

Rumination disorder: causes, epidemiology and treatment

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Rumination disorder is an eating disorder whereby an infant or toddler brings back up and re-chews food that was already swallowed and digested. This is known as regurgitation. In most cases, the re-chewed food is then swallowed again; but occasionally, the child will spit it out. For this to be considered a disorder, the behaviour must have occurred to a child who had been eating normally previously, and it must occur frequently for at least a month. The behaviour may occur during feeding or right after eating.

What Are the Symptoms of Rumination Disorder in Babies and Kids?

Symptoms of rumination disorder in infants and toddlers may include (1) repeated regurgitation of food (2) repeated re-chewing of food (3) weight loss (4) repeated stomach aches (5) raw and chapped lips. Infants, in addition, may make unusual movements such as straining and arching the back, holding the head back, tightening abdominal muscles and making sucking movements with the mouth. These movements could suggest that the infant is trying to bring back up the partially digested food.

What Causes Rumination Disorder?

The exact cause of rumination disorder is unknown although there several speculation. According to () some factors that may contribute to this disorder are those that are physical. Physical illness or stress may trigger the behaviour. It may be a way for the child to get attention; it has been found that neglect from the primary care giver may cause the child to engage in self comfort. It has been found that rumination may occur in a state of self relaxation , self absorption and self pleasure. It appears to have a self

soothing or self stimulating function. The infant gets some satisfaction from this.

For the first four to six months of an infants life, breast milk or an alternative formula is a baby's source of energy and nutrients (Santrock, 2011). it has been found that breast fed infants have lower respiratory tract infections, they are less likely to develop otitis media (a middle ear infection) and breast fed infants have fewer gastrointestinal infections (Santrock, 2011). According to (Chial, Camilleri, Williams, Litzinger, & Perrault, 2003) rumination is a functional gastrointestinal infection. This suggests that there is a possibility that children who develop this disorder may have had a lack of breast feeding as an infant which further elaborates that neglect from the primary caregiver is vital. Rumination is common in disorders such as bulimia nervosa. It is a learned disorder and comes from a manifestation of rejection.

<http://www.webmd.com/children/guide/eating-disorders-in-children-rumination-disorder? page= 3>

Epidemiology

It is difficult to know exactly how many people are affected by this disorder mainly because most cases are not reported. Children tend to outgrow it and as they grow into the adolescent stages and adulthood, they become embarrassed by it and it often happens in secret. Rumination disorder is generally uncommon. Rumination disorder occurs often in infants between the ages of three and twelve months as well as in children with cognitive

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impairments. It may occur slightly more often in boys than in girls, but few studies of the disorder exist to confirm this. (webmd)

For the purpose of this paper, the South African context will be put into consideration. It is important to remember that reality is socially constructed. South Africa is a diversified country with many cultures. Amongst many of the African cultures, western culture is often overlooked and shunned upon. It is difficult to change the minds of others and it would be unethical for an “outsider” to come and talk against their belief systems.

When there is behaviour that is unusual, it is common for the average traditional African woman or man to put their trust in the customary traditional healer. People tend to keep their parental and ancestral roots, this is quite common more often in the homelands where majority of the financially deprived stay; even though sometimes it happens that those who move to the city to look for jobs may adopt new ways of thinking but still truly remaining to their roots. Because of these strong traditional beliefs, primary caregivers may opt for traditional healers than westernised medical attention. It is also much easier to go to a traditional healer than it is finding a good clinic or good health care facility. The social and economic pressures make it hard for children to get the right kind of medical attention. It is common for these primary caregivers to believe it is witch craft, it is something they learn. When something cannot be explained, it is easier to put blame in witchcraft.

—often with grandparents staying in rural areas and the younger people moving to the cities in search of employment, better education, and health

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care. The effects of disrupted bonds are manifold. In our field, the geographical separation between young mothers and the maternal grandmothers has particularly far reaching consequences.

We have called our Service theMdlezana Centre. This is a Xhosa word depicting the early bond between mother and child, when they are still one unit—equivalent to the Winnicottian term of the state of primary maternal preoccupation.

Infant Mental Health was a new concept in 1995, but it took root in the city of Cape Town immediately. There are no problems in obtaining referrals to the Rondebosch pillar—in fact, at times we are inundated, and can barely cope with the workload. In Khayelitsha, the situation is different and the population was initially hard to reach. There are various reasons for this:

1. In a community where unemployment is unimaginably high, where families are disrupted, where there is often no food, the emotional life of the infant is not a priority.
2. Mothers, who are the main caregivers (I have only seen fathers on two occasions in the past five years) are often depressed and suffer in silence. They have a helplessness that is real and in a way adaptive in the sense that the great majority of women have no choice, but to cope and make do with what they have. They bear their fate stoically and will not spontaneously open up.
3. Then there are cultural factors in that one does not easily share with strangers one's intimate family problems. There is a sense of privacy and possibly shame and thus problems are often borne silently. A visit

to a Traditional Healer is for many a more familiar option. I shall return to this point shortly.

4. The infants themselves are mostly not a problem— they are generally quiet and seemingly content—this is an observation that all western visitors who come with me to the clinic make. The wait is often long, but the noise level low and there is immense patience, even in the babies and toddlers. It is only the physically obvious, such as delayed milestones, that will readily be seen as a reason for a consultation.

On a diagnostic level the infants fall into three broad categories: developmental delay, failure to thrive, and increasingly, depression.

When a condition sets in after birth, then the presence of evil spirits or bewitchment is very much in the foreground. For whatever individual reason, the protection of the ancestors has been withdrawn and the child has become exposed to forces of evil, the impundulu. The muthiis said to drive out the evil spirit or to strengthen and protect the child against it. Mostly these interventions are harmless from a medical perspective —however, there are some mixtures which, when ingested, can cause gastrointestinal symptoms.

Operations and anesthetics are at times viewed with great fear. This may have to do with a giving up of the child to be put to sleep —which, in effect, could mean a kind of death. The father of one ill infant whom we saw and who required surgery spoke about “ sacrificing” his child. The healer who was involved in this case also said to the parents that surgery would

interfere with the workings of the machinery he was using. The end result was that the child did not receive the operation in time and died.

A working alliance with traditional healers is being established with the recent founding of the Traditional Healers' Association. It is hoped that with collaborating with the traditional healers in diagnosis and treatment gaps can be bridged and unnecessary suffering be prevented.

I will end this section by giving a brief case illustration.

How Is Rumination Disorder Diagnosed in Infants and Children?

The diagnosis of rumination syndrome is based upon the characteristic symptoms and the absence of signs of disease. Although diagnostic criteria (symptom-based, Rome II) for childhood functional gastrointestinal disorders have been developed, such criteria for children and adolescents with rumination syndrome have not been defined. The lack of formal criteria for diagnosing rumination syndrome in children and adolescents likely contributes to the lack of awareness of the condition and to the difficulty in making the diagnosis. We anticipate that such criteria will be developed in the future.

How Is Rumination Disorder Treated in Children?

Rumination disorder is a voluntary, learned behaviour which patients are frequently unaware of. As infants grow older, clinical features of regurgitation are similar to those of bulimia nervosa. Before one can be diagnosed it has been found that individuals with this disorder undergo several medical

interventions and experience prolonged symptoms before a diagnosis is made. (Chial, La Crosse, Camilleri, & Bean, 2009)

One important aspect in the history is the timing of the regurgitation. Diaphragmatic breathing has been shown to be clinically beneficial in rumination syndrome; although this type of treatment can only take place starting from ages where toddlers can understand. According to (Chiktara, van Tilburg, Whitehead, & Tall, 2006) this method is useful to treat children as young as six years of age. Patients should be encouraged to practice diaphragmatic breathing midway through the meal or after meals for three different 5 min periods of inactivity with 10 min in between periods. They should also repeat this plan after each episode of regurgitation. The goal is for diaphragmatic breathing to occur unconsciously during events that may incur regurgitation.

Treatment of rumination disorder mainly focuses on changing the child's behaviour. Several approaches may be used, including: Continue reading below...

- Changing the child's posture during and right after eating
- Encouraging more interaction between mother and child during feeding; giving the child more attention
- Reducing distractions during feeding
- Making feeding a more relaxing and pleasurable experience
- Distracting the child when he or she begins the rumination behavior
- Aversive conditioning, which involves placing something sour or bad-tasting on the child's tongue when he or she begins to vomit

Psychotherapy for the mother and/or family may be helpful to improve communication and address any negative feelings toward the child due to the behavior.

There are no medications used to treat rumination disorder.

What Complications Are Associated With Rumination Disorder?

Among the many potential complications associated with untreated rumination disorder in infants and children are:

- Malnutrition
- Lowered resistance to infections and diseases
- Failure to grow and thrive
- Weight loss
- Stomach diseases such as ulcers
- Dehydration
- Bad breath and tooth decay
- Aspiration pneumonia and other respiratory problems (from vomit that is breathed into the lungs)
- Choking
- Death

What Is the Outlook for Children With Rumination Disorder?

In most cases, infants and young children with rumination disorder will outgrow the behavior and return to eating normally. For older children, this disorder can continue for months.

Can Rumination Disorder Be Prevented in Infants and Children?

There is no known way to prevent rumination disorder in infants and children. However, careful attention to a child's eating habits may help catch the disorder before serious complications can occur.

(culture and psychiatry journal)

The culture of the patient

In addition to individual factors—such as level of education, medical knowledge, and personal life experiences—culture will contribute to the patient's understanding of illness, perception and presentation of symptoms and problems, and reaction and adjustment to illness. The patient's expectations of the physician, motivation for treatment, and compliance with treatment recommendations are also influenced by culture.