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.

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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.

References


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 comorbidity 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.

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 = 909), 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 (32.0%), and substance abuse among family members (71.1%). In addition, a higher percentage 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 & Sharan, 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

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**Table 1**

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Youth and Family Risk Factors by Eating Problem Category</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Other Problems</td>
</tr>
<tr>
<td></td>
<td>(Neither Eating nor Sadness)</td>
</tr>
<tr>
<td><strong>Youth Risk Factors (lifetime)</strong></td>
<td></td>
</tr>
<tr>
<td>Physical Abuse</td>
<td>22.5%</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>21.0%</td>
</tr>
<tr>
<td>Run Away From Home</td>
<td>34.4%</td>
</tr>
<tr>
<td>Substance Use</td>
<td>19.1%</td>
</tr>
<tr>
<td>Suicide Attempt</td>
<td>15.5%</td>
</tr>
<tr>
<td>Sexually Abusive to Others</td>
<td>7.4%</td>
</tr>
<tr>
<td>Psychiatric Hospitalization</td>
<td>27.5%</td>
</tr>
<tr>
<td><strong>Family Risk Factors (lifetime)</strong></td>
<td></td>
</tr>
<tr>
<td>Mental Illness in Biological Family</td>
<td>54.6%</td>
</tr>
<tr>
<td>Domestic Violence or Spousal Abuse</td>
<td>48.1%</td>
</tr>
<tr>
<td>Biological Parent Convicted of a Crime</td>
<td>46.3%</td>
</tr>
<tr>
<td>Substance Abuse in Biological Family</td>
<td>62.3%</td>
</tr>
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