BEHAVIOURAL CASEWORK AND FAILURE TO THRIVE

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TO SEE the twins, Jimmy and Wayne Grant,** together — on one of our home visits — is to understand something of what the paediatric term 'failure to thrive' means. Jimmy is a chubby, rose-cheeked boisterous two-year old. He appears to be a happy, mischievous boy, running, playing, talking and laughing. He comes to his mother for help and comfort and cuddles up to her spontaneously. He responds readily to her attention and affection. She smiles at him, picks him up, sits him on her lap, plays with him, answers his questions, watches his movements, warns him when he is in danger.

On the edge of the room, like a stranger, stands Wayne — posture rigid, staring fixedly at us. He is a sad, lethargic looking child, very small and extremely thin. His pale face throws into relief the dark shadows under his eyes. He remains in one spot, as if at attention; by now he is gazing unswervingly at his mother. She takes no notice of him. When asked to call Wayne over to her she looks in his direction; as she does so her face hardens and her eyes are angry. She addresses him with a dry command; when he hestitates she shouts at him.

Our observations of his interactions with his mother (several visits over four weeks) which gave us base-line data, indicated that she *never* smiled at him, *never* picked him up, *never* sat him on her knee, *never* played or read to him. The only physical contact came about when she fed, bathed or dressed him, and at such times, her handling was rough and silent. When she approached him he appeared to be frightened and occasionally burst into tears.

He would never come to her for comfort or help and she never approached him except to carry out the bare essentials of care and control. The children were both meticulously clean and well-dressed.

Home-based observations allowed us to see that when the father returned from work, Wayne brightened a little; he became somewhat more alert and lively, especially when mother was out of sight. When she entered the room he stiffened up. Jimmy and Wayne don't play together. Jimmy frequently pushed his brother and smacked him; Wayne's cries were largely ignored by his mother.

Looking at Wayne and Jimmy it is hard to believe that they are twins who were of the same weight at birth. Wayne's small stature was now reflected in a height and weight that were below the third percentile curves of normal growth. Wayne had been hospitalized several times because of his failure to gain weight. During the lastest hospitalization Wayne's mother refused to visit him and requested his reception into care; she appeared to be very depressed and said that she could no longer cope with trying to feed him (he would refuse food, or spit it out screaming loudly). She added that she could no longer tolerate his behaviour ('defiance', whining and crying) and her hostile feelings towards him. At the stage of our entry into the case Wayne had to be fed by a combination of the health visitor, father or a neighbour.

FAILURE TO THRIVE

Failure to thrive has become a popular term to describe infants and children whose growth and development are significantly below expected standards. It is thought of as a 'syndrome' of severe growth retardation, delayed skeletal maturation, and retarded psychomotor development which is frequently associated with a specific disturbance of maternal behaviour and family disorganisation. Certainly, in Wayne's case, it was clear (after the essential exhaustive medical tests) that his retarded growth at this stage of his life was not due to organic disease. Research findings suggest that physical (organic) abnormalities cause such failures to thrive in only a minority of children.

Martha Leonard and her colleagues (Leonard et al, 1966) comment that the frequent exclusion of an organic basis in failure to thrive cases is worrying to both the parents and the physician. As they put it: 'Negative results could not completely resolve their fears of some undetected serious abnormality. Parent's feelings of guilt about their own contribution to the poor thriving of their infant were not helped. Without consideration of psychologic and social factors, it is often concluded that such a child has nothing wrong.'

Studies of such children and their families have shown that the most commonly identified forerunners to these problems are emotional disturbance and environmental deprivation — with the wide range of psycho-social disorganisation that these concepts imply. The deprivation often involves rejection, isolation from social contacts and neglect. Occasionally, physical abuse enters the picture. Wayne showed, on several occasions, severe bruising. The health visitor had placed him on the 'at risk' register.

The association of poor growth with adverse environmental factors has often been pointed out in the context of the maternal deprivation and child abuse literature. A study of two orphanages (Widdowson, 1951) showed that psychological stresses due to harsh and unsympathetic handling may seriously curtail growth-rates. The association between maternal deprivation (in particular) and failure to thrive has led some investigators to hypothesize the existence of a physiological pathway whereby emotional deprivation affects the neuroendocrine system regulating growth. The mechanisms of the growth failure, in fact are not

** These names are purely fictitious.*

clear. It is suggested (Fischhoff et al, 1971) that maternally deprived infants can be underweight because of undereating (which is secondary to being offered inadequate food), *or* because of the refusal of the adquate nourishment offered — rather than as a result of some psychologically induced defect in absorption or metabolism.

ASSESSMENT: BEHAVIOURAL CASEWORK APPROACH

To return to the Grant family — now in acute crisis — they were referred to the authors for a form of assessment and a broadly based form of behaviour therapy which we call 'behavioural casework'. This family orientated approach, which combines behavioural methods of assessment and modification with family-casework methods which include discussion, clarification of problems, developmental counselling and task-setting and support-giving, was developed at the Child Treatment Research Unit (CTRU), attached to the University of Leicester School of Social Work (see: Herbert and O'Driscoll, 1978; Herbert and Iwaniec, 1979).

Wayne was hospitalized five times during his two years and three months of life. Altogether he had spent 68 days in hospital. The first admission was at the age of four weeks. He had been a difficult baby to feed from the word 'go'. He vomited frequently and seemed to cry or scream incessantly for the first few weeks of life. He was suffering from Pyloric Stenosis. After the operation he improved a little. His sucking became more vigorous although he took a long time to feed. The situation deteriorated when solids were introduced at the age of five months. He persistently refused to take them and gradually stopped taking liquids as well. From that time onwards, feeding time became a battle.

Wayne was fourteen months old (weight 6kg., height 69cms.) when his mother finally found it impossible to cope with his reluctance to eat. She screamed at him, smacked him, shook him, getting angrier and more frustrated each day. When she forced him to eat, he screamed, vomited immediately and then had diarrhoea. Soon Wayne began to scream at the sight of his mother. She could not touch him or come near him. In anger and helpless despair she would take him upstairs and leave him there for hours. Wayne took some food from his father and next door neighbours and was fed only when they were available. Because he was losing weight rapidly, he was admitted to hospital for investigation. In hospital, Wayne cried a lot, was at first unresponsive to nurses and movements around him. When not crying he looked blank and lethargic. Gradually he began to take food and became more alert and lively, doing well enough in the end to be discharged. This pattern of 'failure to thrive', improving in hospital and deteriorating soon after going home was to be repeated several times. All of this increased his mother's feelings of hostility and rejection towards the child, not to mention her feelings of inadequacy as a mother. He seemed better all round when he was in different places with different people. In the end she refused to have Wayne back home from the hospital.

Our work is carried out in the home with both parents and children. A brief account is given (with down-to-earth examples) of the theoretical raionale and practical implications of behavioural casework, pointing out how problem behaviour, like normal behaviour (and indeed problematic interactions) can be acquired through failures or anomalies of learning and communication, and how such problems might be alleviated by practical strategies based on theories of learning and development (Herbert, 1975). The 'commonsense' and familiar aspects of child management are stressed. It is emphasized that if a behavioural treatment is felt to be appropriate then this is likely to involve altering the consequences of the child's problem behaviour. But it is also stressed that the parents should be prepared not only to change their present *responses* to the child's supposedly maladaptive behaviours, but also to *initiate* new behaviours provided that they are not required to do anything distasteful or contrary to their values as parents. It is demonstrated how problems are not encapsulated within the child but are contingent upon things he has learned within a social nexus, and that includes the family actions and reactions to him.

The parents are advised that a good deal of time and effort will be required from them.

In order to be able to institute a full programme of assessment and treatment, we had to teach Mrs. G to relax and to structure small, manageable daily tasks to counter her tension and her inertia and apathy. We diagnosed her depression as learned helplessness (see: Seligman, 1975). So as not to exacerbate her feelings of helplessness and demoralization, we underlined the point that we were not there as 'experts' to take over the burden of the child's problem from the parents, but that we would be partners in a co-operative venture with a major part of the responsibility rightfully in their hands. A period of counselling and support-giving and relaxation-training was embarked upon and covered seven weeks. We arranged for full-time attendance by the twins at a day-nursery.

Looking at the history we took at this time, it seems likely that the child learned (on a classical cum operant basis), to avoid food by associating feeding with painful experiences, e.g. forcing, hurrying, shaking, smacking, scolding and throwing. Finally, mother's person became a stimulus to evoke fear which (in proximity) brought physical symptoms like vomiting and diarrhoea, if she was angry. He screamed sometimes even at the sight of his mother approaching him. Being reared in social isolation and lacking stimulation it is not surpirising that Wayne manifested a serious developmental delay in speech. His brother was more generally advanced but also showed speech retardation.

TREATMENT PROGRAMME

Before we could initiate a programme dealing with the aversive interactions between Mrs Grant and her child, we had to cope with the crisis issue of the mother feeding her child. After all, Wayne was wasting away.

Phase I: This was tackled in a highly structured (and thus, directive) manner. Mealtimes had to be made more relaxed. She agreed (albeit reluctantly and sceptically) to desist from screaming, shouting and threatening the child over his meals. The period of eating was made quiet and calm; Mrs. Grant was asked to talk soothingly and pleasantly to him.

This was extremely difficult for her to achieve. (The Social Worker joined the family for a few meals, helping to reassure Wayne, prompting the mother to help him eat in a gentle

manner when he was in difficulties. Mrs Grant was encouraged to look at him, smile, and occasionally touch him). If Wayne refused his food she was to leave him especially if she couldn't encourage or coax him by play or soft words. The food was arranged decoratively to look attractive.

This aspect of the programme (lasting several weeks) was purely 'instrumental' or 'symptomatic' in the sense of encouraging the child to eat by creating less fraught circumstances. As long as the mother kept to this schedule, Wayne would eat (not much, but a life-supporting amount). If she broke the rules because she was moody or unstable, Wayne would not sit in his high chair. We added another rule (on the basis of this observation), that she never fed the twins when feeling acutely angry or tense. There should be a period of quiet relaxation (using the relaxation tape and the training we had given her) if this was difficult to achieve.

Phase II: This phase (as with earlier stages of treatment) was discussed in detail — rationale and method — with both parents. A contract was drawn up specifying the mutual obligations and rules for the family and ourselves (see: Herbert, 1978, 1979).

Objectives:

1. To deliberately, and in planned fashion, increase positive interactions and decrease negative intereations between mother and child;
2. To desensitize Wayne's anxieties with regard to mother's caregiving (and other) activities;
3. To desensitize mother's tension, anger and resentment when in Wayne's company;
4. To increase and make more general the intra-familial interactions (e.g. as a group, between Wayne and his brother, etc).

Methods:

Mrs. Grant agreed to play exclusively with Wayne every evening after her husband returned from work, for 10 minutes during the first week; 15 minutes during the second week, 20 minutes during the third week and 25 minutes during the fourth and subsequent weeks. The father took Jimmy for a walk, or to another room, while Wayne had this period of play. Afterwards they would join in for a family play session. The mother was asked to play with Wayne on the floor — this was demonstrated and rehearsed — and she was encouraged to talk to him in a soft reassuring manner, encouraging him to participate in the play.

She was also instructed to smile at Wayne, look at him, touch him briefly, or praise him for each positive response she detected from him. (His tentative approaches toward her were 'shaped' by just such a series of successive approximations). After a period of weeks she was guided to seek proximity to him by hugging him briefly and then holding him on her lap for increasing intervals of time, eventually holding him close, but gently, while reading him a story.

There is no doubt that Mrs. Grant found all this difficult, and, at times, distasteful; but they became gradually less so as time passed and especially as Wayne began to seek her out shyly and to smile and chat to her. We had to provide a good deal of support and encouragement to both parents during frequent visits or by phone calls. (Reinforcing the reinforcer is critical in this work!). Three months were occupied by this stage of the intervention.

Phase III: The final phase took two weeks and deliberately involved an intensification of Mrs. Grant's interactions (now much improved) with Wayne.

1. She was to take him almost everywhere she went, whatever she was doing from morning until night. She was instructed to chat as much as possibie to him in a soft measured way, smiling and cuddling him at approximate times. (These had to be discussed as Mrs. Grant frequently put Wayne in a double-bind by giving contradictory verbal and non-verbal cues.)
2. She was asked to read to him and Jimmy, encourage them to play together, and read to them both at bedtime. *Their* positive interactions were to be reinforced socially.

The formal programme was faded out gradually (over a period of several weeks) after discussing with parents the importance of a stimulating environment and a rich reinforcement schedule for the maintenance of the improvements they both detected. These were evident in the family interactions and mothers' feelings and attitudes (these were monitored for us by herself). Our perceptions of Wayne's improved health, weight and height (and indeed his general psychological well-being) were confirmed by the assessments of the paediatrician, the nutrition consultant, and a health visitor. Mrs. Grant's sense of attachment and affection (bonding) to Wayne had returned; what is of interest is that although we discussed her feelings and attitudes with her they were not the primary focus of treatment. She found it difficult, and in the end, refused to discuss them. We hoped that old feelings of affection and nurturance would return if we countered the avoidance situations (and sense of helplessness) which stood in the way of her learning to love him again. Feelings (and insights) *followed* actions!

This is but one of 20 failure to thrive cases in which (with 40 control patients) we are studying the efficacy of behavioural casework in family settings.

BIBLIOGRAPHY

Fischoff, J., Whitten, C.F., Pettit, M.G. (1971) 'A psychiatric study of mothers of infants with growth failure secondary to maternal deprivation'. Journal of Paediatrics, *79*, (No.2), 209-215.

Herbert, M. (1979) *Child Treatment Research Unit Behaviour Modification Training Manual*, University of Leicester School of Social Work Occasional Paper No. 3, 86 pp.

Herbert, M. (1975). *Problems of Childhood: A Complete Guide for All Concerned:* Pan Books.

Herbert M. (1978) *Conduct Disorders of Childhood & Adolescence: A Behavioural Approach to Assessment and Treatment*. Brisbane: John Wiley & Sons.

Herbert M. & Iwaniec, D. (1979) *'Managing Children's behavioural problems'* Social Work Today 10, (No. 33) 12-14.

Herbert, M. & O'Discoll, B. (1978) *'Behavioural Casework — A social work method for family settings'*. Australian Child & Family Welfare 3, (No.2) 14-25.

Leonard, M.F., Rhymes, J.P., & Solnit, A.J. (1966) *'Failure to thrive in infants: A family problem'*. American Journal of the Diseased Child. Vol. III June.

Seligman, M. (1975) *Helplessness* San Francisco, Freeman.

Widdowson, E.M. (1951) *'Mental contentment and physical growth'*, Lancet 260, 1316-1318. ●