



THE ADVISOR

AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

RESEARCH AND PRACTICE The Question of Objectivity in the Survivor Therapist

—by Diana M. Elliott

APSAC's *Advisor* recently featured two articles on survivors of child abuse in the helping professions (Courtois, 1992; Sexton, 1992). Sexton noted that mental health professionals who are survivors of childhood abuse often feel compelled to hide their history in order to maintain professional credibility. It is clear that such concerns are well founded, at least in terms of society's current response to abuse and survivors.

In the County of Los Angeles, for example, child evaluators and expert witnesses in the area of childhood sexual abuse have been questioned about their personal abuse history while testifying in the case of an abused minor. There is an assumption that acknowledging such a history will damage the expert's objective credibility and thus hurt the legal case. This can cause significant distress for the would-be witness who is a survivor, and who may fear not only that s/he will hinder the minor's chances for justice, but that s/he may be publicly humiliated in the process.

The appropriateness of what appears to be a violation of the therapist's right to privacy protected by the constitution is a battle that will be fought primarily not by clinicians but by attorneys in the legal arena. While this issue awaits resolution, there are, as of yet, insufficient data available from which to address the court's legitimate concerns that objectivity be maintained in legal matters or to refute

attorneys' discrediting questions posed to the clinician while on the witness stand. This silence is somewhat surprising, since sexual abuse researchers are in a unique position to examine issues related to the impact of childhood abuse on professional practice. Perhaps this reticence is motivated by a fear of giving "the other side" information that will make advocacy for children more difficult. Such reluctance, however, will not make the problem go away—instead, the absence of clear data may allow unduly negative or pejorative arguments by opposing counsel to continue unchallenged. Ultimately, we will do better as a profession if we examine these issues ourselves, and interpret them in the context of our understanding of clinical practice and practitioners.

As a preliminary step toward obtaining accurate information on therapists, the author examined the abuse histories and psychological symptoms of nearly 3,000 professional women across the United States. This sample included 340 mental health workers and more than 2,500 women from 11 other professions (including attorneys, CPAs, engineers, etc.). In a forthcoming article in *Professional Psychology: Theory and Practice*, Elliott and Guy (in press) report a higher rate of childhood abuse among psychotherapists compared to individuals working in other professions. Compared to non-therapists, mental health professionals reported a significantly higher rate of both

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MEDICINE Failure to Thrive

—by Randell Alexander

Failure to thrive (FTT) is a life-threatening condition, whose diagnosis generates considerable confusion among professionals. Estimates of its frequency range up to 1% of all pediatric hospitalizations and 10% of children followed in rural outpatient clinics (Mitchell et al., 1980). When FTT is classified as neglect, foster care often is recommended. Yet standards vary, lower socio-economic groups probably are more likely to be reported for this type of child abuse, and community opinions differ as to whether specific cases should be labelled neglect and how they should be treated. How has FTT become such an acceptable and relatively common diagnostic entity given the murkiness surrounding the subject?

History

Feeding and malnutrition problems have always been present for a certain proportion of the population. With very high mortality rates in the 1800's, efforts were directed towards more humane

institutional living conditions. Pediatrics developed as a medical discipline around the turn of the century, in large part in response to feeding specialization. Holt described children who "ceased to thrive" in his textbook *Diseases of Infancy and Childhood* (Holt, 1899). By 1933, a later edition referred to "failure to thrive" (Holt and McIntosh, 1933). Henry Dwight Chapin spoke of "atrophic infants" in describing children wasting away in poor home environments (Chapin, 1908). Psychological factors were blamed for both malnutrition and developmental deficits in institutionalized children, in pioneering work by R. A. Spitz (Spitz, 1945). His concept of "hospitalism" included the combination of "anaclitic depression," malnutrition, and growth failure. In effect, he blamed FTT on emotional deprivation, the idea being that one could waste away from lack of love (Stevenson, 1992). The concept of "maternal deprivation syndrome" also arose from this viewpoint. In 1969, strong evidence emerged

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that emotionally deprived children actually consumed or were offered fewer calories than needed, indicating a physical basis for growth failures (Whitten, Pettit, and Fischhoff, 1969). As a consequence of the debate between physical and psychological causes for FTT, a distinction was made about organic and non-organic FTT. As discussed below, this distinction has gained wide currency even as it has become obsolete.

Definition

There is no commonly accepted definition of FTT. In part, this is because FTT is a symptom resulting from many causes and not a condition in itself. Operational definitions have included (1) any child below the third percentile for weight when plotted on a standard growth chart, (2) any child whose weight when corrected for height is below the third percentile, and/or (3) any child whose weight curve crosses two or more major "percentiles" on the standard growth curves. None of these definitions prove satisfactory in practice. For example, an infant about 9 months

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of age usually begins some self-feeding. It is not uncommon to find a child who tracked along the 75th percentile for weight up to that time drop to the 25th percentile over the next 4 - 6 months. If the parent was "overfeeding" at the earlier age because the child was crying and it seemed to help, a pattern of relative "growth failure" now that the child is in more control of its own hunger may represent a return to the growth pattern the child was originally destined to have.

A more accurate, if less precise, definition of FTT is a relative growth pattern determined by a physician to be subnormal for a child given the underlying medical status. If a child gains weight slowly, this may be FTT if she is not keeping pace with growth percentiles. Weight loss or weight gain are usually of more acute concern. However, children with certain genetic syndromes or medical conditions may have growth impairments based upon an underlying condition.

For a relatively common condition such as moderate to severe cerebral palsy, FTT may reflect major neurological damage limiting possible growth, a neuromotor feeding disorder requiring special feeding techniques, the need to insert tubes for adequate sustenance, and/or neglect by a parent. Occasionally both limiting physiological factors and neglect co-exist: a child who

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needs small volumes spread out for 60 minute feedings five times a day, and a parent who tries for 10 minutes and quits.

FTT nearly always is equated with a dangerous failure to grow. Most children with FTT are under 2 years of age (before they can get food independently or ask for it more effectively), a critical period during which most brain growth occurs and the fundamentals of language are being learned. Although some professionals still advise that a child is better managed if left small, this attitude is not supported by medical ethics or law, and threatens to deny some children of adequate nutrition to support optimal health and neurological growth. One advantage of a multi-disciplinary approach to FTT is greater attention to other aspects of what it means to *thrive* ("One does not live by bread alone . . .").

Development

The basic job of a child is to develop (grow). Imagine if an adult had the task of a newborn: to double his weight in five months and triple it in one year! (This explains why a newborn eats 6 to 7 times a day and gets up at night to eat again. It does not explain why a parent sees that as a problem.) Failure of a newborn to gain weight over three to four months can be fatal. To accomplish the explosive growth required, all physiologic and environmental systems must be operating satisfactorily. FTT is a non-specific indicator that something is wrong, but does not pinpoint which domains may be affected.

Etiologies

Although clinical circumstances may seem complex, certain basic features always apply. Matter and energy will be conserved: calories that go into the system will show up somewhere. Put most simply, FTT is one of three problems: not enough calories are going into the child, too many calories are being excreted by the child, and/or too many calories are being lost internally. The child may not get enough calories because of failure to feed, neuromotor feeding problems, or refusal of food by the child fail to provide enough caloric input. Too many calories may be excreted because of vomiting, sugar lost in the urine (diabetes), and diarrhea. Internal calorie losses are fairly rare and may be due to fluid accumulations and hypermetabolic states (e.g., hyperthyroidism, dyskinetic cerebral palsy, and possibly extreme hyperactivity). Combinations of these causes of calorie deficiencies are possible.

Physiological problems leading to growth failure were described by Dr. Ray Helfer (personal communication) as usually consisting of five P's: peeing (e.g., calories lost in urine, metabolic problems leading to altered calorie input), pooping (e.g., cystic fibrosis, lactose intolerance), pumping (e.g., cardiac or perfusion problems), pulmonary (e.g., bronchopulmonary dysplasia), or psychiatric (i.e., neurological).

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Psychosocial dwarfism is a particularly difficult form of FTT for the clinician, requiring longer treatment with less immediate success. Many define 24 months of age as a cutoff between environmentally-caused FTT and psychosocial dwarfism. Before that age children may be denied food. After, the child probably has developed maladaptive interactions whereby they refuse food or fail to seek food. When developmental disabilities are considered, the situation can be confusing.

Conceptual models

Medicine may have inadvertently misled the legal profession and others in adopting an approach that divides FTT into "organic" and "non-organic" categories. Although a recent national survey of pediatricians showed that nearly 90% rejected such a distinction, either explicitly or in solving case scenarios, this dichotomy persists in some of the literature and many child abuse cases (Stevenson and Alexander, 1990, unpublished study; Stevenson, 1992). On its face, it is difficult to persuade the non-professional that any given FTT case does not involve both an "organic" component (i.e. the child is not growing normally) or a "non-organic" component (at least someone is upset about it). By the time a diagnosis is made, organic and non-organic issues are inevitably intertwined, making the question of which came first difficult and often pointless. The more important question is what can be done to correct the situation.

Consider the child with a severe congenital heart defect. If she fails to grow normally is it a case of organic FTT? What if the parents are not giving medication as prescribed? Then it may be a question of neglect (non-organic FTT), a child who would not grow well anyway (organic FTT), or both. Breast feeding is another example of the failure of the organic vs. non-organic distinction. If the child does not grow, it may be that the mother's milk supply is insufficient (organic FTT), that she is supposed to feed six to eight times a day (non-organic FTT), and/or she does not make adequate attempts to feed (non-organic FTT). Few pediatricians would report the mother for neglect, at least without making substantial efforts to correct the situation. Nevertheless, the distinction between organic and non-organic FTT is still being taught at many medical schools.

A number of authors have offered alternative models for FTT (e.g. Goldson, 1978; Casey, 1983; Goldson, Milla, and Bentovim, 1985; Stevenson, 1992). A transactional model assumes that the parent brings certain factors to the feeding situation, the

child has inherent physical and temperamental characteristics, and the interaction of the two coupled with environmental forces may work over time to produce malnutrition. Other models (e.g. Engel, 1977) examine the interactions of social, psychological, and physical systems both to explain current circumstances and to suggest methods of treatment. A simple two-dimensional model could consist of a child dimension ranging from no known physiological deficits to severe deficits, and a parent dimension ranging from supportive to failure to attend to the child's needs. The advantage of such a model would be to unlink the child's physical state from the parent's care obligations.

The complexities of the many clinical situations in which FTT is seen demand a simple model. The distinction between "organic" and "non-organic" FTT is obsolete, misleading, and should be abandoned. It confuses "non-organic" with neglect, cause with intervention. Any model assuming two or more dimensions is more helpful and should not confuse neglect with the absence of major underlying physical problems.

Diagnosis

History and physical examination are the most important methods to elucidate FTT. Recording a child's weight, height, and head circumference should be routine at all physician visits. Short stature or microcephaly typically are not considered to be FTT. Weight alone should not be the defining characteristic, but considered as weight for height. Growth velocity charts exist to help determine whether weight gains over time are appropriate. Parental heights and their childhood growth patterns, and the growth of siblings may yield important information as to cause, treatment, and prognosis.

Laboratory testing is rarely useful unless it is to specify what is generally suspected by history and physical examination. In one study an average of 40 laboratory tests and x-rays were performed for each child with FTT, but only 0.8% yielded causes not previously suspected (Berwick, Levy, and Kleinerman, 1982). More recently, when 150 pediatricians were asked which screening tests they routinely perform, a median of 8 were named (Stevenson and Alexander, 1990, unpublished study). A complete blood count, urinalysis, electrolytes, BUN/creatinine, and urine culture were the only tests endorsed by more than 50% of the pediatricians.

X-rays are useful when certain genetic conditions are suspected (e.g., dwarfism). Children with FTT often have "growth arrest lines." These are seen at fast-growing areas of the skeleton such as the knees, and indicate starts and stops in bone growth caused by significant illness, periods of inadequate caloric intake, or other non-specific stressors. For any form of suspected abuse of a child under 2 years of age, a skeletal survey should be obtained.

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Once pediatricians obtain a history, physical, and perhaps a few screening lab tests, nearly all aggressively pursue psychosocial and interactional work-ups concomitant with further physical testing (Stevenson and Alexander, 1990, unpublished study). In reality, pediatricians approach the diagnosis as a multi-dimensional problem with inter-related concerns.

Treatment

The treatment of FTT depends upon which diagnosis is made, or whether a primary cause is found. Most cases can be managed in an outpatient setting. Only a few observations about cases of FTT primarily caused by neglect will be made here.

The goal of treatment for FTT primarily caused by neglect is to permanently alter the environment to be conducive to growth.

Calorie counts are important. If the parents' reports are suspect, admitting the child to a controlled setting can be valuable. A very young infant may need 110 to 120 calories (technically: kcal) per kilogram per day to sustain normal growth. The FTT infant may not grow at this rate and may need in excess of 150 calories/kg/day. This is particularly true if catch-up growth is desired. For a child of any age, the failure to grow at a certain number of calories necessitates increasing input beyond calculations applicable to normal children, until growth or an adverse response such as diarrhea results. Failure of the professional to be sufficiently aggressive prolongs resolution of FTT and may lead to unnecessary testing. As a general rule, children in a hospital setting should quickly have all testing out of the way and be allowed to eat and grow in as positive an environment as possible.

Psychosocial dwarfism, by definition, has taken longer to develop and therefore takes longer to turn around. If inpatient or foster care is necessary, it may take months before regular weight gain is assured.

The goal of treatment for FTT primarily caused by neglect is to permanently alter the environment to be conducive to growth. Sometimes an undemanding infant will gain energy after a period of growth and thereafter more effectively cry for food. However, caregivers often have many needs that must be met before they are able adequately to feed their children and provide other nurturing care.

Prognosis

Most FTT children eventually reach normal weights for their height, although some have residual growth problems (Strum and Drotar, 1989). Of the many studies exploring the question of residual cognitive and psychological effects, nearly all are confounded by other influences of the home environment. As is true for other forms of neglect, language development and microcephaly (but not necessarily I.Q.) may be long-term residuals. Cogni-

tive impairments clearly exist for severe cases, but a positive environment coupled with adequate nutrition can help overcome much of the physical, social, and cognitive delays (Winick, Meyer, and Harris, 1975; Grantham-McGregor, Schofield, and Powell, 1987).

References

- Berwick, D.M., Levy, J.C., Klejnerman, R. (1982). Failure to thrive: Diagnostic yield of hospitalization. *Archives of Disease in Childhood*, 57, 347-351
- Casey, P.H. (1983). Failure to thrive: A reconceptualization. *Developmental and Behavioral Pediatrics*, 4 (1), 63-66.
- Chapin, H.D. (1908). A plan of dealing with atrophic infants and children. *Archives of Pediatrics*, 25, 129-196.
- Engel, G.I. (1977). The need for a new medical model: A challenge for biomedicine. *Science*, 196 (4286), 129-196.
- Goldson, E. (1978). Child abuse: A social-psychological-medical disorder. In Gellert, E. (Ed.) *Psychosocial aspects of pediatric care*. NY, Grune and Stratton
- Goldson, E., Milla P.J., Bentovim, A. (1985). Failure to thrive: A transactional issue. *Family Systems Medicine*, 3 (2), 205-213.
- Gratham-McGregor, S., Schofield W., Powell C. (1987) Development of severely malnourished children who receive psychosocial stimulation: Six-year follow-up. *Pediatrics*, 79, (2), 247-254.
- Holt, L.E. (1899) *Diseases of infancy and childhood*. New York, D. Appleton.
- Holt, L.E. Jr., McIntosh, R. (1933) *Holt's diseases of infancy and childhood* 10th Edition. New York, Appleton-Century
- Mitchell, W.G., Gorrel, R.W., Greenberg, R.A. (1980). Failure to thrive: A study in a primary care setting. *Epidemiology and follow-up Pediatrics*, 65, 971-977.
- Spitz, R.A. (1945). Hospitalism: An inquiry into the genesis of psychiatric conditions in early childhood. *Psychoanalytic Study of the Child*, 1, 53-74.
- Stevenson, R.D. (1992). Failure to thrive. In Greydanus D.E., Wolraich M.L. (Eds.), *Behavioral Pediatrics*, New York, Springer-Verlag
- Strum, L., Drotar, D. (1989). Predictions of weight for height following intervention in three-year-old children with early histories of nonorganic failure to thrive. *Child Abuse and Neglect*, 13, 19-28
- Whitten, C.F., Pettit, M.G., Fischhoff, J. (1969). Evidence that growth failure from maternal deprivation is secondary to underfeeding. *Journal of the American Medical Association*, 209, 1675-1682
- Winick, M., Meyer, K.K., Harris, R.C. (1975). Malnutrition and environmental enrichment by early adoption. *Science*, 190, 1174.
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