

## Stressful Family Life Events and Parental Perception of Poor Appetite in Children

Harmesh Singh  
P.J.S. Gill  
Daljit Singh  
B.K. Jain

Pediatricians are often consulted for poor appetite in children as perceived by parents. A child's poor appetite has indeed many connotations(1). In many instances the complaint exists even though child is fact nutritionally normal. Apart from normal fluctuation of appetite(2,3), drugs(4) and various psychological factors(5-7) have been reported as causes of poor appetite. The role of stress in this context has not been objectively studied. The present study was planned to assess the correlation between stressful events in the family and reportedly poor appetite in normal children.

### Material and Methods

Ninety children aged 1-5 years, brought with the parental complaint of 'poor appetite' were studied. Children who were un-

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*From the Departments of Pediatrics and Social an Preventive Medicine, Dayanand Medical College and Hospital, Ludhiana, Punjab.*

*Reprint requests: Dr. Harmesh Singh, C/o Ganesh Medical Hall, Tagore Nagar Extension I, Ludhiana, Punjab.*

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derweight(8), or had organic causes of poor appetite were excluded. The parents of the selected children were subjected to a structured interview which included: (a) sociodemographic variables, (b) feeding practices, and (c) stressful family life events in the last one year, which was based on Beautrais's modified version(9) of the Holmes and Rahe Social Readjustment Rating scale. The aspects covered were: death or illness in a close family member, change or loss of parent's employment, shifting of house, serious accidents, involvement of the family in litigation, and marital disharmony. The control group included ninety age, sex and socioeconomic status matched children who were stated to have normal appetite. Literacy level of parents and maternal working status were comparable in both the group. Chi square test was used for statistical analysis.

### Results

The study group consisted of 69 boys and 21 girls. Sex wise there was no significant difference with respect to the presence of stressful events. Fifty seven per cent of children were between 1-3 years of age and 43% were 4-5 years old. The total number of children in the family were 1,2,3 and 4 or more in 23%, 30%, 30% and 17%, respectively. There was no correlation between family size and incidence of stressful events.

Stressful family life events (*Table I*) were observed in 66.7% children in the study group compared to 20% in controls. The difference between these two groups was statistically significant ( $p < 0.001$ ).

Various feeding strategies (*Table II*) were reported significantly more frequently (72%) in the study group than among controls (29%)( $p < 0.001$ ). Food forcing,

TABLE I—*Stressful Family Life Events*

Event in preceding 1 year*	Study group (n = 90)		Control group (n = 90)	
	No.	(%)	No.	(%)
Shifting of house	37	(41.4)	7	(7.8)
Chronic illness in family	21	(23.3)	5	(5.6)
Frequent change in job of parents	17	(18.9)	7	(7.8)
Frequent arguments between parents	13	(14.4)	7	(7.8)
Excessive alcohol intake by father	7	(7.8)	3	(3.3)
Death of one/both parents	6	(6.7)	2	(2.2)
Serious accidents in family	6	(6.7)	3	(3.3)
Death of relative	4	(4.4)	1	(1.1)
Family involved in litigation	3	(3.3)	Nil	(0.0)
No stressful events	30	(33.3)	72	(80.0)

\* Multiple responses.

p <0.001 (significant difference between study and control group).

coercion, offering rewards, threat of punishment, smacking, allowing a child to choose exactly what he/she likes and allowing snacks any time between meals were more frequently observed in the study group. Most (92%) parents had tried various tonics and other medicines. Seventy nine per cent of the children were given too frequent milk feeds.

### Discussion

The present study showed clearly that stressful family life events were associated with parental perception of poor appetite in children. It might be suggested that the presence of stress in the family decreases maternal coping ability with resultant undesirable methods of feeding like forced feeding, punishment, *etc.* causing refusal of feeds in children. Adults are known to indulge in excessive intake following stressful

events(10-12) which is a reflection of mal-adjustment and may in turn be a basis for perception of poor appetite in their children. At the same time, the resultant food forcing and other harmful feeding strategies may themselves alter the normal feeding pattern of the child and even cause actual decrease in appetite.

According to Illingworth(4) the commonest cause of poor appetite is food forcing which itself may be due to excessive anxiety about the child's nutrition, dawdling with food and misconceptions regarding food requirement. This study also showed significantly more food forcing in children in the study group as compared to controls. Due to food forcing or punishment in the presence of normal negativism in age group of 9 months to 3 years(3), a child may become conditioned against food and may

TABLE II—Parental Strategy Employed for Feeding

Method*	Study group (n = 90)		Control group (n = 90)	
	No.	(%)	No.	(%)
Providing frequent snacks between meals	54	(58.8)	30	(33.3)
Allowing child to always choose exact food items	44	(48.8)	21	(23.3)
Feeding by force	38	(42.4)	11	(12.2)
Persistently insisting to eat more	36	(40.0)	8	(8.9)
Routinely offering rewards	27	(28.9)	5	(5.5)
Smacking for not eating	26	(27.8)	9	(10.0)
Threatening punishment	25	(27.8)	11	(12.2)
Regularly using various modes of distraction	25	(27.8)	6	(6.7)
No specific method used	28	(31.0)	71	(78.8)

\* Multiple responses.

p < 0.001 (significant). for each item.

develop a real dislike for it. Parents should be advised not to inappropriately force their children to eat. There should be no over-persuasion, coaxing, bribing, threatening or punishment. The inappropriate use of tonics and other appetite stimulating medicines should be avoided. Excess of milk intake may prevent a child from having other more important foods(6) and hence should be avoided. Similarly, frequent eating in between meals should not be allowed.

To conclude, an association between stressful events and 'poor appetite' in children exists. It is important to gain insight into family's psychosocial environment and its problems during assessment and management of this problem.

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## Schinzel-Giedion Syndrome

**Said Alavi**

**A. Kher**

**B.A. Bharucha**

Schinzel-Giedion syndrome is a rare disorder characterized by midface retraction, hypertrichosis, multiple skeletal anomalies, cardiac and renal anomalies and severe developmental retardation(1). This was first described by Schinzel and Giedion in 1978(2). A total of 11 cases have been so far reported(3) and here we report the first case from India.

*From the Department of Pediatrics, K.E.M. Hospital and Seth G.S. Medical College, Parel, Bombay 400 012.*

*Reprint requests: Dr. B.A. Bharucha, Professor, Department of Pediatrics, K.E.M. Hospital, Parel, Bombay 400 012.*

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## Case Report

The patient was a 1-year-old boy, fifth issue of a third degree consanguinous marriage, of a thirty year old gravida five, para three mother and thirty seven year old father. The pregnancy was full term by dates and was uncomplicated by illness, irradiation or teratogenic drug exposure. The three elder siblings were normal, but the fourth issue was a boy who was born at term and had dysmorphic features with club feet like the patient and died at 3 months of age. There was no history of any major illness during infancy. Motor, language and intellectual milestones were markedly delayed.

On physical examination, he was a markedly dysmorphic child with coarse face, wide open anterior fontanelle, frontal bossing, anteverted nostril, midface retraction, ocular hypertelorism and bilateral talipes equinovarus. External genitalia showed bilateral undescended testes with hypoplastic scrotum (*Fig; 1*). Other anomalies are listed in *Table I*. Laboratory investigations revealed normal serum concentration of blood urea, creatinine, thyroid profile, urinary mucopolysaccharides, aminoacids and