

INTRODUCTION

In the first days and weeks of new life, when you are still in a daze from the physical and hormonal tsunami of birth, something quite awful might happen. Your precious little baby may begin to cry for hours on end – shuddering screams convulsing that tiny, wondrous body, fists and limbs flailing, face red and screwed-up, little mouth open wide – and nothing you or anyone else does seems to help. Or it might be that your baby doesn't scream exactly, but just seems unhappy most of the time: grizzling, fussing and fretting, pulling away from the breast or bottle and waking frequently. In these situations, you might find yourself quickly overwhelmed by feelings of exhaustion and despair. Your partner or those close to you may feel helpless, too, as they offer what support they can.

The child health nurse might suggest that you space out the baby's feeds, watch for when she is tired, and put her down in the cot awake, with a view to helping her to 'self-settle'. The doctor might diagnose gastro-oesophageal reflux

disease, or allergy, or lactose problems, and prescribe treatment with medications, maternal diets, or formula changes. Your midwife or lactation consultant might suggest that you ‘breastfeed on demand’, listen to your intuition, carry the baby a lot and avoid formula.

Whatever the advice, the underlying message can seem to be that you are somehow failing: if only you would stop being so weak-willed and sleep-train your baby; if only you eliminated the correct foods from your diet or carried the baby all day; if only you would show some guts and persist through your breastfeeding problems; if only you were the intuitive type who had the capacity to work out what your baby wants.

Your friends might tell you that the fussiness relates to wonder weeks and developmental leaps – a comforting thought since neither you nor the baby are to blame. But you inquire into ages and stages only to discover that your baby fits none of them, since healthy babies mature in such different ways and at such different rates.

It’s true that some babies are born with physical problems that require treatment, and some mothers do struggle with mental or physical illnesses that can interfere with the care they can give their babies. It’s also true that the arrival of your baby will inevitably bring enormous change and adjustment, challenge and weariness, for you and your family, especially in the first 16 weeks. But a great deal of the tumult and misery of both woman and child in these first days, weeks and months can be avoided if they get the right kind of help and they get it early enough. Even when crying and fussing have set in, there is still a lot that can be done to make life easier for a family with a crying baby.

After 25 years of clinical experience as a GP, including in my own mother–baby clinic, and 15 years of research in the field of unsettled infants, it’s clear that the families of babies with cry–fuss problems can’t be helped with a ‘one–size–fits–all’ approach, yet this is what most often happens. Health professionals obviously want the best for mothers and their babies, but tend to wear the lens of one particular discipline, whether it’s behavioural psychology, medicine, or lactation science. Cry–fuss problems need an interdisciplinary approach, integrating evidence from across many different fields. This is what I do in my own practice and in my medical publications, and this is why I have written *The Discontented Little Baby Book*.

Unfortunately, many parents are offered advice that arises out of a lack of trust in a baby’s capacity to accurately communicate his basic biological needs, and also a lack of trust that responding to those needs makes life easier, not harder, for families. This breakdown in trust is quite understandable, for historical reasons. As a society, we’ve not been able to identify, let alone prevent, the problems that interfere with the capacity of parents and their babies to get in sync. Life with a new baby often seems astonishingly chaotic and out of control as a result. Instead of learning to understand a baby’s communications (or ‘cues’) in this situation, parents are advised to impose order in other ways. But the underlying problems remain unidentified, and lack of trust in the baby’s cues can result in poor weight gain and low milk supply in breastfeeding babies and their mothers, in unsettled behaviours regardless of feeding method, and possibly even in an increased risk of obesity down the track for formula–fed infants. Most importantly of all, if

parents are taught that they cannot trust their baby's cues, life with their little one simply isn't as pleasurable or as satisfying.

The Discontented Little Baby Book proposes a new way forward. It offers practical advice to help you identify and sort out problems that might underlie your baby's fussing and crying in the first 16 weeks, regardless of whether you are feeding your baby breast milk or formula or both, and it encourages you to trust not only your baby's communications but your own ability to respond effectively (even if that seems impossible right now!). Chapter 1 explores why babies cry and how much crying is normal. Chapter 2 considers the unsettled baby's nervous system and why most babies have bouts of prolonged and unsoothable crying. Chapter 3 discusses the relationship between hunger pangs and crying, including why spacing out feeds can create problems. In Chapter 4, I explore the role of reflux and allergy in unsettled babies, and the effects of insufficient cream in babies who are breastfed. Chapter 5 is all about feeding: how to get breastfeeds right from the very beginning, what mechanical and physiological problems might interfere, and how to bottle-feed in the healthiest way possible. Chapter 6 looks at the way babies are biologically hardwired to seek out sensory experiences and why settling practices such as placing babies in quiet, darkened rooms during the day can exacerbate crying problems and make life harder, not easier, for the family. Then, in Chapter 7, I examine the biology of parent-baby sleep and why it is often unnecessarily disrupted in our society. I discuss why we don't need to 'teach' babies to sleep, but only to remove the obstacles that get in the way. In particular, I consider why feed-play-sleep routines actually interfere with healthy baby-sleep. Finally, in

Chapter 8, I offer strategies to help you manage the worried thoughts and feelings that inevitably arise when your little one is crying, fussing, and night-waking. These skills are drawn from a new wave of Cognitive Behavioural Therapy that is sweeping the world of psychology and turning conventional approaches upside down.

My work is deeply embedded in the evidence, but there's no need to take everything I say as gospel – experiment for yourself. Families are resilient, and every family will work out what is right for their own unique baby and their own unique situation. By the time you've finished reading this book, I hope you'll have realised that *you* are your baby's best expert, that you will feel confident enough to try something different, and that you can trust yourself to find a way through until the crying and fussing and broken nights stop, as they will. It is also my hope that when the crying period is over, you'll find you've been practising a whole new set of psychological skills that will enrich the rest of your life.

I wish you many pleasurable hours with your baby!

1

HOW MUCH CRYING IS NORMAL?

Your newborn baby has not yet developed the capacity to speak to you using language. However, from birth she communicates her experience in a physical way: through the movement of her little limbs, through facial expressions, changes in skin colour and temperature, the way she turns her head, the sounds she makes, the changes in her breathing. We call her nonverbal communications her ‘cues’. If she is experiencing something unpleasant, such as hunger, she is likely to begin telling us this with more subtle cues at first, such as grimacing and grunting, opening her mouth, moving her head from side to side in a rooting reflex or bobbing her head against your body. Then she may become increasingly agitated, with more jerky physical movement, small cries and grizzles, frowns, flushing, and back-arching. We might call these signs ‘pre-cry cues’, because soon they are likely to build into a full-blown cry if we are unable to work out what she needs or are unable to give it to her at that

moment. A cry is a *late* cue. She's telling us that something is *really* wrong.

Of course, if your previously settled baby suddenly starts crying a lot, or has a temperature of 37.5 degrees Celsius or more, or vomits in a way that is different to his normal possetting, or if you have any other reason to think the baby might be unwell, it's important to see your doctor. Bouts of repeated or forceful vomiting after formula feeds, respiratory problems, or blood in the vomit or stool, for example, are signs that the crying baby needs to be medically assessed. However, less than 5 per cent of crying babies in the first few months of life have an underlying medical condition.

Mostly, unsettled babies are perfectly healthy. It's just that they cry and grizzle a lot, which happens to be heartbreaking for parents. Health professionals in the West have been saying for years that crying for prolonged periods is normal in the first 16 weeks, and won't hurt the baby. We definitely don't want families frantic with worry or lapsing into self-blame. We want to reassure them that the baby is healthy, and that this phase will pass without causing the baby any harm.

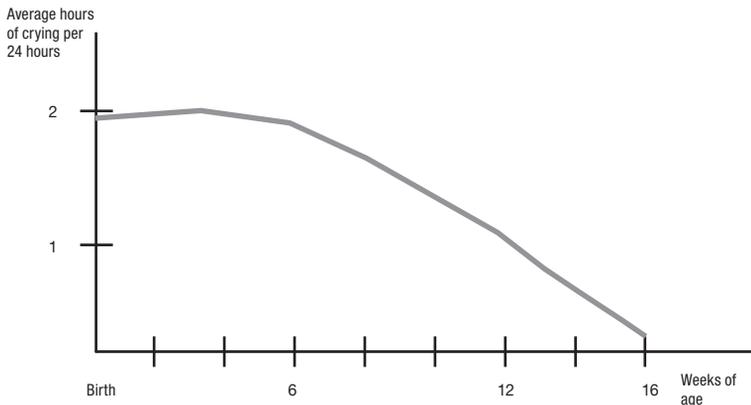
It's certainly true that most babies and their families are remarkably resilient, regardless of what happens, and will get through the crying period in the first few months without any long-term ill-effects. But when parents have such a strong feeling that their baby is signalling distress, our insistence that the crying is 'normal' can make it very difficult for them to trust in both their baby's communications and themselves.

If we consider problem crying in the first months of life across all cultures, we find that there are substantial differences between different societies. Babies *initiate* cries to communicate

need or distress roughly the same number of times with a peak in the evening, no matter what culture they are born into, but they cry *for longer durations over a 24-hour period* in the West compared to traditional cultures. And interestingly, they cry for substantially longer periods in some Western societies, such as the United Kingdom, than in certain other Western societies, such as Denmark. Is it really normal, then, for a baby to cry a lot?

I think of ‘normal’ as a rhetorical device, a phrase that means, ‘It’s common in this part of the world; it’s not your fault; it will pass without hurting the baby’. In this sense, crying in the first few months is normal. In 1962, Dr T Berry Brazelton described a ‘normal crying curve’ that had crying peaking at about 6 weeks. However, a recent meta-analysis of crying duration in twenty-four studies of Western babies demonstrates that they cry, on average, about 2 hours a day from birth until 6 weeks of age, before the crying tapers off to a little over an hour a day at 12 weeks, mostly disappearing by around 16 weeks (Figure 1).

Figure 1: Average amount of crying per day in Western babies



Adapted from Wolke, D. et al. ‘Meta-analysis of fuss/cry durations and colic prevalence across countries’, Presented at the 11th International Infant Cry Research Workshop, June 2011, Zeist, The Netherlands.

So while crying a lot in the first 16 weeks is a normal phenomenon, this should never be confused with the belief that the baby's crying is not a communication of abject misery. Crying is a genuine appeal. Parents know this, in their bones.

SIGNS THAT OFTEN ACCOMPANY CRYING AND FUSSING

From both the medical literature and my years of experience in the clinic working with families and new babies, I've compiled a list of signs that often accompany a baby's crying and fussing:

- excessive feeding
- feeding refusal
- back-arching
- coughing, spluttering or gagging with feeds
- crying when put down
- vomiting
- frothy poo
- tight tummy
- copious belches and flatus
- very frequent waking
- won't 'self-settle'
- piercing shrieks.

Most parents will describe at least one or more of these signs in their unsettled baby, in addition to crying. They might tell me that their baby is unsettled, for example, because he wants

to feed very frequently. He might pull away from the breast or bottle and back-arch. He might complain each time he is put down. He might posset or vomit a lot. He might have a lot of flatus or belching, a tight little tummy, and explosive frothy stools. He might seem to wake after only very short sleeps during the day. He might even be sleeping for only 30-minute or 1-hour periods during the night, a kind of excessive night-waking that happens sometimes in very little babies, in particular. Even though we know that, overall, an unsettled baby in the first few months tends not to wake up at nights more than others on average, he may not go back to sleep as easily, and night-time can be a nightmare of screaming, with everyone up and walking the floor.

KNOWING RISK FACTORS DOESN'T HELP

Research has linked many factors with excessive crying in babies (for example, being premature or small-for-gestational age; nicotine exposure during pregnancy; having a mother who experienced antenatal stress, a previous depression or birth complications; or having a father who was depressed during the pregnancy). That doesn't mean these factors *cause* crying in babies, and it certainly doesn't mean that you are *likely* to have a crying baby if you or the baby fall into these categories. In fact, this information is of little use to families, since it is rarely in a parent's power to change any of these factors retrospectively, and listing them makes everyone more worried and guilty. (Having said that, not smoking during pregnancy is important for a number of reasons.)

Some babies, due to inborn temperamental tendencies, might also be more susceptible to problem crying if things like feeding go wrong in the first hours, days and weeks. If everything had gone well at the beginning, that same baby may not have become a crier. Then, the baby's behaviour in the first weeks affects the parents' perceptions of the baby's temperament, which affects the way they interact with the baby, which affects the baby's temperament.

In the brand-new relationship between babies and their parents, problems can quickly interact in a downward spiral of distress. The reason why your precious little son or daughter cries a lot and shows one or more of the signs I have listed is often complicated, and might be unknowable. As we will see, 'quick-fix' solutions, from medications to sleep-training, while very tempting for us all, usually don't help, and sometimes make things worse.

We need to take the time to understand what lies behind these various signs and begin the detective work of decoding patterns, if we are to make sense of your baby's crying and arrest that downward spiral.

Jane: 'I feel like such a bad mother.'

Jane comes in to see me with her first-born baby. He's 7 weeks old and is grizzling in the pram. She sits down and puts him in her lap. For a moment he looks around the room, but then his little face crumples and he begins to fret again, an incessant, upset, anxious sound.

'He wakes, oh, I don't know, half a dozen times from when we put him down for the night. It's really bad. I'm getting maybe

5 hours' sleep. And during the day he's either fussing like this or screaming, or sometimes sleeping, but he won't sleep for more than 20 minutes. When he starts to scream, there's nothing I can do.

'Oh, and he hates feeding,' she adds. 'At first he used to arch his back and pull off the breast, and wouldn't go back on even though I knew he was hungry. We started formula 2 weeks ago and he's been a bit more settled at night since then. The child health nurse has never been worried about his weight, but he still fights the bottle.'

'That must be hard for you,' I say.

Then suddenly, before I know it, she is in tears, shoulders heaving, wiping her eyes with the back of her one free hand and struggling to regain control. The baby arches his back on her lap and cries in earnest. She grabs three or four tissues from the box which is always ready on my desk.

'I feel like such a bad mother ...' she says with a sob.

'I can see you are an absolutely devoted mother!' I exclaim.

Jane confides through her tears, over the baby's racket, that she even feels ashamed to go out, for fear of attracting attention. For fear that others will think her incompetent because her baby cries.

Soon she is standing and jogging on the spot with the baby over her shoulder. He settles down a bit, and we converse to the sound of his grizzles. She tells me that her friend's baby girl lies in the cot cooing and gurgling before dropping quietly off to sleep. In fact, her friend's baby is happy to lie for an hour or two under a mobile gazing up at big red, yellow and blue felt flowers when her mother needs a break! She says her friend's baby only wants to feed every 3 or 4 hours, and sleeps through the night.

‘But you see, baby’s personalities are so different,’ I explain, ‘we just can’t compare! Some babies *are* like your friend’s little girl, although I have to say she’s quite unusual. She’s at the very far end of the spectrum of normal. Your little fellow is a high needs baby, that’s for sure, right at the other end of the spectrum. Most babies lie somewhere in between, but they are all normal!’

Jane nods, jogging and patting.

Once I’ve finished asking the necessary questions, I check the baby over. He cries loudly as Jane undresses him then calms down a little, lying on the examination couch as we play with him and try to elicit a smile. He seems to be jumpy and easily startled, always on the edge of tears, with a subtle jerkiness to his movements. He’s not easy to examine but I satisfy myself that he doesn’t have a medical problem and is developing normally.

‘Healthy babies are born with quite remarkable differences in their developmental maturity, too,’ I explain. ‘Boys are often much less developmentally mature at birth than girls. And the rates of development for different skills vary even for the same baby. One little girl might be quite late in being able to direct the movement of her hand, for example, but speaks words very early. She’s still normal. Your little bubby is perfectly healthy, but you’re right – he does cry a lot.’

Jane sighs in despair.

‘We need to talk,’ I say. ‘I think there’s probably quite a bit we can do to help settle him down. But did you happen to bring a bottle? Do you mind if I watch a feed first?’