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Characteristics of Children Referred Into Systems of Care With Eating and Sadness Problems

Introduction

An estimated 0.5% to 3.7% of females suffer from anorexia nervosa and 1.1% to 4.2% of females have bulimia nervosa during their lifetimes (American Psychiatric Association Work Group on Eating Disorders, 2000). Although eating disorders are more prevalent among young women, they also affect young men (National Eating Disorder Association [NEDA], 2002). NEDA estimates that 9% of those who suffer from eating problems and disorders are male.

Research has shown that adolescents who demonstrate disordered eating behaviors may also frequently experience associated psychological and psychosocial problems. For example, the comorbidity of eating disorders with depressive disorders has been well documented (e.g., Johnson, Cohen, Kasen, & Brooks, 2002; Johnson, Cohen, Kotler, & Kasen, 2002; Rowe, Pickles, Simonoff, Bulik, & Silberg, 2002), while the comordibity with anxiety, substance use, and disruptive behavior disorders among adolescents has also been demonstrated (e.g., Zaider, Johnson, & Cockell, 1999). Clearly, understanding the unique characteristics of children and youth seeking mental health treatment who present with eating problems, as well as the types of problems they manifest, is critical to ensure comprehensive assessment of their needs and the development of appropriate individualized service planning and delivery of services.

Study Highlights

- ***Nearly 7% of children who entered system-of-care services presented with eating problems; nearly 28% presented with sadness, and approximately 13% of those with eating or sadness problems presented with both eating and sadness problems.***
- ***Youth who entered services with eating problems, with or without sadness, presented more behavioral problems, greater functional impairment, and lower behavioral and emotional strengths than their peers. Youth who entered services with both eating and sadness problems also demonstrated high levels of behavioral and functional problems.***
- ***A higher percentage of youth who entered services with both eating and sadness problems, had been exposed to family risk factors such as family mental illness, violence, and substance use, as well as parental felony, than their peers.***
- ***More youth who presented to services with both eating and sadness problems had attempted suicide than their peers, and more youth who presented with eating problems (without sadness) had a reported experience of sexual abuse than their peers.***
- ***The prevalence and comorbidity of eating and sadness presenting problems among children referred into system-of-care services, as well as their unique characteristics and experiences, highlight the essential need for the availability of thorough and appropriate assessment and differential service planning for these children.***

The Study Sample

The Comprehensive Community Mental Health Services for Children and Their Families Program

is a federally funded children's mental health initiative that funds the development and provision of family-driven, culturally competent, community-based services to children with serious emotional disturbance, some of whom present with eating problems and disorders. Data from the congressionally mandated national evaluation of this initiative offer the opportunity to better understand this unique group of children and youth referred for community-based mental health services.

This study sample included a subset of data collected between 1998 and 2004 from the 45 communities funded under the Comprehensive Community Mental Health Services for Children and Their Families Program between 1997 and 2000. The sample (N = 3,767) for the current study consisted of children and youth enrolled in the national evaluation outcome study with complete data available for the following variables: reason for referral into service, demographic characteristics, child and family risk factors, and child behavior and functioning. Of those, 4.0% had both eating problems and sadness indicated as their reasons for referral into services (n = 152), 23.6% had only sadness (n = 890), 2.7% had only eating problems (n = 103), and 69.6% had problems other than eating or sadness (n = 2,622).

Demographic Characteristics

Nearly twice the number of girls, as compared to boys, entered services with an indicated eating problem (4.0% vs. 2.2%). A similar pattern was identified for youth who entered services with both eating and sadness problems (5.5% of girls vs. 3.3% of boys). While the distribution of presenting problems did not vary as a function of race/ethnicity, on average, children with eating problems were younger (M = 11.2, SD = 3.6) than those with sadness (M = 12.0, SD = 3.2), neither eating or sadness problems (M = 12.2, SD = 3.2) or both eating and sadness problems (M = 12.8, SD = 2.8).

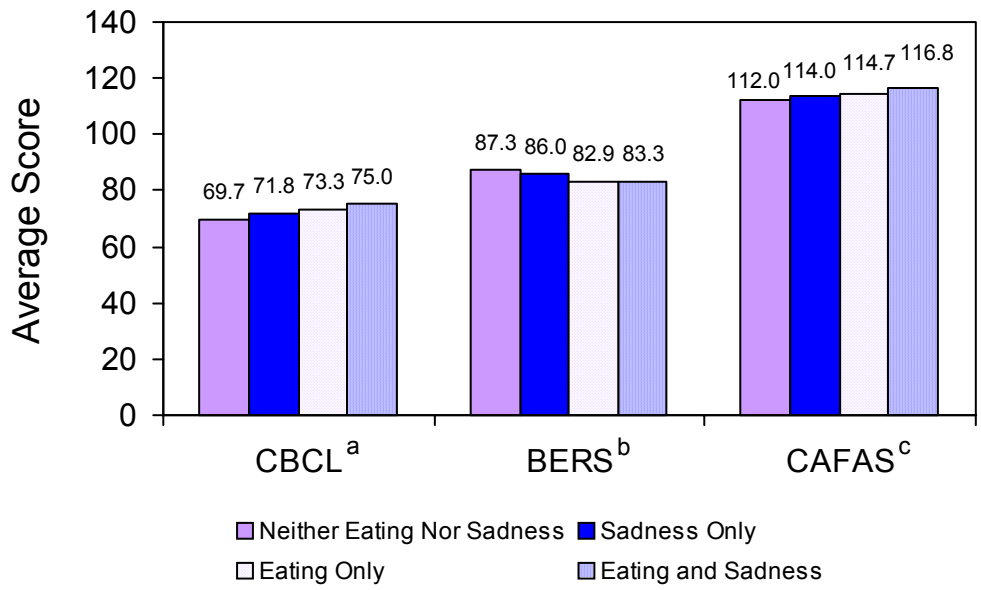
Youth and Family Risk Factors

As indicated in Table 1, youth who presented for services with both eating and sadness problems, as compared to eating, sadness, and other problems, had varying constellations of risk factors. For example, when compared to other eating problem categories, a high percentage of these youth had lifetime histories of family mental illness (72.4%), family violence (60.5%), parent felony conviction (52.0%), and substance abuse among family members (71.1%). In addition, a higher percentage

Table 1
Youth and Family Risk Factors by Eating Problem Category

	Other Problems (Neither Eating nor Sadness)	Sadness Problem	Eating Problem	Both Eating and Sadness Problems
Youth Risk Factors (lifetime)				
Physical Abuse	22.5%	28.0%	26.2%	27.0%
Sexual Abuse	21.0%	22.5%	35.0%	29.6%
Run Away From Home	34.4%	30.8%	30.1%	27.0%
Substance Use	19.1%	16.0%	19.4%	18.4%
Suicide Attempt	15.3%	21.8%	18.4%	26.3%
Sexually Abusive to Others	7.4%	8.1%	3.9%	8.6%
Psychiatric Hospitalization	27.5%	36.4%	26.2%	33.6%
Family Risk Factors (lifetime)				
Mental Illness in Biological Family	54.6%	63.7%	60.2%	72.4%
Domestic Violence or Spousal Abuse	48.1%	54.4%	56.3%	60.5%
Biological Parent Convicted of a Crime	46.3%	47.4%	46.6%	52.0%
Substance Abuse in Biological Family	62.3%	67.5%	63.1%	71.1%

Figure 1
Youth Behavior and Functioning by Eating Problem Category



[a] CBCL Total Problem scores greater than 60 indicate clinical range problems.
[b] BERS Overall Strength Quotient scores below 80 indicate poor behavioral and emotional strength.
[c] CAFAS Total Impairment scores greater than 100 indicate marked and severe impairment.

of youth who presented to services with both eating and sadness problems had attempted suicide (26.3%) than youth in any of the other eating problem categories (18.4% of eating, 21.8% of sadness, and 15.3% of other problems).

Although the rate of psychiatric hospitalization was high among youth with both eating and sadness problems (33.6%), it was slightly lower than that of youth with only sadness problems (36.4%). Interestingly, while the percentage of youth who had experienced physical abuse was comparable for the eating (26.2%), sadness (28.0%), and both eating and sadness (27.0%) problem groups, a higher percentage of youth with eating problems had experienced sexual abuse (35.0%) when compared to the other categories (29.6% of eating and sadness, 22.5% of sadness, and 21.0% of other problems).

Youth Behavior and Functioning

Upon entry into service, an assessment of behavioral problems using the Child Behavior Checklist (CBCL; Achenbach, 1991), behavioral and emotional strengths using the Behavioral and Emotional Rating Scale (BERS; Epstein & Sharma, 1998), and functional impairment using the Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 2000) was completed for each child in the current sample.

Inspection of Figure 1 indicates that youth who presented to community-based mental health services with eating problems, either alone or in combination with sadness, demonstrated significantly more behavioral problems, significantly lower behavioral and emotional strengths, and a trend (although not statistically significant) of greater functional impairment those who presented with either sadness alone or with problems other than eating and/or sadness. Those who entered services with comorbid eating and sadness had a tendency to present with the highest behavior and functional problems.

Conclusions

Study results suggest that from 1998 to 2004, 6.7% of children entering federally funded systems of

care presented with eating problems (either alone or in combination with other problems), 27.6% presented with sadness (either alone or in combination with other problems), and of those with eating or sadness problems (n = 1,145), 13.3% presented with both eating and sadness problems. These children's demographic characteristics, presence of youth and family risk factors, and youth behavior and functioning differed as a function of eating problem category.

While the literature to date has documented the association between eating disorders/problems and other psychological problems and disorders, less has been described about community-based individualized service planning and delivery approaches for these children as a function of their unique eating problem. The findings from this study indicate that youth with comorbid eating and sadness problems present consistently to services with higher levels of behavioral and emotional problems and family risk factor experience than their peers. However, youth risk experience varies more as a function of the problem in question and less as a function of the comorbidity of problems.

The prevalence of children with eating and sadness problems and the unique characteristics associated with these children who are referred into community-based system-of-care services highlights the need for appropriate interventions. Specifically, community-based mental health providers must appropriately assess and differentially plan services as a function of both the presence and comorbidity of eating and sadness problems, as well as their related psychosocial and clinical characteristics. More research is needed to better understand differential service constellations and differential outcomes for these children and youth.

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