (2009). The NSCH was conducted through computer-assisted telephone interviews administered in English, Spanish, Chinese, Korean, and Vietnamese with the parent or guardian who knew most about a specific randomly selected child. The

survey included 11 sections and was designed to produce national and state-specific prevalence estimates for a variety of children's physical, emotional, and behavioral health indicators and their experiences with the current health care system. It also included questions about the parent's health status, stress and coping behaviors, family activities, and neighborhood perceptions. The total number of completed interviews was 91,642, with a response rate of 46.7%; 77.1% of respondents were mothers (Blumberg et al., 2009). The reliability and validity of the NSCH items have not been documented.

Sample

Inclusion criteria were being ages 6–11 yr (to represent elementary schoolchildren), having a defined disability, and having parents who responded “yes” to one of the following three questions:

1. Does the child need or get special therapy, such as physical, occupational, or speech therapy?
2. Does the child have any kind of emotional, developmental, or behavioral problem for which he or she needs treatment or counseling?
3. Does the child have a health problem, condition, or disability for which he or she has a written intervention plan called an individualized education program?

The sample size for the current study was 4,336 children (2,776 boys and 1,560 girls). Children outside the age range or with missing data were excluded.

Variables

The independent variable, frequency of FMs, was determined by one open-ended question: During the past week, on how many days did all the family members who live in the household eat a meal together? Analyses used a continuous response of days per week for frequency of FMs.

Sociodemographic variables and covariates included age, gender, race or ethnicity (non-Hispanic White, non-Hispanic Black, Hispanic, and other), poverty level ($\leq 100\%$, 101% – 299% , $\geq 300\%$ of the Federal Poverty Level), and family structure (two-parent biological or adopted

family, two-parent blended family, single mother, other).

Outcomes

We selected four social and family health outcomes, constructed from NSCH data: positive social skills, problematic social behaviors, engagement in school, and parental aggravation with child. We chose these outcomes because we inferred a relationship between them and frequency of family dining (Sisson, Broyles, Newton, Baker, & Chernausek, 2011).

The positive social skills category was created from responses to the following four items: shows respect for teachers and neighbors; gets along well with other children; tries to understand other people's feelings; and tries to resolve conflicts with classmates, family, or friends. Possible responses were *never*, *rarely*, *sometimes*, *usually*, and *always*. Positive social skills were coded as either seldom exhibits positive social skills (*usually* or *always* response on one item) or often exhibits positive social skills (*usually* or *always* response on two items). *Often exhibits positive social skills* was the desirable social behavior and dependent variable.

Problematic social behavior was created from responses to the following four items: argues too much; bullies or is cruel or mean to others; is disobedient; and is stubborn, sullen, or irritable. Problematic social behavior was coded as seldom exhibits problematic social behaviors (*usually* or *always* response on one item) or often exhibits problematic social behaviors (*usually* or *always* response on two items). *Seldom exhibits problem social behaviors* was the desirable social behavior and dependent variable.

Engagement in school was created from responses to the following two items: cares about doing well in school and does all required homework (responses of *never*, *rarely*, or *sometimes* on both items) and usually or always engaged in school (responses of *usually* or *always*). *Usually or always engaged in school* was the desirable social behavior and dependent variable.

Parental aggravation with child was created from responses to the following three questions: How often have you felt [child] is much harder to care for than

most children (his/her) age? How often have you felt [he/she] does things that really bother you a lot? and How often have you felt angry with [him/her]? (responses of *never*, *rarely*, or *sometimes* to all items). Parental aggravation with child was coded as seldom aggravated with child or often aggravated with child (responses of *usually* or *always* to one or more questions). *Seldom aggravated with child* was the desirable social behavior and dependent variable.

Data Analysis

Weighted descriptive characteristics were calculated on the sample (means [standard error] or frequencies) using appropriate strata and survey analysis procedures to ensure national representation and to account for the complex sampling design. Unadjusted and adjusted logistic regression analyses were completed for each of the four dependent social health indicators. SAS 9.2 (SAS Institute, Cary, NC) software was used for all analyses.

Results

The sample included in these analyses was $N = 4,336$ (64.5% male; mean age, 8.5 ± 0.05 yr; 63.3% non-Hispanic White; 23.6% $< 100\%$ of federal poverty level; 52.7% two-parent biological or adopted family). The mean frequency of FMs was 5.1 ± 0.07 days per week. Social health characteristics of this nationally representative sample of children with disabilities are presented in Table 1.

The relationships among frequency of FMs, children's social behaviors, and parental aggravation are presented in Table 2. More frequent FMs were associated with more desirable social health indicators. Specifically, for each day per week increase in the frequency of dining as a family, there was a 9% increased likelihood (odds ratio [OR] = 1.09, 95% confidence interval [CI] [1.01, 1.19]) that the child often exhibited positive social skills. For each day per week increase in the frequency of dining as a family, there was a 9% increase in the likelihood (OR = 1.09, 95% CI [1.02, 1.16]) that the child was usually or always engaged in school. There was no association between frequency of FMs and parental

Table 1. Disability and Social Health Characteristics (N = 4,336)

Characteristic	%
Child needs/gets special therapy (occupational, physical, speech)	
Yes	55.1
No	44.9
Child has any kind of emotional, developmental, or behavioral problem for which he/she needs treatment	
Yes	51.1
No	48.9
Child has a health problem, condition, or disability for which he/she has a written intervention plan	
Yes	61.8
No	38.2
Positive social skills	
Seldom exhibits	16.9
Often exhibits	83.1
Problematic social behaviors	
Seldom exhibits	80.0
Often exhibits	20.0
School engagement	
Never, rarely, or sometimes engaged	31.4
Usually or always engaged	68.6
Parental aggravation with child	
Seldom aggravated	79.7
Often aggravated	20.3

aggravation with child or with the child exhibiting problematic social behavior.

Other covariates, such as child gender and family structure, were significant in the models. Girls were more likely to be usually or always engaged in school, but no gender difference was found for other social health indicators. Children in two-parent blended family or single-mother homes were less likely than children in two-parent biological or adopted family homes to often exhibit positive social skills or be usually or always engaged in school. Single mothers and parents in two-parent blended families were more likely to respond that their child often exhibits problematic social behaviors and that they were often aggravated with the child (Table 2). Note that the relationship between frequency of FMs and children's social behaviors and engagement in school was independent of these covariates.

Discussion

This cross-sectional and secondary analysis study examined the association between frequency of FMs and specific social and behavioral outcomes for children with disabilities and their families. The results of

these data analyses indicated that children with disabilities whose families participated in more frequent FMs had a greater likelihood of positive social and family health outcomes. Previous studies have provided strong evidence supporting a positive relationship between regularly practiced family rituals and family health (Fiese et al., 2002; Kiser, Medoff, Black, Nurse, & Fiese, 2010). The association of frequency of FMs with psychosocial well-being, academic achievement, and decreased participation in problematic behaviors (Eisenberg et al., 2004; Fulkerson, Story, Neumark-Sztainer, & Rydell, 2008) is supported by these analyses, which found similar benefits for children with disabilities. Therefore, the findings from this study suggest a need for interventions that target the context of FMs and for research that further explores the relationship between FMs and improved social skills and engagement in school, two areas frequently problematic in children with disabilities.

Social skills, which are learned, interactive behaviors that allow people to respond to social demands, are often impaired in children with disabilities (Azad, Blacher, & Marcoulides, 2013; Case-Smith, 2013; Tse et al., 2007). Our study showed

that increased frequency of FMs was associated with greater odds for positive social behaviors and social skills in children with disabilities. These findings were in agreement with the findings from a similar study using data from the NSCH that explored the social behavioral outcomes of children ages 6–11 yr not controlled for disability (Lora, Sisson, DeGrace, & Morris, 2014). Lora et al. (2014) also found a positive relationship between FMs and school engagement. Although FMs may influence school engagement in children with disabilities, we could not verify this relationship with the items used in the NSCH to represent school engagement (i.e., Child cares about doing well in school and Child does all homework). This finding may be because children with severe motor or behavioral disabilities may have difficulty expressing caring about school and may have problems completing all homework.

Because FMs are an important means of socializing children toward competent and appropriate social behavior, frequent FMs may provide families of children with disabilities increased opportunities to practice appropriate social behaviors. Children with disabilities often have impaired social skills that may not be easily remediated as they get older (Tse et al., 2007). Occupational therapy practitioners working with children with disabilities should consider the benefits of frequent FMs in promoting social competence and support families in establishing FM routines when children are young. Moreover, practitioners should prioritize interventions that maximize the experience and success of FMs, a routine families of children with disabilities may find stressful (Bagatell, Cram, Alvarez, & Loehle, 2014; Larson, 2006; Marquenie, Rodger, Mangohig, & Cronin, 2011).

Students with disabilities are more likely to have difficulty engaging in school-related occupations, which can lead to poor educational outcomes (Rock, 2005). The results of this study indicate that more frequent FMs were associated with a higher probability that children with disabilities were usually or always engaged in school. Family occupations, such as FMs, provide an opportunity for daily communication and a means for parental involvement in and

Table 2. Frequency of Family Meals, Social Behaviors, and Parental Aggravation

Variable	OR [95% CI]			
	Often Exhibits Positive Social Skills	Often Exhibits Problematic Social Behavior	Usually/Always Engaged in School	Usually/Always Aggravated With Child
No. family meals/wk	1.09 [1.01, 1.19]	0.95 [0.87, 1.04]	1.09 [1.02, 1.16]	1.03 [0.94, 1.12]
Age, yr	0.99 [0.89, 1.10]	0.97 [0.86, 1.08]	0.97 [0.89, 1.06]	1.04 [0.93, 1.16]
Female vs. male	1.24 [0.83, 1.84]	1.06 [0.74, 1.50]	1.86 [1.36, 2.54]	0.79 [0.57, 1.10]
Family structure				
Two-parent blended	0.45 [0.23, 0.91]	2.49 [1.27, 4.86]	0.40 [0.24, 0.67]	2.41 [1.33, 4.38]
Single mother	0.90 [0.55, 1.46]	1.60 [1.06, 2.39]	0.49 [0.35, 0.69]	1.29 [0.87, 1.90]
Other	0.60 [0.31, 1.16]	1.22 [0.62, 2.38]	0.50 [0.29, 0.85]	1.38 [0.77, 2.48]
Ethnicity/race				
NHB vs. NHW	0.53 [0.31, 0.90]	0.86 [0.51, 1.45]	0.94 [0.61, 1.44]	1.05 [0.65, 1.67]
Hispanic vs. NHW	3.54 [2.01, 6.23]	0.93 [0.57, 1.50]	1.35 [0.87, 2.10]	0.90 [0.49, 1.66]
Other vs. NHW	1.17 [0.65, 2.10]	1.03 [0.60, 1.75]	0.89 [0.57, 1.39]	0.90 [0.55, 1.49]
Poverty level				
101%–299% vs. ≥300%	0.58 [0.34, 0.97]	1.47 [0.88, 2.47]	0.76 [0.53, 1.08]	1.20 [0.78, 1.86]
<100% vs. ≥300%	0.44 [0.24, 0.79]	3.58 [2.04, 6.29]	0.51 [0.33, 0.78]	1.49 [0.90, 2.37]

Note. CI = confidence interval; NHB = non-Hispanic Black; NHW = non-Hispanic White; OR = odds ratio. **Bold** indicates significant relationships. Adjusted models include age, gender, race/ethnicity, and family poverty level.

monitoring of occupations that support engagement in school. Thus, therapeutic interventions that bridge the educational and home environments to support regular FMs are warranted (Fiese & Schwartz, 2008).

No relationship was found between frequency of FMs and parental aggravation with child and child's problematic social behaviors. However, children with disabilities in two-parent blended family or single-mother homes were less likely than children in two-parent biological or adoptive family homes to often show positive social skills and engagement in schools and were more likely to elicit parent aggravation or have problematic social behaviors. Evidence suggests that parents of children with disabilities experience multiple stressors that affect family functioning (Green, 2007; Murphy, Christian, Caplin, & Young, 2007). Families headed by married, biological parents have increased resources and experience less chaos than single parents, unmarried biological parents, or blended families (Teachman, 2008). Parents with fewer economic resources are less likely to engage in regular FMs with their children and are more likely to often argue with their children (Burnier, Dubois, & Girard, 2011). Moreover, families raising a child with a disability experience additional health care costs and financial strain. Therefore, occupational therapy practitioners should be mindful of family characteristics that

may bring extra challenges to the orchestration of harmonious FMs.

Strengths and Limitations

Although the cross-sectional nature of our data collection precludes causality, no other studies have used nationally representative data to examine the benefits of frequent FMs for children with disabilities. In addition, this type of data collection may involve respondent bias as a possible confounder because categorization of a child with a disability was dependent on parent or caregiver response. Because a cross-sectional study allows analysis only at a single point in time, further study is needed that tracks trends over time in families with children with disabilities regarding frequency of FMs and outcomes such as school engagement, academic achievement, and social skills as reported by parents. Additionally, the lack of psychometric information for the NSCH is a limitation; however, the value of examining the association between frequency of FMs and positive social behaviors and academic engagement for children with disabilities in a national sample offsets this limitation.

Although the results indicate that more frequent FMs are associated with positive child outcomes, there was no way to examine the effects of severity of disability on frequency of FMs or child outcomes. It is possible that children with

multiple behavioral or therapeutic needs are heavily represented in the portion of the sample having less frequent FMs or less favorable child outcomes. In addition, frequency of FMs did not influence the presence of the negative child outcomes of problematic social behaviors or parental aggravation in this study. It is possible that these indicators are also related to severity of disability.

Implications for Occupational Therapy Practice

The results of this study have the following implications for occupational therapy practice:

- More frequent meals, a family occupation, were associated with higher engagement in school for students with disabilities.
- Occupational therapy is uniquely situated to investigate the frequency and integrity of family occupations for children with disabilities.
- Occupational therapy practitioners have the knowledge and skills to promote occupational performance and engagement in family occupations.

Conclusion

As part of a growing endorsement for the importance of family occupation and its relationship to family health and child outcome (DeGrace, Hoffman, Hutson, &

Kolobe, 2014; Price & Stephenson, 2009), our findings underscore the value of promoting engagement in FMs. Results of this study indicate that in families with children with disabilities, more frequent weekly FMs are associated with children having positive social skills and usually or always being engaged in school. Therefore, occupational therapy practitioners providing interventions for children with disabilities need to be cognizant of the benefits that frequent FMs can have on child outcomes. Moreover, two potential strategies for practitioners to use to promote improved child outcomes are to schedule interventions so they do not interfere with this prominent family occupation and educate families about the protective benefits gained from positive family interactions during more frequent FMs. Additionally, practitioners who provide services in the home have a unique opportunity to promote increased frequency of FMs.

Further research on the longitudinal effects of frequent FMs and child social and behavioral outcomes should be conducted. Moreover, although the relationship between frequency of FMs and children's social behaviors and engagement in school was independent of covariates related to family structure and child gender, examining the role and influences of poverty, gender, and ethnicity in children with disabilities on these outcomes would be helpful in developing beneficial occupational therapy interventions. Because school engagement and social behaviors represent only partial occupational roles of the growing child, future studies should explore the influence of frequent FMs on other areas of occupation such as leisure, social participation, and instrumental activities of daily living. ▲

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