Two Subtypes of Food Refusal in Preteens Found

BY DOUG BRUNK
San Diego Bureau

SAN DIEGO — The presence or absence of body image distortion can help clinicians identify two distinct groups of latency-age children who present with severe food refusal, Robin S. Mehlenbeck, Ph.D., reported at the annual meeting of the Society for Developmental and Behavioral Pediatrics.

The finding is important because latency-age patients do not fit neatly into categories of anorexia or feeding disorder of early childhood, said Dr. Mehlenbeck of the department of psychiatry at Rhode Island Hospital, Brown Medical School, Providence, R.I.

“There’s a lot of confusion about these kids who don’t fit [a definition] and we really don’t know what to call them, let alone what to do for them,” she said, adding that there are no good estimates on the number of younger children with eating disorders.

She and her colleagues reviewed the medical charts of 44 patients, aged 6-12 years, who presented with food refusal and restrictive eating habits to a day treatment program at Rhode Island Hospital between 1999 and 2003. The treatment program was a multidisciplinary team approach, collaborating closely with families and community providers. At intake, families completed questionnaire about behaviors and family functioning, and quality of life. The mean age of study participants was 10 years, and more than half of the participants were female (67%). Most were white (82%), and 30% were on public insurance. The average length of stay in the program was 21 days.

The investigators divided the children into two distinct groups: early onset anorexia, which involved body image distortion, and atypical eating disorder.

The two groups of children did not differ in terms of gender, insurance type, or program length of stay, but children in the AED group were about 2 years younger than their EOA counterparts (a mean of 9.7 years vs. 11.4 years, respectively).

All eight children from minority backgrounds were in the atypical eating disorder group; the children in the AED group were more likely to come from single-parent households than those in the early onset anorexia group.

The two groups did not differ in terms of body mass index and most medical factors, but those in the EOA group were more likely to show cardiovascular abnormalities, such as choreiform movements, motor hyperactivity, and adventitious movements. This occurred in only two participants.

Other studies have documented PTSD responses to childhood cancer, diabetes, and burns, said Dr. Stuber, professor of psychiatry at the University of California, Los Angeles.

The purpose of the current study was to try to tease out what specific factors lead to PTSD. Hence, the study included and compared kidney, heart, and liver transplant patients—those in the transplant group; the children with EOA; and children with very different courses and etiologies of eating disorders, according to a posttraumatic stress disorder (PTSD) diagnosis, and 14% met one of the three criteria, said Margaret L. Stuber, M.D., at the annual meeting of the Society for Adolescent Medicine.

While PTSD does seem to play a significant role in determining risk for PTSD, he noted. Other studies have found that PTSD can have a negative impact on a patient’s compliance with their medical regimen. One report describing six non-compliant patients with PTSD indicated that treating them for PTSD improved their adherence to medical therapy.

Overall, the work in this field also suggests general anxiety level is an important predictor of the risk that an adolescent will develop PTSD. Dr. Stuber thus recommended focusing on general anxiety level as a risk factor for PTSD. “It is essential we find out what the patient’s subjective experience is,” he said. “I would screen for anxiety.”

Symptoms of PTSD include recurrent and distressing recollections of the traumatic event, avoidance, and increased arousal. Avoidance may entail efforts to stay away from reminders of the event but can also manifest as an inability to recall important aspects of the event, diminished interest in activities, feelings of detachment from others, and a restricted range of affect. Features of increased arousal can be sleep problems, irritability, and lack of concentration, hypervigilance, and an exaggerated startle response.

The finding of patients with similar risk factors for PTSD, regardless of the type of transplant the patients had had. The factors associated with an adolescent developing PTSD were more complex and included the experience of an acute illness (rather than a chronic one), meaning it is uncertainty, anxiety, and what Dr. Stuber called “disruption of expectations” that triggers the PTSD reaction.

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