

one types of eating problem

The eating problems that children suffer from are very different to those experienced by adolescents and adults. There are a larger number of different eating problems found in children, which have different causes, different characteristics and need different forms of treatment. Also, some of the eating problems found, for example childhood-onset anorexia nervosa and food avoidance emotional disorder, have a more serious effect on the child's physical and psychological well-being compared with others, for example restrictive eating (poor appetite) and selective eating (extreme faddiness).

CLASSIFICATION

A classification of mental disorders is important for clinical practice, research and statistical information. At the present time, there are two widely recognised classification systems. These are the DSM-IV (American Psychiatric Association (APA), 1994) and the ICD-10 (World Health Organization (WHO), 1992). These systems provide criteria for the identification of the different mental disorders, enabling diagnosis and treatment, identification and comparison of different groups of individuals.

As mentioned already, the names of the eating problems found in childhood are purely descriptive and have been created by those working in the field in order to describe the children that present to them for treatment. This is a consequence of there being no standardised classification system for the eating problems found in school-age children. In fact, neither the ICD-10 nor the DSM-IV offers diagnostic categories appropriate for the diagnosis of childhood-onset eating problems.

As a result, alternative methods of classification of have arisen. These have been descriptive (Lask & Bryant-Waugh, 1993; APA, 1994; Babbitt *et al*, 1994a), causal (Budd *et al*, 1992; Linscheid, 1992) and multidimensional (Chatoor *et al*, 1985) approaches. Lask & Bryant-Waugh (2000) have suggested a useful method using working definitions of the different types of eating problems found in children (see Box 1.1).

Research has given support to the existence of the different types of disorder put forward by Lask & Bryant-Waugh (2000). Cooper *et al* at the Academy of Eating Disorders 9th International Conference in New York (2000) presented a study that aimed to clarify the psychopathology of childhood-onset eating problems. The study consisted of 126 patients who had been referred to a specialist eating disorder service. Eighty-eight presented with an early-onset eating disorder (girls who were pre-menarchal and boys who were pre-pubertal at onset) and the remaining 34 later-onset. Among the early-onset group, 43% had a diagnosis of anorexia nervosa, 29% a diagnosis of food avoidance emotional disorder (FAED), 19% selective eating and 9% another eating disorder

such as functional dysphagia. Results indicated that children in the early-onset anorexia nervosa group showed a similar level of disturbance to that present in the later-onset group. The authors concluded that the study confirmed the diagnostic validity of early-onset anorexia nervosa.

EATING PROBLEMS

The following sections provide a brief description of each of the eating problems found in children. It is also important to point out that the descriptions given are true for the majority of children who present with each condition. For example, children who present with selective eating (extreme faddiness), restrictive eating (poor appetite), food refusal and inappropriate texture of food for age will usually have no problems with health or growth. However, a very small number of children presenting with these conditions will have a problem with health and/or growth. This is particularly true if the problem has continued for a number of years.

Childhood-onset anorexia nervosa

Children with anorexia nervosa are preoccupied with their weight and body shape. They have a distorted view of their body and an abnormal or inadequate intake of food. They have a strong need to lose weight and so avoid eating in order to do so. If they have to eat, then they will eat as little as they possibly can in terms of quantity or they will avoid foods that contain a large amount of calories. These children still feel hungry, and sometimes the feelings of hunger may be so strong that they have to eat. Having done so, they will feel very guilty and have to get rid of what they have just eaten. This may be in the form of making themselves sick, taking laxatives or exercising. In terms of personality characteristics, people that develop anorexia nervosa tend to have perfectionist tendencies and will set themselves high standards, which they will then work hard to achieve.

Childhood-onset bulimia nervosa

Children with bulimia nervosa frequently engage in binges, in that they will eat excessive quantities of food at one time. A binge may consist of eating up to four times the amount that would constitute a normal meal for most people. They may eat unusual combinations of food or eat large amounts of the same food. Having binged, these children will feel very guilty for having done so. They will therefore make themselves sick in order to get rid of the food that they have just ingested. Alternatively, they may use laxatives in an attempt to control weight gain. Children with bulimia nervosa are also preoccupied with their weight and body shape. They make judgements about themselves on the basis of the way that they think that they look. They are extremely critical of themselves and think that they are worthless. Their weight may be low, normal or high, so it can be more difficult to ascertain that a child is suffering from bulimia nervosa.

Pervasive refusal syndrome

This is a very serious condition where children present with a profound refusal to walk, talk, eat, drink or care for themselves in any way. Physical examination provides no organic explanation for the symptoms. These children are often very determined, angry or frightened. Their families deny any conflicts or other problems; however, there are often histories of violence within the family. It also appears that a history of sexual abuse contributes to this problem.

Box 1.1 Working definitions of the different types of eating problems found in children (adapted with permission from Lask & Bryant-Waugh, 2000)

Childhood-onset anorexia nervosa

- (i) Determined weight loss
- (ii) Abnormal cognitions regarding weight and/or shape
- (iii) Morbid preoccupation with weight and/or shape, food and/or eating

Childhood-onset bulimia nervosa

- (i) Recurrent binges and purges and/or food restriction
- (ii) Sense of lack of control
- (iii) Abnormal cognitions regarding weight and/or shape

Food avoidance emotional disorder (FAED)

- (i) Food avoidance
- (ii) Weight loss
- (iii) Mood disturbance
- (iv) No abnormal cognitions regarding weight and/or shape
- (v) No morbid preoccupation with weight and/or shape
- (vi) No organic brain disease, psychosis, illicit drug use, or prescribed drug-related side-effects

Selective eating/extreme faddiness

- (i) Narrow range of foods (for at least two years)
- (ii) Unwillingness to try new foods
- (iii) No abnormal cognitions regarding weight and/or shape
- (iv) No morbid preoccupation with weight and/or shape
- (v) Weight may be low, normal or high

Restrictive eating/poor appetite

- (i) Smaller than usual amounts for age eaten
- (ii) Diet normal in terms of nutritional content but not in amount
- (iii) No abnormal cognitions regarding weight and/or shape
- (iv) No morbid preoccupation with weight and/or shape
- (v) Weight and height tend to be low

Food refusal

- (i) Food refusal tends to be episodic, intermittent or situational
- (ii) No abnormal cognitions regarding weight and/or shape
- (iii) No morbid preoccupation with weight and/or shape

Functional dysphagia/food phobia

- (i) Food avoidance
- (ii) Fear of swallowing, choking or vomiting
- (iii) No abnormal cognitions regarding weight and/or shape
- (iv) No morbid preoccupation with weight and/or shape

Pervasive refusal syndrome

- (i) Profound refusal to eat, drink, walk, talk, or self-care
- (ii) Determined resistance to efforts to help

Food avoidance emotional disorder

Children who suffer from FAED are usually between the ages of five and 16 years. The presenting symptoms of this condition may be confused with that of anorexia nervosa or an emotional disorder, such as depression or anxiety. These children have difficulties with eating but cannot be diagnosed with any of the other types of eating problems. The concept of this disorder is that the children experience some emotional problems, for example sadness, worries or obsessionality, which interfere with their appetite and eating. These children are not preoccupied with their weight or body shape and in fact may even express that they recognise that they need to put on weight, but do not feel hungry.

Functional dysphagia/food phobia

In general, these children are fearful of eating, and in particular of eating lumpy or solid foods. They do not want to put food into their mouths and swallow it for fear that it may poison them, or cause them to gag, choke or vomit. These children are not preoccupied with their body shape and do not want to lose weight. They may have experienced some traumatic incident that has triggered the phobia. Alternatively, they may have made a peculiar or illogical association in their mind that may lead to them developing the phobia.

Selective eating/extreme faddiness

It is believed that children who suffer from selective eating or extreme faddiness have not grown out of the normal developmental phase of eating a restricted range of foods. This is commonly seen in pre-school children. These children eat a very narrow range of foods – maybe just five or six that are usually carbohydrate-based – and do not like to try new foods. It is hard to get them to try new foods and when presented with a novel food type, they may wretch. These children have no difficulty in swallowing or keeping down their favoured foods, however. Children with selective eating (extreme faddiness) tend to be of normal weight and height and are healthy. They seem to acquire adequate calories to sustain growth and development. In terms of cause, there is sometimes a history of a close relative having had a similar problem, but there is no underlying organic cause to explain the symptoms. These children are not preoccupied with their weight or body shape, and are usually seen between the ages of seven and 11 years. This is because at this age they start to go to school and socialise more with other children, so they can no longer get away with 'faddy' eating as they did when they were younger.

Restrictive eating/poor appetite

Children who suffer from restrictive eating or poor appetite seem not to eat very much at all. They will eat a normal range of foods, but have a small appetite and seem disinterested in food. These children are not preoccupied with their weight, do not want to lose weight and seem perfectly happy. This condition is more common in the pre-school years and is relatively harmless as children tend to grow and develop in the normal way. If the problem persists for several years, however, it may have an impact on the growth of the child and so may become problematic. It is important to ascertain that the restrictive eating (poor appetite) is not owing to associated emotional problems.

Food refusal

This is commonly found in pre-school children, where the food refusal can be used as a means to obtain other things. However, this can persist in slightly older children and is characterised by an

inconsistent avoidance of food. They tend to eat favourite foods without any problem at all. They may only refuse food when in the presence of particular people or in certain situations, for example refusing to eat at school but eating normally at home. These children are not preoccupied with weight and shape, and tend not to have any weight problems. Worry or unhappiness may underlie the food refusal in many cases. This problem does not usually pose a threat to the child's health and well-being.

Inappropriate texture of food for age

These children eat only pureed or semi-solid food, which is appropriate for a 6–10-month-old infant, when they should be eating a normal solid diet of food that requires biting and chewing. If presented with lumps in their food they may spit the food out, gag or refuse to eat it altogether. In addition, these children may or may not refuse to eat finger foods. The majority of children will have their weight well-maintained on the inappropriate textures; however, some will be of low weight. Although children eat a full range of food types, parents tend to show concern about the impact that this disorder has on the social functioning of the child. For example, in children over four years of age, this causes great concern where difficulties arise around school lunchtimes.

IDENTIFICATION OF CHILDHOOD-ONSET EATING PROBLEMS

Before referral to child and adolescent mental health services (CAMHS), families with children with eating problems may spend a number of months seeking advice from various health professionals. In fact, one study has found an average of 7.4 months between initially requesting professional

Table 1.1 Summary of the types of eating problems

Eating problem	Pre-school	School age	Adolescence
Childhood-onset anorexia nervosa	✗	✓✓	✓✓
Childhood-onset bulimia nervosa	✗	✓	✓✓
Pervasive refusal syndrome (syndrome rare)	✗	✓✓	✓
Food avoidance emotional disorder	✗	✓✓	✓
Functional dysphagia/food phobia (syndrome rare)	✗	✓✓	✓
Selective eating/extreme faddiness (quality)	✓✓	✓✓	✓
Restrictive eating/poor appetite (quantity)	✓✓	✓✓	✓
Food refusal	✓✓	✓	✗
Inappropriate texture of food for age (texture)	✓✓	✓	✗

✓✓, disorder mostly found in this age group; ✓, disorder sometimes found in this age group; ✗, disorder does not occur in this age group

help and referral to specialist services (Fosson *et al*, 1987). This delay in referral has been linked to doctors not recognising the eating problems that children suffer from. Some empirical research investigating older patients with eating disorders has found that a shorter history of illness is a predictor of good outcome (Morgan & Russell, 1975; Hsu *et al*, 1979). This raises questions in terms of the treatment of eating problems in children, as a longer referral period may lead to the eating problem becoming more established and difficult to treat.

Bryant-Waugh *et al* (1992) carried out a study in order to investigate whether doctors recognise eating problems in children. Paediatricians, school doctors and general practitioners were presented with two short vignettes describing common presenting features of childhood-onset anorexia nervosa. They were then asked questions regarding diagnosis and management. The authors found that the awareness of childhood-onset eating problems was limited. This was particularly true in the case of doctors.

Simple diagnostic flowchart

In utilising the working definitions proposed by Lask & Bryant-Waugh (2000), it has been possible to construct a diagnostic flowchart. The chart incorporates a number of important features that may be used to identify the eating problems found in children. This is achieved through answering the questions presented in the flowchart (see Fig. 1.1).

It is important to note, however, that this is a simple diagnostic flowchart – alternative diagnoses that are not included in the chart should not therefore be ruled out. For example, if a child presents with low weight and short stature, then the following diagnoses are all possibilities: genetic syndromes, such as silver Russel syndrome and Turner syndrome, gastrointestinal disease, endocrine disease or renal disease. These conditions, although rare (they occur in less than 5% of short children), are all possibilities.

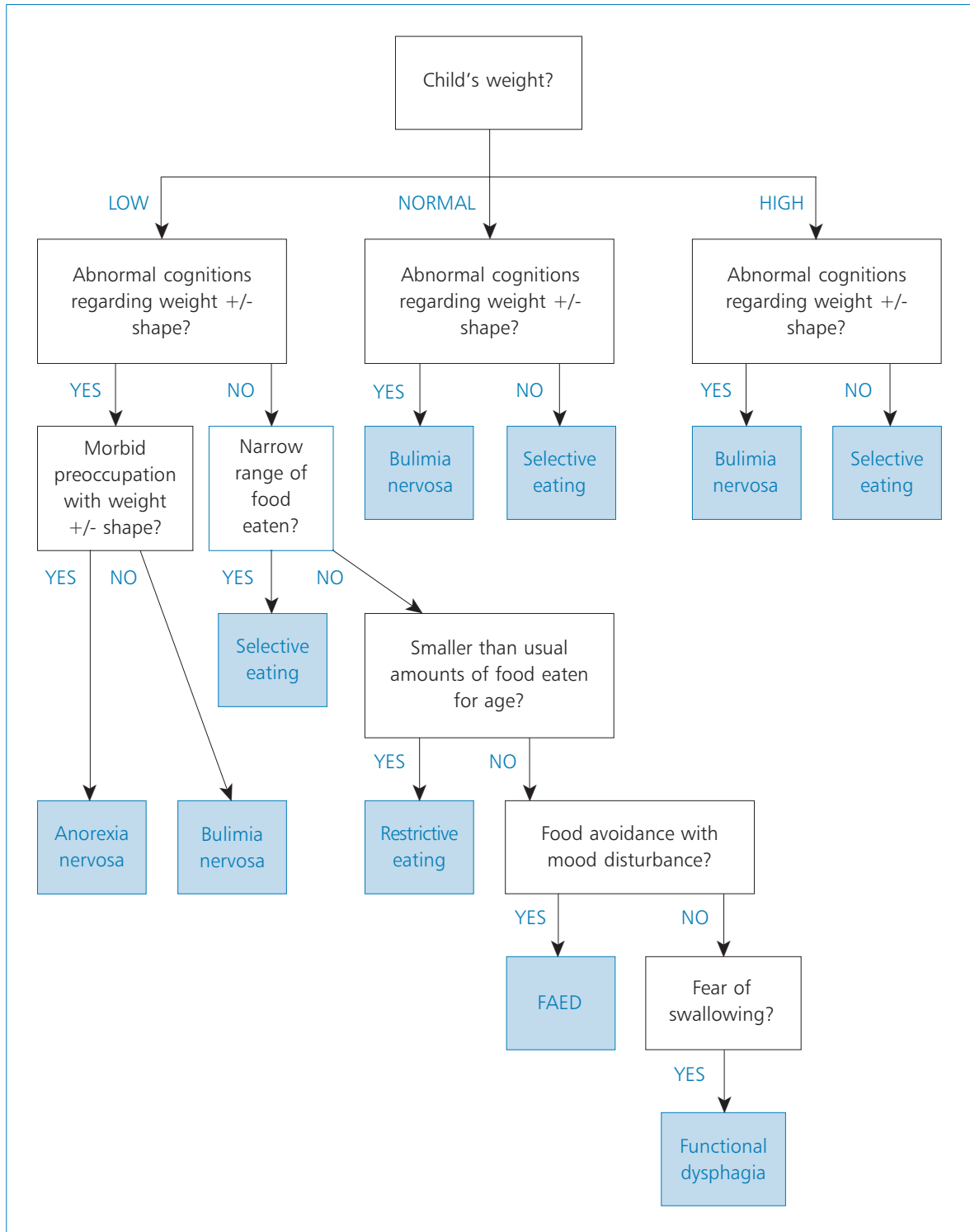


Fig. 1.1 A simple diagnostic flowchart for the eating problems found in childhood