Professional Failure to Thrive: A Threat to High-Quality Care?

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Abstract
The term professional failure to thrive arose from descriptions of non-organic failure to thrive in infants and observations of nurses' behaviours. First coined by Stamler in 1997, subsequent unrelated research results have supported the theoretical construct. In an era when patient safety and high-quality care have never been more important, and nursing retention has reached heretofore unknown levels of global concern, critical examination of factors that may alleviate professional issues and support high-quality healthcare is especially useful. In this paper, we suggest theoretical causes for professional failure to thrive (PFTT) and associated behaviours exhibited by nurses, and draw links to current research to support the theory. Given the theoretical support, PFTT represents an additional avenue that should be considered and explored through research studies.

Introduction
A common topic of discussion in healthcare is the acute and growing global nursing shortage. While recruitment and increased education of qualified nurses is certainly one of the strategies to ensure healthcare for all, retention is an equally important issue. The emphasis on retention becomes even more important when one reads about the large numbers of young nurses who are no longer registered or who indicate intent to leave (CNA 2002; Flinkman et al. 2008). It seems

counter-intuitive to place all of our efforts on adding numbers into the nursing pipeline and ignore the substantial leakage of nurses leaving the profession. A confounding factor is the very real possibility that some of the nurses remaining in the workplace are no longer providing high-quality care. Literature indicates that we can link patient outcomes and organizational structure to the work environment of nurses (Aiken et al. 2008). Thus, this paper juxtaposes behaviours exhibited by nurses and a medical diagnosis for young children (now a nursing diagnosis for adults) of non-organic failure to thrive in an attempt to create an approach to nurses' healthcare environment that may improve nurse and patient safety and outcomes.

Background

Infant non-organic failure to thrive was first observed in orphans following the Second World War and described by Spitz (1965). The condition was identified as a result of maternal deprivation through absence of a physical maternal presence, or the presence of mothers who were unable to exhibit nurturing behaviours such as cuddling the infant, demonstrating joy in the baby's presence or expressing loving attention. Thirty years later, Stamler (1997) postulated that this disorder could be linked to hopelessness and depression in adults, and suggested that members of the helping professions were particularly vulnerable to what she termed professional failure to thrive (PFTT). Nurses were included within that scope of vulnerability.

Stamler (1997) suggested that PFTT was a progressive functional deterioration in relation to the psycho-social work environment of a healthcare professional, wherein the ability to cope with problems and manage care diminishes. She also suggested that PFTT might be initially manifested in professionals through protest, resignation and detachment behaviours. For example, the nurse may experience an unrelenting sadness or note that there in an increasing need for energy in her or his professional life, or feel hopeless in relation to solving issues arising at work. Eventually, the nurse may feel isolated from peers. Stamler suggested that these behaviours related to a lack of support or reinforcement within the work environment. She identified potential long-term consequences, including diminished ability to provide care to clients by depletion of the nurse's problem-solving resources, or inability to adapt to new work situations. Finally, she noted that the identification of progressive negative perceptions or behaviours by peers or within healthcare institutions was important because few healthcare providers are able to analyze their own practice objectively and identify signs of hopelessness or PFTT.

Since then, additional research exploring nursing and workplaces has increased knowledge about nurses' work lives, their working culture and its effect on recruit-

ment and retention. One important development has been the cultivation of magnet hospitals and a description of their work environments and desirable characteristics, giving institutions both a benchmark and a level of recognition toward which to strive (American Nurses Credentialing Center 2009a). Further, within the nursing profession, we now know more about what nurses need to achieve professional satisfaction and deliver high-quality care while willingly remaining in the profession (Best and Thurston 2006; Hasson and Arnetz 2007; Ulrich et al. 2007b). Yet, retention in the workplace and the profession continue to afflict healthcare institutions and nursing alike. In Canada, the Canadian Nurses' Association notes that "of the 81,044 graduates of Canadian nursing schools who graduated in the 11 years between 1990 and 2000, only 64,394, 79 per cent, were registered in the year 2001. This means that over 16,650 very recent graduates were not registered and available to deliver nursing services in Canada" (CNA 2002: 55). The Canadian Federation of Nurses Unions holds that "if experienced nurses could be retained, the projected losses could be reduced by about 53%" (CFNU 2006). In Finland, Flinkman and colleagues (2008) noted large numbers of recently graduated nurses signifying intent to leave the profession, potentially leading to a similar deficit. The current and impending nursing shortage and concerns related to it have never been greater. Is there something here that we are missing? Are we as a profession just not doing what we know is necessary within the work environment, or are there other factors hindering our success?

Infant Failure to Thrive

In pediatric circles, failure to thrive continues to be widely understood as a diagnosis of poor growth caused by organic symptoms and/or non-organic reactions to the environment (Schwartz 2000). Rudolf and Levene (2006: 195–98) stated that "the commonest causes for failure to thrive are psychosocial [and related to] difficulties in the home, limitations in the parents, disturbed attachment between the mother and child, maternal depression or psychiatric disorder and eating difficulties." Spitz (1965) noted three identifiable phases of infant failure to thrive: (a) angry protest, (b) resignation and depression and (c) withdrawal and reorganization. In the infant, the behaviours associated with angry protest included crying and waving of limbs and otherwise attempting to gain the attention of orphanage staff. In the first stage, this crying would be almost constant, but could easily be silenced by staff attention – nurturing. In the second stage, resignation and depression, the crying would be more intermittent, with the infant giving up after many tries, and then beginning again following staff attention. Over time, the crying would lessen in frequency and no longer be tied entirely to receiving staff attention. In the third phase, withdrawal and reorganization, attention elicited not the attention-getting response of crying, but rather, apathy. Repeated attention to the infant could reverse the process, but at some point, either the resignation was complete, and the infants died with no apparent organic cause, or the infant

found some way of coping with the dearth of attention, and survived regardless. Spitz had a captive sample to observe in that the orphans were present throughout the continuum of failure to thrive. Healthcare professionals would most likely observe only the final phase of the syndrome, when the infant's condition required medical intervention.

Adult Failure to Thrive

Although historically, this term has been applied only to young children, the notion of failure to thrive has migrated into care of adult and geriatric populations. The North American Nursing Diagnosis Association International (NANDA-I) defines adult failure to thrive (AFTT) as "progressive functional deterioration of a physical and cognitive nature, [wherein] the individual's ability to live with multi-system diseases, cope with ensuing problems, and manage his/her self care are remarkably diminished" (2007: 78). NANDA-I does not view the AFTT diagnosis as part of normal aging, the unavoidable result of chronic disease or a symptom of the terminal stages of dying. While NANDA-I (2007) does not describe specific phases in AFTT, the defining characteristics identified include altered mood state, anorexia, apathy, cognitive decline, consumption of minimal to no food at most meals and decreased participation in activities of daily living. NANDA-I also reports related factors such as depression, decreased social skills, expression of loss of interest in pleasurable outlets, frequent exacerbations of chronic health problems, inadequate nutritional intake, neglect of home, neglect of financial responsibilities, physical decline, self-care deficit, social withdrawal, unintentional weight loss and verbalization of desire for death. NANDA-I is the sole source of information about adult failure to thrive. Literature on the geriatric population ascribes the genesis of the condition to chronic co-morbidity and functional impairments, with depression as both "a cause and a consequence of failure to thrive" (Robertson and Montagnini 2004: 346).

Professional Failure to Thrive

The NANDA-I diagnosis suggests factors or observable behaviours that can be seen in adult patient populations. However, the genesis of those behaviours originates well before contact with a health professional, just as in the infant syndrome described by Spitz (1965). It is therefore not unreasonable to suggest that those same factors may be observed in adults who are not part of a patient population, including vulnerable adults, such as healthcare professionals. Healthcare professionals may be vulnerable on several fronts – first, because work relationships occupy a significant part of the individual's work life. Second, many healthcare professionals complete their work in relative isolation (e.g., one-to-one with patients or families), leading to the third factor, that value or recognition may come primarily from patients or family rather than peers, and may be perceived to have less worth than the same recognition from peers or superiors (Stamler 1997). Stamler (1997), in

describing professional failure to thrive, linked the term to the behavioural depression described by Lewinsohn (1974), wherein the triggering factor appeared to be the lack of positive reinforcement as perceived by the individual. Lewinsohn noted that this lack of reinforcement could be either a response to the individual's own irritating behaviour, or due to the environment being incapable of providing positive reinforcement regardless of the individual's behaviour.

Conversely, it is common knowledge that magnet hospitals report higher quality outcomes. Research by Ulrich and colleagues (2007a) has reported that institutions in the process of applying for magnet status, versus non-magnet hospitals, benefited through a perceived improvement in the overall quality of the work environment via newly available nursing resources, such as professional development opportunities and recognition of accomplishments. This finding makes sense in light of the "forces of magnetism," which "differentiated organizations that were best able to recruit and retain nurses during the nursing shortages of the 1970s and 1980s" (American Nurses Credentialing Center 2009a). From that research, organizational criteria were developed upon which magnet status depends, including the presence of a well-educated chief nursing officer, the use of standards for nursing administrators, feedback policies that protect staff and a process in place for the collection of "nurse-sensitive quality indicators" (American Nurses Credentialing Centre 2009b). If the achievement of magnet status produces a supportive and protective nursing environment, capable of giving positive reinforcement to its employees, it follows that the absence of these criteria may result in an institutional environment incapable of providing positive reinforcement. However, Lewinsohn (1974) might argue that despite a supportive environment some individuals may be incapable of recognizing and utilizing available resources, even in a magnet hospital.

The question then arises: If PFTT indeed exists, and if we use the three phases identified by Spitz (1965), coupled with the limited literature describing failure to thrive in adult and geriatric populations, what might be the behavioural characteristics of the nurse to whom this label could apply?

In the angry protest phase, we might observe a nurse who continually seeks a voice within the unit and the organization – through volunteering to sit on committees, bringing electronic or paper published research results suggesting a new process or procedure for a particular patient's care to the attention of the other staff, or offering suggestions for staff-identified concerns or issues. These identified behaviours would contribute, whether the focus seemed to be personal satisfaction with job performance, the general excellence of care provided on the unit or a contribution to making the institution known for excellence. If the staff member perceives that his or her voice is not heard, not valued or unwelcome, the behav-

iours described above would diminish in number and intensity (as Spitz observed in infants) as the member becomes aware of his or her perceptions. Over time, the nurse might vary the intensity to see whether more or less behaviour might elicit recognition and valuing of his or her contribution. Alternatively, a nurse in this phase may engage in less positive methods to achieve work-related recognition, such as becoming argumentative or sarcastic towards others' attempts to initiate new ideas or procedures, and engaging in behaviours that disrupt the flow of the work environment and cause conflict among co-workers.

In the second phase described by Spitz (1965), resignation and depression, as the behaviours continued to fail to elicit the desired response, the nurse's efforts would continue to diminish until he or she was completing only the bare minimum of needed work and had ceased all attempts to gain either positive or negative recognition.

During the third phase, withdrawal and reorganization, the staff member might detach and undergo the process of psychologically "quitting before leaving" (Burris et al. 2008), or engage in coping mechanisms to deal with the perceived lack of recognition. For the staff nurse, these might include leaving the unit, the institution or the profession. While the former behaviours associated with withdrawal leave the unit with a pair of hands, it is questionable which of the two alternatives is worse for patient care, as either appears to reduce the possibility of improving the work environment and patient care. Again according to Spitz's description of infant behaviour, it is the attention (especially positive, encouraging attention) that mitigates the behaviour, and stops or reverses the movement towards irreversible failure to thrive. It is therefore interesting to note that within the criteria for magnet hospitals, support for all nursing staff is embedded within the whole process (American Nurses Credentialing Center 2009a,b).

Wysong and Driver (2009) interviewed ICU patients to ascertain the qualities that patients observed that indicated satisfaction with their nurses' skills. These included interpersonal skills (e.g., confidence, positive attitude towards work), critical thinking skills (e.g., good clinical judgment, advice and suggestions) and technical skills (e.g., operating equipment). The behaviours described in the first stage of PFTT are similar to those noted by Wysong and Driver, suggesting that those behaviours are seen as positive. Why, then, do the behaviours diminish? If this diminution occurs because of perceived lack of valuing, where does the valuing come from, and how can it be expressed?

Spitz (1965) suggested that the absence of mothering was a primary trigger for infant failure to thrive, and noted that individuals who lived to adulthood without a notion of mothering had difficulty participating in that activity – lead-

ing perhaps to another generation of infants who were vulnerable to failure to thrive. Stamler (1997), when discussing PFTT, suggested a domino effect within an institution, a finding that current nursing research supports. For example, in a hospital, staff members look to the unit manager for recognition (Ilies et al. 2007; Laschinger et al. 2006b), the unit manager looks up the hierarchy of the institution for continued recognition (Laschinger et al. 2007a), and the effectiveness of nurses in executive positions is influenced by the support they give their staff (Kirk 2008). Thus, if recognition and positive regard are lacking at the top of the hierarchy, the professionals at the base would feel the effect.

Further, Stamler (1997) identified that the point of origin of the positive reinforcement and recognition was important. For instance, positive regard on the part of the patient and family is valued, but not to the same extent as the same behaviour or action from the supervisor or a colleague with recognized clinical expertise. To this end, literature suggests that leaders who are able to communicate the requirements of the job and their expectations of the work, encourage participation in decision-making, provide coaching, lead by example and show concern for individual employees, can expect better performance (Janssen and Van Yperen 2004; Thrall 2003).

Is This Really Burnout?

While the term burnout does not seem to be as popular as it once was, it is important to consider it as part of a discussion of PFTT. Manojilovich and Laschinger, in applying a nursing work life model to an ICU setting, noted that "[n]urses are at high risk of burnout because their emotional resources become depleted in trying to psychologically give of themselves to their patients, a situation that quickly leads to emotional exhaustion" (2008: 482). These authors clearly note that here the cause of the nurse's distress is the emotional depletion related to consciously or unconsciously giving away emotional stores, not necessarily expecting reciprocal deposits to those stores by patient actions. Gilbert and Daloz (2008: 264), on the other hand, postulate that "[b]urnout could be understood as a growing dissatisfaction and a discrepancy between what the subject desires at work, although this area of life remains central to him, this dissatisfaction could then fuel a psychological and an emotional tension in a much larger framework than the simple relationship to work." These authors go on to note that professional burnout is related to lower self-esteem on the professional level. Ericson-Lidman and Strandberg (2007), in a study of co-workers' perceptions of signs preceding another worker's burnout, identified five themes from their qualitative analysis: struggling to manage alone, showing self-sacrifice, struggling to achieve unattainable goals, becoming distanced and isolated, and showing signs of falling apart.

In the subthemes named by Ericson-Lidman and Strandberg (2007), it was striking that almost all are internal in nature, difficult to observe by others and difficult to prevent with engagement or voice facilitated by the leader. In contrast, the theoretical notion of PFTT postulates that the individual's perception of voice or value to the unit could alleviate or reverse movement towards the endpoint of professional failure to thrive. The strongest links to the theoretical notion of PFTT are the themes of distancing and isolation, and showing signs of falling apart. Similarly, the description of burnout by Gilbert and Daloz (2008) is more clearly linked to the notion of PFTT, as it is the desire of voice and belonging to the profession and the unit that becomes at odds with the perception of the reality of the work situation. Eventually, the nurse's professional self-esteem becomes diminished, and if not reversed, leads to failure to thrive. So while there are certainly some similarities to burnout, PFTT, if visible and mitigated by leader intervention, seems to be more amenable to reversal by a nurturing workplace environment.

Is PFTT a recognizable and measurable factor within the work life of nurses as health professionals, and can it be mitigated by a nurturing work environment? Is it the work environment that generates PFTT, or is an unsupportive work environment a result of several staff exhibiting the late stages of the disorder? The idea of PFTT appears to fit with research results already reported regarding the importance of leadership behaviours in the nursing workplace. The link to high-quality patient care, while theoretically congruent, needs to be tested. In an era of recognizing the importance of patient safety coupled with global efforts to retain nurses and provide high-quality care, there are theoretical linkages to suggest that PFTT is a notion well worth pursuing. The existence of a recognized nursing diagnosis of adult failure to thrive suggests that the disorder can be observed in the behaviours of hospitalized and community-dwelling adults. If the theoretical links gain support through research with nurses, and leader interventions of recognition and positive support are found to ameliorate perceptions or reverse manifestations of PFTT, these findings would contribute not only to the retention of badly needed nursing expertise, but would have the potential to enhance patient care and patient safety.

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