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Revisiting Geriatric Failure to Thrive

A Complex and Compelling Clinical Condition

ABSTRACT

Geriatric failure to thrive (GFTT) poses a complex clinical issue in gerontological nursing practice. GFTT is not a normal part of aging, nor is it an outcome of chronic illness. Rather, GFTT describes a lack of vitality and diminished capacity for life and outlines a process of functional decline that is often difficult to explain. The purpose of this article is to review GFTT, examine the literature on GFTT, and suggest strategies for the identification, assessment, and creative management of this complex condition that affects millions of older adults.

Caring for frail older adults is a significant challenge for both practitioners and caregivers. These patients, whether living in the community or in nursing homes, are dehydrated, malnourished, bedridden, and often depressed. They are often characterized by a loss of vitality, a seeming lack of will to live, and an inability to thrive in their current environment. Often, these older adults complain of "just not feeling too well," and family members note their loved ones are "going downhill" for no apparent reason (Roth, 2001). Unfortunately, attitudes of "they are just old" or "they are just depressed and want to die, so there is nothing we can do" prevail; however, there is considerable need for accurate diagnosis, comprehensive assessment, and creative management of these patients.

Geriatric failure to thrive (GFTT) poses a complex clinical issue in gerontological nursing practice that requires comprehensive assessment and creative

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care. In the late 1980s and 1990s, it was estimated that GFTT affected 5% to 35% of community-dwelling older adults, 25% to 40% of nursing home residents, and more than 50% of all veterans hospitalized in acute care institutions (Berkman, Foster, & Campion, 1989; Silver, Morley, Strome, Jones, & Vickers, 1988; Verdery, 1996). Although more recent literature on GFTT does not offer any additional statistics, it is only reasonable to assume, based on demographics of aging, that GFTT is more prevalent than it was in the recent past, suggesting that clinicians seriously revisit this complex and challenging issue.

The concept of thriving is multidimensional and may mean different things to different providers. To be useful, the concept of thriving must integrate physical, functional, and psychosocial aspects. For psychologists, counselors, and social workers, failure to thrive may suggest unresolved psychosocial issues, cognitive changes, depression, or dysfunctional grieving. In medicine and nursing, failure to thrive may describe weight loss, immune system changes, or challenging nutritional issues. Consequently, differential diagnoses and interventions that are best suited to treat the individual must be selected.

For a condition to be classified as a disease, there must be an identifiable cause and discernible findings that include anatomy, pathophysiology, and functional effect (Sarkisian & Lachs, 1996). The precipitants of failure to thrive include multiple possible underlying causes, many of which may be reversible if accurately identified and treated early. According to Robertson and Montagnini (2004), the four syndromes of GFTT are impaired physical functioning, malnutrition, depression, and cognitive impairment and are often the result of multiple underlying disease states and not a single entity in the older adult population.

The purpose of this article is to review GFTT, examine the literature on GFTT, and suggest strategies for the identification, assessment, and creative management of this complex condition that affects millions of older adults.

DEFINITION

The syndrome of GFTT mimics the language of a similar pediatrics syndrome, which was adapted in the 1970s for use in the geriatric population to describe a syndrome of impaired physical functioning. Whereas pediatric failure to thrive is related to delayed growth and development in physical, psychological, and social function, GFTT refers to the regression or inability to maintain body weight, functional capacity, and cognitive or social skills, as well as depression, cognitive impairment, and malnutrition (Egbert, 1996; Sarkisian & Lachs, 1996). In 1979, failure to thrive was assigned an International Classification of Diseases (ICD-9) code to identify it as a meaningful clinical diagnosis (Sarkisian & Lachs, 1996).

GFTT is not a normal part of aging, nor is it an outcome of chronic illness. Rather, GFTT describes a lack of vitality and diminished capacity for life and outlines a process of functional decline that is often difficult to explain. Robertson and Montagnini (2004) suggested that failure to thrive describes a state of decline that is multifactorial and may be caused by chronic illness and functional impairments. Social manifestations of failure to thrive may accompany late-life losses and a perceived diminished state of existence that may be accompanied by sensory deprivation or loss, as well as depression.

GFTT has many causes and may be physiological and psychosocial in origin. The Institute of Medicine defined failure to thrive late in life as a syndrome manifested by weight loss greater than 5% of baseline, decreased appetite, malnutrition, and inactivity, accompanied by dehydration, depressive symptoms, impaired immune function, and low cholesterol levels (Lonergan, 1991). Egbert (1996) noted failure to thrive as "the dwindles" and identified three elements in the syndrome:

- Deterioration in the biological, psychological, and social domains.
- Weight loss or undernutrition.
- Lack of any obvious explanation for the condition.

Egbert (1996) further reported that failure to thrive often results from the combined effects of normal aging, malnutrition, and specific physical, social, or psychological precipitants to include chronic disease, dementia, medication use, dysphagia, depression, or social isolation. Roth (2001) suggested that causes of GFTT include occult organic illness, polypharmacy, malnutrition, and decreased homeostatic reserves. Schreiber and Lerer (1997) stated that the deterioration noted in GFTT is beyond the expected, age-associated, "normal" decline noted in most elderly patients. These authors characterized GFTT as deterioration in self-care abilities, loss of weight, loss of interest in social activities, gradual decline in physical and/or cognitive functioning, and increased dependence on family members.

Psychosocial factors also contribute to the development of GFTT, including large and small, sometimes irreplaceable losses affecting individuals during the journey of life. Loss of function can relate to dependence and a feeling of being excluded from life. Feelings of shame, helplessness, and worthlessness are also significant indicators (Groom, 1993; Newbern, 1992). Older adults who lose their ability to make independent decisions, as well as those who encounter losses of relationships, are also at high risk. Loneliness and role loss have also been mentioned (Newbern & Krowchuk, 1994).

LITERATURE REVIEW

Failure to thrive is a common diagnosis in elderly patients and is often seen in acute care. Interestingly, there is little research on GFTT in recent medical literature, even though the diagnosis is common. A MEDLINE search in January of 2008 using the search terms *failure to thrive*, *frailty*, *elders and depression*, and *thriving* revealed a total of 30 articles, mostly theoretical in nature and written in the 1980s and 1990s, many from Europe and Asia. A PsycINFO search at the same time using similar search terms revealed an additional 15 contributions, most written during the same period. Of the 45 articles located, less than 20% were research studies. Articles selected for this review included all research and theoretical articles that described the definition and current assessment of and practice in failure to thrive.

Physiological Factors in GFTT

Robertson and Montagnini (2004) reported that failure to thrive as a primary clinical diagnosis is not particularly useful and is more a description of the effects of concurrent chronic diseases or functional impairment. An evaluation for underlying causes of GFTT symptoms should include a comprehensive approach, with the goal of treatment focused on maintaining or improving functioning. Osato, Takano Stone, Phillips, and Winne (1993) suggested that there is a lack of specificity in the diagnosis of GFTT, and it is often overdiagnosed when patients experience weight loss, depression, and anorexia or when changes occur in a patient's activities of daily living (ADLs).

Palmer (1990) asserted that although failure to thrive is not the consequence of normal aging, normal aging may cause specific changes that predispose older individuals to GFTT. For example, aging is characterized by a decrease in homeostatic reserves during physical stress, and this decrease affects an older adult's ability to respond and recover from physical stressors. In addition, disease presentation in older adults may be nonspecific, absent, or atypical and may be caused by more than one contributing factor or disease (Palmer, 1990). Functional decline and weight loss may occur with aging, secondary to age-related changes in the senses and oral function. According to Palmer (1990), 5% of adults 65 years old require assistance with ADLs versus 33% of those age 85 or older, reflecting a functional decline with increased age.

Egbert (1996) identified 11 "Ds" as possible precipitants of failure to thrive:

- Disease (physical).
- Dementia.
- Delirium.
- Drinking of alcohol.
- Drug use.
- Dysphagia.
- Deafness or other sensory deficits.
- Depression.
- Desertion.
- Destitution.
- Despair.

According to Egbert (1996), the most common diseases associated with failure to thrive are cancer, heart failure, chronic lung disease, and uncontrolled diabetes. Dementia has been noted in 40% of patients with failure to thrive. Delirium is noted most often as confusion. Older adults should be carefully screened for alcohol and substance abuse. Alcoholism may frequently be missed in older adults, as they are more likely to drink in private. The quantity of alcohol required for intoxication and dependence in older adults is much less than in younger drinkers (Egbert, 1996). A review of prescription drugs, as well as over-the-counter drugs, is necessary to identify drug interactions or side effects possibly producing anorexia or nausea. Dysphagia and swallowing difficulties should be evaluated for underlying causes, such as diseases affecting swallowing, ill-fitting dentures, or poor dental hygiene.

Egbert (1996) also stated that hearing loss, visual impairment, and other sensory deficits may affect older individuals' ability to communicate effectively, leading to social withdrawal and isolation. Depression, which is rarely described as the primary complaint by geriatric patients, may lead to weight loss, malnutrition, and social withdrawal. Desertion may occur through death, indifference, or relocation by family and friends. Destitution, resulting from the lower socioeconomic status of many older adults, may limit access to an adequate diet, medications, and transportation. Despair may be associated with the loss of the will to live, resulting in many of the same symptoms of failure to thrive (Egbert, 1996).

Frailty may be a physiological component of the GFTT complex. Frailty is described in the literature as a clinical syndrome of unintentional weight loss, self-reported exhaustion, weakness, slow walking speed, and low physical activity, with high risk of adverse outcomes (Fried et al., 2001). The diagnosis of frailty is more frequently based on biological markers of decreased reserve and resistance to stressors, such as lean body mass, endurance, balance, walking performance, and activity, in comparison to failure to thrive (Fried et al., 2001). Diehr, Williamson, Burke, and Psaty (2002) noted a decline in human functioning unrelated to chronological age but markedly related to decline prior to death. The period of functional decline associated with the dying process is termed *terminal drop* and is characterized by weight loss, depression, and decreased cognitive and functional status, with all variables declining closer to death. The period of terminal drop, or predeath, is difficult to dissociate from failure to thrive, as the point of death is uncertain.

Robertson and Montagnini (2004) cautioned against diagnosing geriatric patients with failure to thrive to explain the multitude of symptoms. By age 75, most older adults will have two to three chronic illnesses (Sarkisian & Lachs, 1996). The presence of chronic disease and reported life satisfaction may be closely related to earlier social interactions and the development of positive coping abilities. Clinicians need to be very astute when using failure to thrive as a clinical diagnosis. A reversible pathophysiological process may underlie the observed syndrome of weight loss, decreased cognitive function, malnutrition, and decreased overall function (Robertson & Montagnini, 2004).

A danger may lie in incorrectly labeling the geriatric patient with failure to thrive just to explain the multitude of symptoms.

Psychosocial Aspects in GFTT

Numerous and irreplaceable losses, large and small, that affect an individual during late life are examples of psychosocial factors that contribute to the development of GFTT. An inadequate social support system can put older adults at risk for functional decline and institutionalization (Palmer, 1990). Loss of function and role loss can cause dependence and a feeling of being excluded from life. Feelings of shame, helplessness, and worthlessness, as well as decreased opportunities for decision making, may also be significant. This also applies to loss of relationships, which can reduce older adults' social networks, thus causing loneliness (Groom, 1993; Newbern, 1992; Newbern & Krowchuk, 1994).

Newsom and Schulz (1996) reported findings that revealed lack of social support as an important reason for decrease in older adults' life satisfaction. Lack of social support was associated with fewer friendships and family contacts and less perceived belonging. Reported lower levels of social support were also associated with increased depressive symptoms and an increase in physical disability. Lack of perceived social support from friends and family may be responsible for the increased prevalence of failure to thrive in nursing home settings. Clinical manifestations of depression in older adults can include weight loss, anorexia, fatigue, functional impairment, and poor concentration and memory (Beers & Berkow, 2000). Older adults who meet these criteria may be diagnosed with failure to thrive, and a diagnosis of depression may be overlooked.

In a study that examined the positive and negative social exchanges in relation to positive well-being and psychological distress, Newsom, Rook, Nishishiba, Sorkin, and Mahan (2005) revealed that negative social exchanges are related to less positive well-being and greater psychological distress, whereas positive social exchanges were related to positive well-being. Loss of perceived health and physical function, as well as sensory losses, in old age can lead to feelings of emptiness and loneliness (Austin, 1989). Losses experienced by older adults can occur in a number of ways, such as through retirement and the loss of a professional identity. Loss of friends and family can result through death or relocation, leading to the loss of social support. Impaired hearing and vision may make communication difficult, thus leading to further avoidance of social situations.

Katz, Beaston-Wimmer, Parmelee, Friedman, and Lawton (1993) examined the relationship between routine clinical laboratory tests and the clinical status of elderly patients (mean age = 84) and demonstrated that low albumin levels and anemia are associated with decreased survival, mortality rates, self-care deficits, cognitive impairment, depression, and summary measures of the severity of medical illness. Findings suggest that the interrelationships observed among variables support the usefulness of the concept of failure to thrive.

Functional Limitations in GFTT

Functional limitation scales are generally used to evaluate the degree of disability in older adults. Functional limitations may be present in many older adults with failure to thrive; these limitations reflect an inability to care for oneself or are concerned with some loss or inability to use parts of the body.

Scales that assess ADLs or instrumental activities of daily living (IADLs) are often used to evaluate functional limitations noted in older adults with GFTT. ADLs include eating, walking, toileting, dressing, bathing, and getting in and out of bed. These are considered fundamental to survival. IADLs reflect activities required for independent living, but are less essential than ADLs (e.g., cooking, shopping, managing money, using a telephone, doing light or heavy housework, getting outside the home). People normally experience needs with IADLs before they do with ADLs. Limitations in ADLs tend to evolve in a pattern: Bathing oneself is commonly the first to occur and is the most frequent ADL requiring assistance. Eating and toileting are the least frequently identified ADLs among noninstitutionalized older adults (Sahyoun, Pratt, Lentzner, Dey, & Robinson, 2001). Specific instruments used to mea-

sure ADLs are noted in the section below.

ASSESSMENT AND MANAGEMENT OF GFTT

The nurse's role in the assessment and management of patients with symptoms of failure to thrive is integral, particularly in the primary care setting. Schreiber and Lerer (1997) noted that early recognition of GFTT may lead to appropriate supportive treatment before an advanced level of deterioration occurs. Contributing to the well-being of physically frail nursing home and community residents is an important challenge for nursing. Robertson and Montagnini (2004) recommend that, because GFTT generally occurs near the end of life, the benefits of treatment be carefully considered before initiation of and be limited to interventions with few risks for the frail older adult. The nursing profession needs an approach that takes into account both the psychosocial experiences and physical problems of this population.

A diagnosis of failure to thrive should be abandoned for a measure-oriented approach.

Although the management of GFTT is directed at its etiology, the impact of contributing factors must be considered (Palmer, 1990). A danger may lie in incorrectly labeling the geriatric patient with failure to thrive just to explain the multitude of symptoms. Robertson and Montagnini (2004) suggested that diseases often overlooked in GFTT diagnoses include cancer, chronic lung and renal diseases, diabetes, stroke, and tuberculosis. Advanced practice nurses must be very astute when using failure to thrive as a clinical diagnosis, as a reversible pathophysiological process may underlie the observed syndrome of weight loss, decreased cognitive function, malnutrition, and decreased functional status.

Nurses must also be mindful that older patients take multiple medications and have many comorbidities and physiological changes that may alter drug pharmacokinetics (Rocchiccioli, Sanford, & Caplinger, 2007). Problems with polypharmacy often manifest as physical, behavioral, and psychological changes that may be mistaken for GFTT. Medications can also induce adverse side effects for older adults. For example, anorexia, subsequent weight loss, and gastrointestinal disturbances often result from the use of antibiotic medications and the drug digoxin (Palmer, 1990).

Nurses treating patients with weight loss, malnutrition, and impaired physical and cognitive function should collaborate closely with the patient and family. An extensive evaluation for underlying causes should be a treatment goal. The 15-item Geriatric Depression Scale (Yesavage et al., 1982-1983) is often useful as a reliable scale to assess for depression in older adults. Another useful screening instrument is the Mini-Mental State Examination (MMSE) (Folstein, Folstein, & McHugh, 1975), a simple inventory that allows quick screening for potential cognitive disorders in older adults in community, nursing home, and acute care settings. Diagnosis and management of older adults with depression is often difficult and overlooked (Palmer, 1990). The gold standard for management of depression in older adults with GFTT continues to be antidepressant medications and appropriate psychotherapy (Palmer, 1990; Robertson & Montagnini, 2004).

A comprehensive assessment includes searching for a treatable underlying physiological and functional condition. The assessment of physical function should include former and current documentation of a patient's ability to perform ADLs and IADLs. The Katz Index of Independence in Activities of Daily Living (Katz, Ford, Moskowitz, Jackson, & Jaffe, 1963) assesses a patient's ability to perform six related functions: bathing, dressing, toileting, transferring, continence, and eating. Obtaining this information can help the nurse compare any changes that may have occurred in recent weeks with the patient and the family. Resistance and strength training with older adults has shown improvement in counteracting muscle weakness and frailty (Robertson & Montagnini, 2004). In older adults with cognitive impairment, functional status may be improved by treating the underlying condition and optimizing the patient's living conditions (Robertson & Montagnini, 2004).

A nutritional assessment is central to diagnosis and should include assessment of physiological indications of malnutrition. The Mini Nutritional Assessment (MNA) is a valuable tool for measuring nutritional risk in older adults that combines anthropometrical measures and dietary history and is easy to use in the office setting (Guigoz, Vellas, & Garry, 1996). Routine monitoring of weight, a component of the MNA, will help determine whether unintentional weight loss is present, which may indicate malnutrition (Huffman, 2002). Older adults with GFTT and their caregivers may benefit from nutritional counseling and appropriate referrals to other health care professionals (Palmer, 1990). Nutritional supplementa-

tion, especially between meals, may be needed to provide adequate energy and protein intake. Other recommendations include limiting the presence of friends or family members at meals, improving palatability of meals, and choosing better locations and times for meals (Robertson & Montagnini, 2004). Continuity of care by advanced practice nurses for older adults with GFTT is critical in avoiding adverse effects, duplication of services, and other negative outcomes, such as polypharmacy.

A socioeconomic review is also essential in the assessment and management of older adults with GFTT. Older adults with limited incomes or those without experience in meal preparation may benefit from social services resources. Screening for drug and alcohol abuse and polypharmacy is also critical. Dementia, depression, and limited social supports are risk factors for failure to thrive and should be assessed. Because providing care for family members with GFTT can lead to emotional strain or physical stress, assessment of caregiver burden must also be included in the management of older adults with GFTT (Palmer, 1990).

All nurses need to help older adults transition through the life span, aiding through periods of wellness, illness, and the dying process. An open discussion about end-of-life care, advanced decision making, and spiritual needs are always a priority and should include the patient and his or her family members. Opening a dialogue is crucial and enables the patient to be an active participant in end-of-life decision making.

INDIVIDUAL EXAMPLE

Mrs. Jones is an 83-year-old woman who comes to her primary care office with her 62-year-old daughter, Martha. Martha scheduled the appointment to discuss a decline in her mother's condition. Martha noticed a worsening in her mother's mental status during the past 3 months. She reports that her mother is frequently confused and often talks about her late husband as though he were still alive.

During the visit, Mrs. Jones is oriented to person only. Six months ago, Mrs. Jones was ambulatory without the assistance of a walker or cane; now, she is using a walker and assistance from family members to ambulate 20 feet to the bathroom. She only eats a few bites of food at each meal. Martha has noticed that most of her mother's clothes fit loosely. According to the office chart, Mrs. Jones has lost 10 pounds since her last visit 6 months ago. A conversation with Mrs. Jones suggests that she "just really doesn't feel good" and that "she doesn't know what is really wrong." Her nutritional status is evaluated using the MNA and results in a score of 16, which indicates a malnourished state.

Mrs. Jones meets all criteria for a diagnosis of GFTT. A discussion is held with Martha in Mrs. Jones' presence regarding how to proceed. They discuss a comprehensive approach, including laboratory work (complete blood count, chemistry panel, thyroid function, blood cultures, and urinalysis), x-rays, and an MMSE to evaluate for an underlying disease process. End-of-life issues are also discussed. Martha states that she is her mother's medical power of attorney and that her mother has shared that she has had a "good life" and did not wish for aggressive medical treatment. Mrs. Jones states, "I don't want all that done, and I don't want to be in pain." Martha does not wish to pursue an evaluation for an underlying process but is interested in additional support systems for in-home care. Appropriate referrals are made for supportive care. Nutritional counseling is initiated to include further assessment of weight loss and provision of supplementation as desired. Over the next 3 months, Mrs. Jones' condition progressively

KEYPOINTS

GERIATRIC FAILURE TO THRIVE

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1. Older adults with geriatric failure to thrive (GFTT) are characterized by a loss of vitality, a seemingly lack of will to live, and an inability to thrive in their current environment. Such patients often complain of "just not feeling too well," and family members note their loved ones are "going downhill" for no apparent reason.
2. The four syndromes of failure to thrive include impaired physical functioning, malnutrition, depression, and cognitive impairment.
3. Psychosocial factors also contribute to the development of GFTT and include those numerous and irreplaceable losses, both large and small, that affect individuals during the journey of life.
4. Nurses treating patients with weight loss, malnutrition, and impaired physical and cognitive function should collaborate closely with the patient and family. An extensive evaluation for underlying causes should be a treatment goal in all cases.

deteriorated until she experienced a peaceful death at home surrounded by her family.

CONCLUSION

Failure to thrive is descriptive of many symptoms of possible underlying pathophysiological diseases or complex social issues. The use of failure to thrive as a medical diagnosis is limited in that it is not a single disease process but instead the possible effect of one or more conditions. GFTT may be part of the natural dying process, and the opportunity for providing end-of-life care should not be overlooked by health care professionals. As recommended by Sarkisian and Lachs (1996), a diagnosis of failure to thrive should be abandoned for a measure-oriented approach that gives special attention to impaired physical and cognitive functional status, malnutrition, and dementia.

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