

BRIEF INTERVENTIONS: THE CRYING INFANT

**BI-PED PROJECT (BRIEF INTERVENTIONS: PEDIATRICS)
Emotional Health Committee Maryland Chapter American Academy of
Pediatrics**

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**(This article is an updated version of Dr Howard's article that originally
appeared in Pediatric News 2009**

<http://www.pediatricnews.com/columnists/behavioral-consult.html>)

All babies cry, but some babies cry a lot. Some infants will have real pathology such as GERD, food allergies, volvulus, a hair tourniquet or an injury. However, the vast majority of high crying infants are not ill but are instead suffering from overstimulation or a normal but immature digestive system. Keep in mind that although your level of concern may be low, parental anxiety may be extremely high particularly in the case of new parents. In what has been referred to as the "fourth trimester", babies and mothers are making significant adjustments during the first few months of life and the inability of a parent to comfort their infant can be emotionally devastating. An extremely fussy baby for which there is no quick fix is also a challenging problem for the pediatric practitioner.

What's more is that the stakes couldn't be higher because a third of child abuse occurs in the first 6 months of life. Why on earth would parents vigorously shake or physically injure a defenseless newborn? Because the parents are physically exhausted and the baby won't stop crying despite traditional interventions: breastfeeding or bottle feeding, a new diaper, rocking and cradling.

Pediatric practitioners may grasp for a solution that is quick to implement, advising a switch of formulas or worse, suggesting a breastfeeding mother switch to formula. Monitor for clinical symptoms that suggest a dietary intolerance such as vomiting (not just spitting up), diarrhea or blood in the stools, rashes or hives. In such cases a switch in formula or having a breast

feeding mother restrict certain foods in her diet such as dairy, soy or eggs can be reasonable interventions.

Studies have shown that when infant formulas are switched, years later parents are more likely to falsely believe that their child has gastrointestinal disease.² By the time these children are in preschool, they are statistically more likely to be overprotected by their parents. So making these changes should be carefully considered before going down the slippery slope of non- evidence based medicine.

A better alternative is to undertake a systematic overview of the problem through a thorough a comprehensive history, physical exam including monitoring of growth parameters and observing parent infant interactions.

Assessment of the crying infant:

- The onset of *developmentally normal crying* is usually at age 2 weeks and the peak of 2-3 hrs per day of crying occurs at age 6-8 weeks post term. It is important to distinguish if crying occurs during only one part of the day in a baby that is otherwise happy, engaged and easily soothed. In this setting, a feeding intolerance is less likely.
- Monitor for *colic* which is technically defined as crying for at least 3 hours per day, at least 3 days per week and starting before 3 months post term.
- Monitor for *underfeeding* (especially in a baby younger than age 2 weeks) or *overfeeding* (marked by excessive non forceful spitting up) that can be the source of excessive crying.
- Monitor for *overstimulation*: does the crying get worse following a trip to the store or following attendance at a party with a lot of people?
- Inquire about *family support* and *maternal depression* which can make the experience of a crying infant more overwhelming. Ask mothers if they have been feeling down or depressed, crying more than usual or have lost pleasure or interest in activities. Infant crying has been associated with post partum depression.⁵

- ***Observe parent infant interactions*** in the office setting. Is the parent warm and nurturing, angry, overly anxious or cold and detached? These latter behaviors may be a red flag for problems that require an early mental health intervention.

Interventions:

One approach that gives concrete steps for soothing is using the 5 S's proposed by Harvey Karp M.D.³ and informed by the work of T. Berry Brazelton.⁶

It is important to give each "S" several minutes to have an effect.

- **Swaddling in a wrap:** this can be demonstrated during the office visit
- **Side or Stomach holding**
- **Shush sounds by voice, white noise such as radio static, the hum of a fan or air conditioner or the engine sound of a car ride**
- **Swinging gently**
- **Sucking on a pacifier or finger or hand**

Additional approaches may include:

- **Reducing overstimulation of noise, visual stimuli or exposure to a lot of people**
- **Using chamomile tea (but not as a substitute for feeding)**

- **Researchers have found value in a family prescription for REST: Reassurance, Empathy, Support and Time Away⁴**

➤ **Reassurance**: Ask parents how the crying makes them feel, what worries them about the crying and why they think their baby is crying. These questions can provide helpful insight into how well a parent is coping with their young infant as well as their specific concerns.

Demystifying crying for parents can be a critical step. Explain that crying is a normal activity of babies and it is a way for them to work off infant tension. Reframe that it is not necessarily a sign of severe pain or discomfort. Inform parents that crying in young infants tends to be a phase and that most babies improve by age 3-4 months. Provide positive feedback to parents: “I know you are very worried, but your baby seems to be doing well and you are doing a great job caring for her”. Design a plan of interventions such as the ones listed above that will give parents concrete tasks to attempt. The acronym PURPLE has been used to teach parents some of the characteristics of normal crying.¹

P: Peak of Crying- babies may cry more each week, the most in month 2, then less in months 3-5

U: Unexpected- crying can come and go and it may not be apparent as to why

R: Resists Soothing- babies may not stop crying no matter what parents try

P: Pain like face- a crying baby may look like they are in pain, even though they are not

L: Long lasting- crying can last as much as 5 hours a day or more

E: Evening- babies may cry more in the late afternoon and evening

- **Empathy**: an empathetic approach that acknowledges how overwhelmed parents feel can be very helpful.
Try statements such as: “I can see that your baby’s crying has been very stressful for you and that you have been very worried that something serious is going on”, “Crying is very scary to parents and even seems worse because new parents are so extremely tired” or “Some parents feel guilty or like they are bad parents when their baby cries a lot... have you ever felt this way?”
- **Support**: encourage parents to tap into their family and friend supports to prevent feeling isolated. Many hospitals run new parent support groups to allow for networking.
- **Time Away**: Encourage caretakers to provide each other with breaks. Use family and friend networks for caretakers to schedule some brief time away together to recharge. Parents can also create safe zones within the home (e.g. baby is safe in the crib with parents out of earshot for a brief period of time)
Also encourage parents to engage in activities that provide them with stress relief (music, meditation, yoga, exercise, etc)
- **Mental Health Referrals**: When parents appear depressed or are coping poorly, a mental health referral may be appropriate.
Broach this subject by making statements such as:
“It seems like you are feeling really stressed and overwhelmed...would it be helpful for you to meet with someone to help you through this challenging time?” Providing a name and contact information for a mental health consultant can be very helpful.

Also try to gauge whether the parent is stressed out enough to potentially harm their infant.

Broach this subject by making statements such as:

“Sometimes parents feel upset and angry and even guilty when their baby cries a lot. Have you ever felt so angry or overwhelmed that you felt that you might harm your baby?”

Make a mental health referral if indicated. Contact Child Protective Services if there is any evidence of neglect or abuse.

The pediatric practitioner is often the first professional working with new parents. When it comes to the crying baby, the pediatric clinician can have significant impact in allaying parental anxiety, building parental confidence through positive feedback and identifying early signs of family dysfunction that may require a mental health referral and heading off potential child abuse.

References:

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Fussy baby network <http://www.erison.edu/fussybaby/>

PURPLE <http://purplecrying.info>