

# Section I

## THE PROBLEM



# 1

## INTRODUCTION

*Nourish thy children, O thou good nurse; 'stablish their feet.*

Apocrypha, II *Esdras* Ch. 2, v. 25

### PREAMBLE

This book is based on more than a quarter of a century of research, clinical work, and independent assessment work concerning children who fail to thrive. It also draws upon a 20-year follow-up study of 31 subjects, and so contributes to an understanding of the problems of such children, as well as shedding light on parental perceptions and management of difficulties associated with failure to thrive.

Many years of direct contact with these children and their families provided invaluable experience and the accumulation of knowledge about characteristics of children and parents, family dynamics, and problems associated with growth and development. Most importantly, it became clear that there were many aspects of failure to thrive, ranging from mild problems of weight-faltering (due to some feeding problems, parental anxiety, and lack of experience in rearing children) to far more persistent and difficult failure to thrive (associated with inadequate parenting, distorted perceptions and relationships, and neglect and abuse).

Since the mid-1970s, when the present writer began to study children who fail to thrive, knowledge has expanded enormously, and many well-designed studies have been carried out, examining different facets of the subject, in several parts of the world. We now know far more about the prevalence of failure to thrive (FTT), as a result of community-based studies, than we knew years ago when most samples were drawn from hospitalised children with severe failure to thrive. We have also learned that children identified during the early onset of weight-faltering can be helped relatively quickly without any long-term negative effects. But, equally, we have established that some children with more severe FTT may have had the condition induced because of poor

or inadequate parenting, and may require more extensive intervention: such children tend to show a very poor prognosis for improvement or recovery. Longitudinal studies have confirmed these findings.

For these reasons, all those who have responsibilities for overseeing children's growth and development should take the first signs of growth-faltering very seriously indeed. 'Prevention is better than cure' may be a cliché, but the sooner the problem is recognised, the better it is for both baby and care-giver. Some children may grow out of early difficulties, but some do not; for them, their problems grow as they do.

During the author's involvement in this field, it became apparent that the failure-to-thrive syndrome can have many shades, and is not a simple matter of faltering growth during the first few months of a child's life. If that were the case, most problems would be resolved by recourse to services and resources available to everybody. However, despite the fact that mandatory help is given by health visitors, many children fail to thrive, so there must be other psychosocial factors at work which create the problems and prove resistant to nutritional treatment alone. Such factors are many and varied, and so no two cases will be exactly the same, although there may be similarities between them. All children displaying symptoms of FTT are undernourished, and all fail to grow according to expected norms, but that is where the similarities end.

There are substantial variations in reasons why certain children fail to thrive, not least those connected with poor nutrition. Some children may have sucking/eating problems, or mild oral-motor dysfunction, while others may not be acquiring sufficient nutrition because of parental lack of understanding of what and how to feed, or because of neglect. In addition, some parents may react to presenting problems and to caring tasks in many different ways. Some worry and become anxious about their children's poor intake of food and poor growth; others become angry and frustrated; some may perceive their children's refusal of food as personal affronts, involving rejection by the children themselves; others may assume that their children are simply not hungry.

Parental attitudes to food will play roles as well. How food is presented to children, and what is fed to them will often establish that fears concerning potential obesity of children will be important factors in those parental attitudes. Some will deliberately withhold food, and some will fabricate illnesses: in both instances the children will fail to thrive.

On the other hand, children will also react to parental behaviour: some will be anxious, apprehensive, and fearful; while others will withdraw, becoming lethargic and detached. Thus, the behaviours of parents and of children may influence each other and create tension, a sense of lack of achievement (and therefore of disappointment), and trigger feelings of depression. Such problems are not conducive to healthy growth, and vicious circles may be created which produce major difficulties requiring complex remedies.

To illustrate different routes to under-nutrition resulting in FTT, a few examples are given below:

### **Examples**

- Previn, who was referred when he was 3 months old, was not given a sufficient amount of food and the right formula as his mother did not like fat babies or fat people in general;
- Indira was referred when she was 2 years and 3 months old. She had presented with feeding difficulties from birth. Her mother would spend hours trying to feed her. Indira would spit out food, heave, store food in her mouth, and refuse to chew and swallow;
- At the age of 1 year 11 months, Kevin looked extremely thin, and sick, and developmentally was delayed. His mother abandoned him after birth, but was forced to take him back by her parents. He was an unwanted child;
- Penny's birth-weight was 4.1 kg (9 lb. 1 oz.). At 2½ months her weight dropped to 3.75 kg (8 lb. 3 oz.). Her mother was informed two days after Penny was born that her 32-year-old sister had died of cancer;
- Rose was 13 months old, the third child in the family. She looked thin, small, lethargic, and withdrawn. Rose's weight dropped to under the 2nd percentile from the 25th percentile, and at 6 weeks she still was under the 2nd percentile. Her mother suffered from post-natal depression;
- Rebecca's birth-weight was on the 25th percentile. She stopped gaining weight at 5 months, and fell below the 2nd percentile at 7 months. Parental worries that there might be an organic reason for poor intake of food and poor growth were dismissed. At 16 months it was discovered that she suffered from severe neuromuscular incoordination of the oesophagus;
- Nancy, aged 6 months, gained only just under 1 kg (2 lb. 2 oz.) following her birth. Her mother was 16 years old and had spent all her life in care. She was an immature person and there was nobody to help her.

All these children failed to thrive, and they had one thing in common: they did not get a sufficient amount of nutrition into their systems and all of them were undernourished. The reasons why they were underfed, however, differ from case to case.

Previn was underfed because of maternal and paternal attitudes towards food and preoccupation with weight. Penny did not gain weight in spite of unsuccessful attempts by her mother to feed her: this was associated with her mother's depression connected with sudden bereavement and trauma. Rebecca did not thrive because of physical illness which was not detected and dealt with early on. Kevin's physical and psychosocial growth was poor because of severe neglect and rejection. Indira was extremely difficult to feed from birth and demonstrated oral-motor dysfunction. Nancy was starved unintentionally, as her mother proved unable to read her signals of hunger and did not know much about the nutritional needs of children and generally about parenting.

Many of these children presented feeding problems of one kind or another: some were not fed regularly, sufficiently, and in a manner which would facilitate interest and enjoyment of food; some, because of illness, found swallowing and digestion painful; some had mothers who, because of their depressed state, could not tune into their babies' emotional and nutritional needs; some mothers did not know what their children's nutritional needs were; and a few mothers were simply neglectful or rejectful. Many children are difficult to feed and to care for, so parent-child interaction might be influenced by unexpected problems.

Nowadays, support from the extended family generally has diminished: children tend to live far away from their parents (whence traditional child care support came), and there is often no one to turn to for regular help and advice. Many young parents (particularly mothers) may find child-rearing difficult as they have little experience and even less knowledge about the challenges of child care. They may be unaccustomed to infants because they were brought up in small families and were not given responsibilities for caring for their younger siblings, as older children of yesteryear were obliged to do. They may themselves have been brought up in neglectful and uncaring homes, and had no opportunities to acquire parenting skills or any understanding of children's developmental needs. They may live in adverse social and economic circumstances that may affect the quality of everyday child care. Growing numbers of single, young, and immature mothers (often living in poverty), who are socially isolated and unsupported, are unprepared for the demands of child-rearing, and therefore unable to provide basic physical and emotional nurturance and to meet adequately the nutritional needs of small infants. Most parents, however, successfully carry out the complex tasks involved in child-rearing, using a variety of methods in very diverse family, cultural, and social circumstances.

It must be said that the majority of parents of FTT children do their best and provide adequate care and attention for their offspring, but for one reason or another are not successful in feeding them. Failing to feed a child is a devastating experience for most mothers, as they feel inadequate as carers and worry about the child's health and even survival. They also fear that they may be judged by others as neglectful and uncaring, so they become anxious and overwhelmed with the tasks associated with child care, but more specifically with the baby's feeding behaviour and poor weight gain.

All these children and their families need help. Furthermore, help is needed early on to prevent escalation of problems associated with attachment, interaction, relationships, and inadequate growth and development. Unresolved early difficulties can have a long-term negative effect on children and parents. These children are not always identified as potentially at risk at the onset of presenting nutritional and interactional problems. A 'wait-and-see' approach is often favoured, leaving vulnerable children and equally vulnerable parents at a chance juncture. Some of them do survive but some do not. 'Survival' here

is used to mean a healthy and relatively problem-free childhood, with parents who enjoy parenthood, and the sense of a job well done.

## **WHAT IS FAILURE TO THRIVE?**

From the day a baby is born, parents will focus their attention on the child's growth and development: their major preoccupation will be connected with feeding, health, and the baby's contentment, and they will be eager to see how much weight the baby gains, how it responds to their nurturing, and what developmental progress it makes.

In order for a baby to grow adequately and according to expected norms, it will need to get sufficient nutrition on a regular basis: this should be provided in a manner which will be anxiety-free, enjoyable, and satisfying. So, to give and accept nutrition is at the core of the emerging relationship and interactional synchrony between mother and child. The mutual satisfaction and success of feeding and caring will determine not only the speed of physical growth but also psychomotor development and general responsiveness and alertness. In a secure, caring home, and fuelled by adequate nutrition, children will thrive, giving parents pleasure and confidence in their parenting. In homes riddled with conflict, stress, and chaos, or where parents are ill informed, the children's progress might be slowed down or even impaired if nutritional intake and the quality of nurturing are inadequate for their chronological ages.

Early childhood is a very busy and demanding time where growth and development are concerned, for children grow rapidly, both physically and psychologically. Growth in the first year of life will be quicker than at any other stage during childhood, decreasing rapidly until the end of the third year, then continuing at about one-third of its post-natal rate until puberty (Bee, 1985).

Not all children grow at the same rate. There are considerable variations in rates of growth, and some children have very poor rates of growth. These children have been labelled as FTT and, compared with children of the same age, are significantly smaller and thinner, and can be expected to have poor outcomes. They can be found in all social classes and levels of society. Without early detection and help, the likelihood is that their physical growth, cognitive progress, and emotional development will suffer, and that these negative effects will be long-lasting (Iwaniec & Sneddon, 2002). Additionally, failure to identify these children at an early stage, and failure to take appropriate action to provide suitable help, may lead to distortion of the parent-child relationship, attachment disorders, disturbed behaviour, and developmental (especially cognitive) impairment (Iwaniec, 1995).

Failure to thrive can emerge at different times in an infant's life, as the result of illness or trauma, but under-nutrition during early infancy can have

the most detrimental effects as the nutritional requirements at that time are at their most critical. Given the period of rapid growth, particularly brain growth, which occurs during the first few years, particular attention should be given to sufficient and appropriate provision of food (Wynne, 1996; Wright (C.M.), 2000).

So what is failure to thrive? In children it is seen as failure to grow because of under-nutrition in terms of weight gain, height, and head circumference according to expected standards and speed for the child's age. Aetiological factors of inadequate intake of food are complex and varied, but the fact remains that all children who fail to thrive (for whatever reason) do not get sufficient calories into their systems.

The phrase 'failure to thrive' was used as early as 1887 and was introduced by Holt in the first edition of *Diseases of Infancy and Childhood* to describe babies who fail to grow after weaning from the breast. The following quotation from his book described chronic disorder of those children:

The history in severe cases is strikingly uniform. The following is the story most frequently told. 'At birth the infant was plump and well-nourished and continued to thrive for a month or six weeks while the mother was nursing him; at the end of that period *circumstances* made weaning necessary. From that time on the child *ceased to thrive*. He began to lose weight and strength, at first slowly then rapidly, in spite of the fact that every known infant food was tried.' As a last resort the child, wasted to a skeleton, is brought to hospital.

The term has changed its meaning substantially and has been interpreted in many different ways over the last century. Until the first part of the twentieth century the condition of a wasted body was called *marasmus*, and was always associated with some known or unknown physical disease: it was only a few decades ago (when growth began to be studied scientifically) that failure to thrive was recognised as not necessarily a disease, but as an amalgamation of symptoms which might have many causes. Aetiological factors are varied, but the *primary* reason is inadequate nutrition. Contributory factors include: malabsorption, chronic infection, major structural congenital abnormalities, and metabolic and endocrine defects. However, there are some infants and young children who fail to thrive in whom none of the above factors is obvious (apart from inadequate nutrition), who do not grow, and whose well-being gives cause for concern. This is referred to as *non-organic failure to thrive*. It has been recognised in recent years, however, that making a distinction between organic and non-organic failure to thrive is not useful, because it is better to view failure to thrive as a syndrome of malnutrition associated with all possible roots (Taylor & Daniel, 1999). Ill children who are failing to thrive might be neglected or inadequately cared for as well, so both organic and non-organic factors should be investigated.

The term 'failure to thrive' is not generally used (although often applicable) when speaking of a large population of children world-wide who suffer from

serious malnutrition as a result of the shortage of food for themselves or their breast-feeding mothers. Where there is total food deficiency resulting in the stunting of growth, we still refer to it as *marasmus*. It has been estimated by the World Health Organisation (1999) that more than 150 million small children throughout the world are severely or moderately malnourished. Most of these children are living in the under-developed countries where famine, war, widespread poverty, and, in some cases, corruption, make food scarce. Yet we know that malnutrition is not exclusively located in the Third World. In Britain and other well-developed countries many children suffer from malnutrition, which is often undetected because of inadequate screening or lack of child-friendly social policies.

Failure to thrive as a diagnosis becomes significant in a society which can presume food will be available to all its children and where knowledge of childhood illnesses and normal growth and development have become sufficiently precise to define the reasons for growth failure. Failure to thrive over the last six decades has acquired various labels, such as:

- *maternal deprivation* (Bowlby, 1953);
- *environmental retardation* (Coleman & Provence, 1957);
- *mask deprivation* (Prugh & Harlow, 1962);
- *environmental failure to thrive* (Barbero & Shaheen, 1967);
- *deprivation-dwarfism* (Silver & Finkelstein, 1967);
- *psychosocial dwarfism* (Wolff & Money, 1973); and
- *psychosocial short stature and stunting of growth* (MacCarthy & Booth, 1970).

Following the introduction of maternal-deprivation theory and studies of the effects on children living in institutions, new theories and new interpretations and practice policies were evolved. Maternal-deprivation theory had long been disregarded in relation to failure to thrive. Before it was rejected, however, the child-abuse syndrome emerged, which firmly pointed a finger at the mother as a main contributory factor in child growth failure. Various small-scale, uncontrolled studies (mostly based on clinical observation in the 1960s and 1970s) were closely linked theoretically to child-abuse and neglect cases. Although there is an undoubted association between abuse, neglect, and failure to thrive, it applies only in some cases. From the 1980s onwards, control studies began to emerge, as well as the results of the first long-term follow-up studies, shedding new light on the problem and greatly expanding current knowledge.

## AIMS OF THE BOOK

In the present book the author aims to review existing research and practice literature and to share with readers personal experiences acquired over

many years. This book is written for busy practitioners to assist them in finding some facts, assessment tools, and various intervention and treatment strategies and methods to help these children and their parents. It is hoped that multi-disciplinary teams will find a few things of interest and that inter-agency work associated with failure to thrive will be informed by tips and ideas provided in the book.

As failure to thrive is multi-factorial, and, therefore, multi-disciplinary in assessment and treatment, the book might be of interest and help to health visitors, paediatricians, GPs, paediatric nurses, social workers, dieticians, psychologists, day-nursery staff, teachers, and others who work or have some responsibility to this client group.

It is also anticipated that the book will provide useful material for teaching in professional courses, as well as in multi-disciplinary child care and child-protection courses.

## ORGANISATION OF THE BOOK

The book is organised in three sections.

- Section I** **The Problem** deals with various causal factors and manifestations of failure-to-thrive syndrome.
- Section II** **The Framework of Assessment** examines issues and presenting problems associated with children, their families, and the environment in which they live. Ecological theory-based assessment is described.
- Section III** **Intervention and Treatment** discusses various methods, techniques, and approaches to helping these children and their families. It also puts forward some recommendations for future practice and research.

## SECTION I: THE PROBLEM

- Chapter 1** is an introduction to the book, briefly discussing the complexity of failure to thrive and different aetiological factors leading to inadequate nutrition and subsequent faltering of growth.
- Chapter 2** looks at the history of child care over many centuries, and discusses the development of knowledge of the failure-to-thrive concept through research and practice.
- Chapter 3** discusses difficulties of defining failure to thrive and problems associated with measuring growth and development. It provides a profile and characteristics of these children and their carers, as well as different types of failure to thrive. Case studies are also presented.

- Chapter 4** describes characteristic features of children suffering from psychosocial short-stature syndrome, and draws attention to the emotional abuse of such children, the plight of whom is illustrated by case studies.
- Chapter 5** outlines various feeding/eating problems in infancy and early childhood. Parental attitudes to food, oral-motor dysfunctions, faddiness, force-feeding, weaning and transition, and parental feeding styles are reviewed.
- Chapter 6** examines parent-child interaction generally, and during feeding time specifically. Children's and parental temperamental attributes and how they affect each other are discussed. A pilot study examining FTT parent-child interaction compared with thriving siblings is included.
- Chapter 7** describes different attachment styles in children and adults, and discusses why many failure-to-thrive children are insecurely attached to their mothers. Case studies to illustrate insecure attachment styles are provided. A comparison between childhood attachment style with attachment style in adulthood is presented, based on the author's longitudinal study of FTT children.
- Chapter 8** describes fabricated or induced illnesses which can lead to failure to thrive. It includes deliberate withholding of food due to fabricated symptoms (such as non-existing allergies or other illnesses).

## **SECTION II: THE FRAMEWORK OF ASSESSMENT**

- Chapter 9** This extensive chapter deals with the assessment of FTT in a holistic and comprehensive way. It includes factors associated with the children's developmental needs, parental capacity, and family and environmental issues. The child-centred assessment is based on the ecological theory recommended by the Department of Health in 2000.

## **SECTION III: INTERVENTION AND TREATMENT**

- Chapter 10** describes four levels of intervention: universal level—available to all; targeted level—available to those in need of family support; selected level of intervention—for those who are causing concern and may be at risk; and Civil Court intervention—for those who are suffering or may suffer significant harm.

- Chapter 11** appraises examples of interventions based on ecological, behavioural, cognitive, and attachment theories. It also briefly explains why children fail to thrive from each theoretical point of view.
- Chapter 12** provides a multidimensional model of intervention developed by the author using behavioural, cognitive, and psychosocial methods of treatment, as well as a number of services to promote positive change in children and parents.
- Chapter 13** reviews approaches to failure-to-thrive interventions, such as multi-disciplinary and inter-agency approaches as well as the suitability and effectiveness of the involvement of health visitors and social workers. Additionally, a brief discussion of the necessity to view failure to thrive as a psychosocial problem (and not just as a health problem) is provided.
- Chapter 14** puts forward considerations arising from FTT intervention research such as: parental beliefs, parental history of nurturance, psychosocial issues, parental competence and compliance, self-efficacy, individual differences, and methodological issues. The chapter ends with recommendations regarding practice and research.
- Epilogue** sums up current practice.