Transient Eating Problems in an Adolescent without Body Image Disturbances: A Diagnostic Quandary

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ABSTRACT

Eating problems are commonly encountered in childhood and adolescents, and may be manifestation of a variety of psychiatric disorders when medical causes are excluded. We present the case of a young lady presenting with problems of eating which presented with difficulties of ascribing a diagnostic label for eating problems. The patient, a 12-year-old girl with history suggestive of mild mental retardation and juvenile myoclonic epilepsy presented with selective eating of foodstuffs which improved spontaneously in 2 months. The different diagnostic possibilities entertained for the case are discussed.

Key words: Anorexia, diagnostic issues, eating problems, mental retardation

INTRODUCTION

Eating problems are common in childhood and fussiness in eating is quite often encountered.[1] When do such problems become abnormal and merit a specific psychiatric diagnostic label, remains a question under study with no clear cut answers. We present a case of a young girl for whom clinical attention was sought for transient eating problems. The diagnostic issues surrounding the case are discussed.

CASE REPORT

A 12-year-old young lady belonging to lower socioeconomic rural background was seen by the psychiatry services when referred for problems of eating since past 2 months. The patient had a history of delayed development and achieved milestones slower than other siblings. She would mostly be shy and would interact with children younger than her age. She would answer briefly when spoken to by classmates and teachers. She would eat what was given to her by her mother, and ask for specific food items occasionally. Her school performance remained below average and had difficulties in making small purchases.

Around 2 years back, the patient developed generalized tonic clonic seizures during sleep which were followed by myoclonic jerks. The electencephalogram (EEG) findings were consistent with a diagnosis of juvenile myoclonic epilepsy (JME). Sodium valproate was started, which was gradually increased to 600 mg per day. The episodes of generalized tonic clonic seizures were well controlled with valproate, but myoclonic jerks continued to recur. Due to the occurrence of jerks at school, other children would tease her. Hence she started to refuse going to school. She became irritable with her family members quite often, and would hit the siblings when provoked. She did not have depressive cognitions or change in sleep or appetite then. Due to behavioral problems of refusal to go to school and irritability, she was evaluated in psychiatry outpatient. Intelligence...
quotient (IQ) assessment was done and reported as 57 with a diagnosis of mild mental retardation.

Since around 2 months prior, the patient started to refuse specific food stuffs. She would eat rice at the previous amounts, but would refuse to eat rotis, the staple diet of the family. If persuaded, she would get irritable and start crying and go to sleep without eating anything. She would also refuse to eat biscuits and bread at times. She would not give any specific reason for the refusal. At times she said that she was hungry and would ask for food, and would eat rice but refuse rotis. She did not have any associated loose stools, abdominal pain, vomiting, or regurgitation. She would not demand for specific food items like chocolates, etc.; would not appear sad, withdrawn or fearful, or have any disturbances in sleep. Over the period of 1 month, the weight reduced by about 1 kg. On further exploration, no preoccupation with body image, of previously fussiness of eating was reported by the family members. The child had a slow to warm up temperament and there was no history suggestive of eating inedible objects, delusions, hallucinations or repetitive behaviors, significant obstinacy, hyperactivity or inattentiveness. There was no family history of psychiatric illness. The general physical examination was within normal limits, the height and weight was over the 10th percentile and there were no signs of chronic malnutrition. Rapport could be established with difficulty and the child answered briefly only after urging from the mother and therapist. The patient was followed up with the suggestion of keeping a watch on weight. Mother was encouraged to observe the diet and no structured behavioral intervention was done. When patient returned in 2 weeks, there was no further decrement in weight and the patient started to eat all kinds of food stuffs again and to the previous amounts. Even on recovery, she did not elaborate the cause of decreased intake of certain foodstuffs and that of resumption.

**DISCUSSION**

Multiple possibilities can be entertained in this child while evaluating a child presenting with such eating problems. The age appropriateness of such behaviors, development level aptness, sociocultural background, parenting style, and medical conditions need to be ascertained before considering whether such a behavior can be assessed as abnormal.

Feeding habits in adolescents reveals deficits in calories and proteins in apparently healthy school-going children from relatively well-to-do backgrounds. With such a premise, is diagnosing the transient problems of eating as a separate disorder in this child a useful and relevant exercise, or whether these problems can be passed off as developmentally appropriate erratic behaviors? Even if a diagnostic label is required, where does the child fit in? Is the diagnosis of mental retardation sufficient to subsume these symptoms or an additional diagnosis is needed? Since the diagnostic categories of affective, psychotic, and anxiety spectrum disorders do not apply in this case, whether the problems can be better characterized as eating disorder not other specified (eating disorder NOS)? However, there was no evidence of body image disturbances. Does feeding disorder of infancy and childhood better characterize this case, though the obvious atypicality being age of presentation and transient symptoms in this case; Or does this case remain a ‘diagnostic orphan’ according to the present psychiatric nosological systems.

Many researchers have proposed alternate pragmatic classification systems for characterizing the problems of eating in childhood. Some of these classifications incorporate medical as well as behavioral problems as the cause. Fox and Joughin have described a variety of eating problems that are encountered in the childhood and adolescence. Among these, the index case exhibits symptoms closest to food avoidance emotional disorder which occurs in the age range of 5-16 years and is characterized by avoidance of food and emotionality in the absence of preoccupation of body weight or body image.

Many children who present with behavioral problems of eating cannot be pigeonholed into diagnostic class of present nosology, but still benefit with interventions. Hence, we suggest that these disorders should be treated pragmatically after detailed assessment without being excessively concerned about the diagnostic label, at the same time not overlooking the obvious diagnostic possibilities.

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