Failure to Thrive: The Silent Epidemic of the Elderly
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Demographic changes have created the need for psychiatric nurses to examine knowledge and practice in the area of geropsychiatry. Older adults present unique challenges. The interaction of biological and psychosocial problems are most evident in the oldest old and necessitate a holistic approach. This report addresses psychosocial causes and treatment of "Failure to Thrive" (FTT) in the elderly. FTT is a label commonly used to describe a complex of nonspecific symptoms that often leads to increased disability and premature death. Psychiatric nurses are challenged to take a leadership role in case finding, as well as assessment and intervention.

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WHEN OLDER adults enter the health care system, they may complain of "just not feeling well". Family members may note that they are "going down hill". Their condition is sometimes referred to as "failure to thrive" (FTT), a syndrome of nonspecific symptoms in the elderly including (a) unexplained weight loss, (b) deterioration in mental status and functional ability, and (c) social isolation (Newbern, 1992). Organic causes are most frequently addressed in the literature; however, psychosocial factors also play a critical role in the etiology of this syndrome. Nurses need to understand the nonorganic factors associated with FTT, because this is specifically nursing's domain of concern and area of independent practice.

REVIEW OF THE LITERATURE

FTT in older adults has been defined as "...a gradual decline in physical and/or cognitive function of an elderly patient, usually associated with weight loss and social withdrawal, that occurs without immediate explanation" (Palmer, 1990, p. 47). Causes mentioned in the literature include occult organic illness and polypharmacy (Sandrick, 1988) malnutrition, depression and dementing illnesses (Groom, 1993), age-related changes in the presence of decreased homeostatic reserves, and an inadequate support system (Palmer, 1990). Newburn and Krowchuk (1994) identify the following critical attributes of FTT: problems in social relatedness; physical/cognitive dysfunction; loss; dependency; feelings of exclusion, shame, helplessness, and worthlessness; loneliness; inadequate nutritional intake; nonresponsiveness to medical and non-medical interventions; giving up; and psychogenic mortality. The term FTT implies that the older adult "should" thrive despite chronic illnesses and age-related changes (Berkman, Foster, & Campion, 1989). In other words, fatigue and ill health are not a normal part of the aging process. The label helps to counteract the complacent attitude that health care providers sometimes take in dealing with decline in the frail older adult. Elders may also underreport their symptoms and thus contribute to the denial that something is wrong. Families need to be taught to discriminate between normal age-related changes and symptoms that need expert assessment. Dementia is one example of a symptom that may be accepted as part of the aging process, when in fact, it is never a normal part of aging (Bender, 1992).

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The prevalence of FTT is difficult to estimate because it is a nonspecific syndrome which has not been accepted as a formal diagnosis in any of the health care disciplines. Among the barriers to accurate estimation of incidence and prevalence are the complex interaction of symptoms, lack of consistency in applying the term FTT, and the paucity of studies of the old and the old-old. Using malnutrition as an indicator of FTT, studies of nursing home populations reveal rates as high as 50% to 60% in the newly admitted (Sahyoun et al., 1988). When the prevalence of depression co-occurring with physical illness such as stroke has been examined, rates have been cited at 10% to 27% (Depression Guideline Panel, 1993). Duthie and Gambert (1983) reported that 15% of their requests for geriatric consultation in an acute care setting in a 2-year period were for FTT.

Little formal research has been published that specifically addresses FTT in older adults. Berkman et al. (1989) reported a retrospective study of 85 patients age 65 years and older, admitted for FTT to a major teaching hospital over the course of 1 year. They conclude that FTT results when the elder can no longer cope with multiple chronic illnesses and the functional impairments that accompany these conditions. The authors recommend further study in this area and a more comprehensive approach to assessment in the older adult population, taking into account not only the biomedical, but psychosocial and environmental factors as well. Osato, Stone, Phillips, and Winne (1993) conducted a chart review of 62 patients admitted for FTT to two VA Medical Centers over a 2-year period. They conclude that FTT results when the elder can no longer cope with multiple chronic illnesses and the functional impairments that accompany these conditions. The authors recommend further study in this area and a more comprehensive approach to assessment in the older adult population, taking into account not only the biomedical, but psychosocial and environmental factors as well. Osato, Stone, Phillips, and Winne (1993) conducted a chart review of 62 patients admitted for FTT to two VA Medical Centers over a 2-year period. They conclude that FTT was a frequently used admitting diagnosis and often depicted the chronically-ill patient whose treatment focused on managing symptoms rather than cure. They point out that the nurse plays a critical role in caring for patients with FTT. Comfort, prevention, and preservation of functional abilities is nursing's area of expertise.

Several authors have written about FTT based on their practice with older adult clients. Sandrick (1988) points out the importance of taking an inventory of all current medications that the elder is taking. The cumulative effects of numerous prescriptions, each one having been prescribed at different times for different problems, may lead to vague complaints of weakness, lack of interest, and "just not feeling right". Elders may also self-medicate with nonprescription drugs and may swap medications with friends or family members.

Adding to the difficulty in understanding FTT is the fact that there are overlapping symptoms for a number of relevant conditions in older adults (Groom, 1993). Mental status changes, appetite, and mood are interrelated. The elderly who is depressed may not complain of sadness but may instead be confused or may focus on numerous somatic complaints. The malnourished client may also seem depressed and the depressed client may have decreased appetite. Dementia, delirium, and depression may coexist (Gomez & Gomez, 1989). Dementia is a gradual loss of intellectual abilities such as abstract thinking, usually caused by irreversible organic causes. Delirium is a clouding of consciousness that decreases awareness of the environment and is more likely to be reversible, as in hypoxia. When delirium complicates even the early stages of dementia, it can lead to decreased function. Depression may also accompany the early stages of dementia when the client becomes aware of his/her loss of abilities. Further, pseudodementia may be secondary to a major depressive disorder in the older adult (Depression Guideline Panel, 1993). The interaction of these conditions may lead to a downward spiral including weight loss, loss of functional abilities, immobility, FTT, and even death.

CASE STUDIES

Case 1

Depression and emotional lability commonly accompany stroke (Conn, 1989). The multiple organic and affective consequences of stroke may readily interact and eventually lead to FTT. The following case study illustrates the challenge health care providers encounter when a client displays a number of symptoms following a stroke that do not respond to interventions and for which no specific cause can be found.

Mr. C. was a 71-year-old divorced man of Italian descent who was admitted to the hospital following a stroke. He had worked as a stone mason and had lived in the home of a ladyfriend, Ms. S. who was also divorced. Mr. C. financially supported Ms. S. and helped to raise her four children. Ms. S. confided to staff that she "would have been on the street without him." Mr. C. and Ms. S. never married because of religious differences.
Mr. C. had one son from his marriage with whom he remained in contact.

Mr. C's stroke left him wheelchair-bound with a residual left hemiplegia and neurogenic bladder. He complained of constant pain on his hemiplegic side and severe bladder spasms. Continued complaints of bladder spasms, penile pain, and irritation from the catheter were repeatedly evaluated by Urology. The placement of a suprapubic tube did not decrease the pain, nor were antispasmodics beneficial.

Choking and difficulty swallowing were ongoing complaints, but repeated esophagrams were negative for aspiration and showed only minimal slowing in motility. Although his medications were few, he frequently refused them because of his perceived swallowing difficulties. Crushed or liquid medication made little difference in his symptoms. He refused to eat any meals in bed, yet would not get out of bed for breakfast because it was "too early". Although his dentition was poor, he was able to tolerate a mechanical diet. He refused restorative dental care and would only agree to treatment on an emergency basis. Mr. C. was able to feed himself and resisted any assistance from the nursing staff. His intake at mealtimes was poor, but when Ms. S. brought in foods during her afternoon visits, he was able to eat without any apparent swallowing difficulties.

Mr. C. frequently expressed anger and discontent. For example, he accused the nurses of deliberately hurting him during routine care. Mr. C. was cognitively intact and his mental status score on the SPMSQ was 10/10 (Pfeiffer, 1975) and 27/30 on the Folstein (Folstein, Folstein, & McHugh, 1975) survey. He adamantly denied being depressed but continued to display negativity. He was routinely followed by a psychiatrist and several trials of different antidepressants had neither subjective nor objective effects.

Mr. C. hoped to return home with Ms. S. as his primary caregiver; however, Ms. S. confided to the staff that she was both unwilling and unable to fulfill his expectations. She still needed to work and Mr. C. required 24-hour care. The team agreed with Ms. S. that home care was an unrealistic goal even with maximum community supports. During discharge planning, Mr. C. was approached with the need for community nursing home placement. He became very angry with Ms. S. Consequently, they agreed to and received both individual and joint counseling. Eventually, Mr. C. agreed to community nursing home placement.

During the month after discharge, he was readmitted to the hospital twice for complaints of severe bladder spasms and difficulty swallowing. The medical evaluation did not reveal any new pathology. The community nursing home was hesitant to accept Mr. C. for readmission a third time and labeled him "medically unstable." Because of the two unsuccessful transfers to the community, an interdisciplinary team, Mr. C. and Ms. S. agreed that it was in his best interest to remain at the hospital and he was transferred to an intermediate care unit. Mr. C. and Ms. S. seemed relieved by the decision.

Mr. C. continued to have numerous somatic complaints and negative diagnostic outcomes. He became increasingly anemic and lost weight. He was offered a feeding tube and declined. He became paler and weaker. His voice became hoarse and his skin transparent. An occult malignancy was suspected but a metastatic work-up was negative. He eventually refused all medication and food but would accept analgesia in the form of a topical patch. Mr. C. died from dehydration and respiratory failure.

On autopsy, there was evidence of bilateral bronchopneumonia, pulmonary fibrosis, multiple lymphadenopathy, and extensive adhesions. No malignancy was found. Mr. C.'s assessment revealed a complex interplay of psychosocial, cultural, and organic factors that led to the FFT syndrome. Among the psychosocial factors were loss of function, loss of control over decisions, loss of hope that he would ever return home, and unresolved developmental issues. Closely related cultural factors were the loss of his highly valued worker/provider role and his status as head of household. Organic factors include neuroendocrine changes as a result of the brain injury.

Dreyfus (1988) writes that depressed elders often conceal their mood and instead present as critical of others, pessimistic, unmotivated, withdrawn, and preoccupied with somatic complaints. Mr. C. was overwhelmed with despair and loss. He focused on somatic discomforts and directed anger at those closest to him. He was unable to find any joy in his day-to-day existence. He needed help in finding peace with his past, his current relationships, and the limitations brought on by his health status. Activities that could pro-
vide creative expression and a sense of worth were needed.

Case 2

Mr. M. exemplifies the positive outcomes of effective nursing management for a patient with presumed FTT. Mr. M. was a 72-year-old married man, native to the New England area, with a history of hypertension, coronary artery disease, left total hip replacement, deep vein thrombosis, and cataracts. He worked as a carpenter and lived with his wife in a ranch-style home. His only child, a daughter, works as a nursing assistant for the local Visiting Nurses' Association.

Mr. M. sustained a right hemispheric stroke with left-sided hemiplegia. He was treated at an acute care hospital and discharged home after a 3-week stay. While at home, Mr. M.'s condition began to deteriorate. He became incontinent of bowel and bladder. His mobility was impaired from both hemiplegia and total hip replacement. He complained of generalized pain and diminishing vision in his left eye. Mr. M. became withdrawn and had no interest in eating. He was extremely discouraged by his lack of progress and stated he was "useless."

Mr. M.'s wife and daughter expressed concern over his failing health and were frustrated in their attempts to help him. Mr. M.'s wife and daughter brought him to an extended care facility for re-evaluation and further rehabilitation. They described Mr. M. as an active person, a "workaholic" who kept busy with carpentry jobs and gardening. The physical and psychological effects of his stroke left him unable to pursue these interests.

Mr. M. was a bright, alert man but was also obviously angry and depressed. He stated he was "sick of hospitals" and resented being dependent on his wife. He was embarrassed by his incontinence and complained of pain. He also had sustained several falls in his home since his stroke. Mr. M. set ambitious goals for himself. He wanted to resume driving and working. Mrs. M. expressed feelings of stress over being the caregiver and having to take over the responsibilities of running the home. Mr. M.'s daughter gave emotional support to both her parents and helped out physically whenever she could.

Mr. M. was admitted for evaluation and underwent a thorough diagnostic workup, functional and cognitive assessment, and psychosocial evaluation. On evaluation, he had a moderate left hemiplegia, intact speech, and mildly impaired cognition. He scored 26/30 on the Folstein Mental Status Exam with deficits in orientation and attention. Functionally, Mr. M. needed assistance in bathing, toileting, and transfers. He was able to feed himself and he ambulated with a walker and supervision.

Radiographs revealed arthritis in his hips and shoulders. His incontinence was caused by detrusor hypotonia secondary to his stroke. Optometry diagnosed a dense cataract in his left eye and he was evaluated by psychiatry for depression. The interdisciplinary team met with the M. family to define reasonable goals. Mr. M. would attend a program of occupational and physical therapy twice a day, five times a week. He was started on an antidepressant and medication to improve bladder tone. Pain was treated with acetaminophen, analgesic balm, and moist heat.

Initially, Mr. M. was tearful and frustrated about his slow progress. The nursing staff provided positive reinforcement by focusing on small goals. For example, Mr. M. became continent during the day through the use of a planned toileting schedule and a therapeutic response to medication. This gave Mr. M. a feeling of self-esteem that he had not had since his stroke. He progressed from a wheelchair to a walker then to a hemicane for ambulation. He was fitted for a brace to improve support and stability of his left knee.

Mr. M. responded to the antidepressant and his mood lifted. He started to joke with the nurses and told them he "couldn't wait to get home" because he "wasn't ever coming back." He was no longer angry and frustrated. His appetite improved, he became more sociable with other patients, and he still talked about getting a job.

Mr. M. was discharged after 3 months. He recently returned to visit the staff. His cataract was removed and his vision improved so that he was now able to drive. He was no longer incontinent, although he was bothered by nocturia. He reported that his wife still gets frustrated with him because he won't use his cane. Lastly, Mr. M. was hired on a part-time basis to work in a hardware store.

Cultural influences played an important role in Mr. M's recovery. His value on independence and individual achievement and his orientation toward the future helped motivate him to set goals based
on improving functional abilities despite his stroke. His perspective was congruent with the nurses’ expectations that he would assume the sick role by cooperating with the health care team and taking responsibility for his health.

ASSESSMENT

The process of assessing and diagnosing FTT in the elderly is threefold: (1) a careful clinical evaluation is necessary to identify new pathology or reversible conditions as well as proper management of these conditions, (2) second, a thorough functional assessment is conducted to ascertain the client’s physical and cognitive abilities and (3) finally, a sensitive psychosocial and cultural assessment is needed to determine the client’s strengths and coping patterns (Abraham et al., 1990).

Weight loss normally occurs in the elderly because of the physical effects of metabolic changes of aging and changes in body composition. Significant weight loss is defined as 1% to 2% of the usual weight per week, 5% per month, 7.5% over 3 months, or 10% over 6 months. Unintentional weight loss is a strong predictor of morbidity and mortality (Braun, Wykle, & Cowling, 1988). Depression, drugs, social isolation, dentition, and functional disability impact on nutritional status and warrant investigation (Fisher & Johnson, 1990; Williams, 1992).

There are numerous evaluation tools available to assist nurses with accurate assessment. The Short Portable Mental Status Questionnaire (SPMSQ) (Pfeiffer, 1975) and the Folstein Mini-Mental Status (Folstein et al., 1975) exam are widely accepted tools for screening cognitive decline. Depression rating scales include the Zung (1965), Beck, Ward, and Mendelson (1961), and Hamilton (1960) Depression scales. The Geriatric Depression Scale was specifically developed as a screening tool for elderly clients (Brink et al., 1982).

Determination of functional ability is measured by evaluating physical activities of daily living (ADL) such as bathing, grooming, toileting, eating, and mobility. Instrumental activities of daily living (IADL) such as shopping, meal preparation, managing finances, housekeeping, using the telephone, and taking medications are included in functional assessment as well. The Barthel Index (Mahoney & Barthel, 1965) and Katz Index (Katz, Ford, & Moskowitz, 1963) are examples of useful standardized functional assessments. The Older Americans Resources and Services (OARS) Multidimensional Functional Assessment Questionnaire developed at Duke University, extensively evaluates economic resources and mental health in addition to ADL and IADL (Durhan, 1978).

Groom (1993) has proposed a model that includes three areas of assessment for older adults with FIT: psychosocial, predisposing, and physical. Psychosocial factors include nonphysical losses, a decreased social network, and changes in control, such as decreased opportunities to make decisions. Predisposing factors refer to “uncontrollable environmental influences” (p. 14) including age-related changes, such as decreased homeostatic reserve and sensory deficits. Physical factors take into account disease processes, medication, and physical limitations. These three categories encompass the “... primary diagnostic entities that comprise FTT: depression, delirium, dementia, and malnourishment” (p. 15). The categories have overlapping symptoms and may share one etiology or one may be the etiology of another. This model provides a framework for assessing the complexities of FTT. If a client presents with depression, the nurse can use the model to guide him/her to other relevant areas to assess. The model also provides a guide for intervention. If the problem is primarily physical and environmental, the plan of care will be different than if the problem is psychosocial.

Relevant nursing diagnoses may include Altered Thought Processes, Reactive Depression, Altered Health Maintenance, Hopelessness, and Ineffective Coping and Spiritual Distress, to name a few. When appropriate diagnoses are identified, outcomes are described, and a plan to achieve those outcomes is developed. Other disciplines may take responsibility for carrying out some aspects of the plan.

INTERVENTION

Failure to thrive in the elderly lends itself to a host of interventions including validation therapy, life review and reminiscence. Validation is an approach developed by Feil (1993) for the oldest-old, maloriented and disoriented person, which is said to restore self worth, reduce stress, justify living, and facilitate the resolution of unfinished conflicts from the past. An underlying principle of validation therapy is that by acknowledging the person’s feelings as valid, dignity will be restored. This
approach has been subjected to few empirical studies. Two small studies have failed to show that validation therapy has any effect on mood (Robb, Stegman, & Wolonin, 1986; Scanland & Emerson, 1993).

Other psychological approaches include a guided recollection called reminiscence that helps the elder remember pleasurable life experiences (Haight & Burnside, 1993). Reminiscence focuses on strengths and does not encourage the elder to dwell on losses. Reminiscing can raise self-esteem and generate feelings of satisfaction with one’s past accomplishments and a sense of well being in the present. This intervention helps to reintegrate the past and allows the client to engage in meaningful sharing with another. It is particularly well suited to clients who have had generally positive life experiences.

Life review is an intervention based on Erikson’s theory (1950) of the ages of man with the goal of facilitating integrity. In life review, the nurse encourages the elder to critically examine their past and to uncover the reasons for their despair (Haight & Burnside, 1993). Unpleasant experiences are remembered and reframed so that they no longer interfere with a positive self image. The effectiveness of both reminiscence and life review in the treatment of depression has not been demonstrated consistently (David, 1990; Thornton & Brotchie, 1987; Youssef, 1990).

Cognitive therapy focuses on changing the way the client interprets events and attempts to alter negatively biased thinking. For example, when Mr. M. stated that he felt “useless”, he needed to be challenged to view his potential in a more positive way. This approach can be utilized in either a one-to-one or a group format. Maladaptive behavior is modified by teaching the client to eliminate irrational patterns of thought (Abraham, Neundorfer, & Currie, 1992).

Behavior therapy includes self-control therapy, activity scheduling, and social skills training (Depression Guideline Panel, 1993). It can take the form of individual or group format and is used to counteract the withdrawal and lack of motivation often seen in the depressed client. There are conflicting reports regarding the frequency of relapse associated with behavioral approaches. Previous history of depression, poor health, and younger age are associated with greater probability of relapse (Depression Guideline Panel, 1993).

Interpersonal therapy works to resolve problems in relationships. It can be used to help depressed clients create more supportive relationships with significant others. Cognitive, interpersonal, and behavioral therapies have been studied in randomized clinical trials and found to be effective in alleviating depression in older adults (Depression Guideline Panel, 1993).

Psychological approaches can be combined with other interventions such as day care, antidepressants and hospitalization as needed. When tricyclic antidepressants are contraindicated, selective serotonin reuptake inhibitors as well as psychostimulants or electroconvulsive therapy may be effective (Depression Guideline Panel, 1993).

IMPLICATIONS FOR NURSES

FTT is becoming a more common reason for admission to acute or long-term care facilities in the older adult population particularly in the oldest old (Osato et al., 1993; Palmer, 1990). FTT is a complex problem which challenges the nurse to view the client holistically. A comprehensive assessment using careful interviewing, standardized instruments, and a thorough physical exam is needed to determine all relevant nursing diagnoses. The plan of care should involve all available disciplines and address the physical, psychosocial and predisposing factors which place elders at risk for FTT.

Clients with FTT may be encountered by nurses in ambulatory, acute and long term care settings. Nurses in acute care settings and especially geropsychiatric units, are in a unique position to intervene on behalf of clients with FTT. Nurses bring a holistic focus to the treatment team and facilitate assessment and intervention with psychosocial, predisposing and physical factors. When older adult clients are encountered in medical units, emergency departments, and even critical care units, nurses can help to counteract ageism by insisting that health care professionals intervene aggressively when the older adult client is “going downhill” without explanation. Advanced practice nurses in ambulatory settings can play an important role in early recognition and treatment of this syndrome before the downward spiral leads to loss of independent living.

REFERENCES
