CASE

At her 6-month health-supervision visit, Julie is accompanied by both her mother and father. Their main concern is persistent “colicky” behavior with “uncontrollable” episodes of crying and night wakening every 2 to 3 hours. The pediatrician discussed persistent crying and various soothing techniques at each previous health-supervision visit. Julie’s mother could not hold back tears as she described the baby’s behavior and her own sleep deprivation. The parents portrayed the crying as “an off/on switch” without variations in volume. They read a book on sleep problems in infants and followed the advice. For a week, they allowed Julie to cry when she awakened. She cried for 1 to 3 hours each time without being able to settle herself. When her mother breastfeeds, Julie settles and then sleeps for a few hours before awakening in a crying state. However, her mother is unable to return to sleep quickly.

As the pediatrician explored the family and home environment, a new behavior, beginning about 1 month before the office visit, emerged. Both parents were concerned that when Julie looked at her mother, she became agitated and anxious. The pediatrician, somewhat doubtful, then saw Julie smiling while in her father’s arms. When she was turned toward her mother, Julie’s facial features became tense and she appeared anxious. This was followed by what the pediatrician described as “fussy vocalizations . . . as if she was stressed.” Later in the office visit, the pediatrician deliberately repeated the same event, and the baby had a similar response when turning to her mother. When she was transferred to her mother’s arms, she did not console immediately but only after about 3 minutes. Julie’s mother expressed loving feelings for her child alternating with “hating her and counting the days until she grows up.” The father and maternal grandmother, who helps during the day with child care, are supportive but frustrated as the crying persists and the mother’s sleep deteriorates. Along with Julie’s mother, they are concerned about what they perceive to be a negative relationship between Julie and her mother.

The parents are in their early thirties and this is their first child. The prenatal and perinatal history is normal. During the first 2 weeks of life, Julie was described as cuddly and easy to feed at breast. Frequent crying and night awakening began after the second week. Both parents work in sales in small retail stores. Julie’s mother was planning to return to work 3 months after the birth of the baby, but sleep deprivation altered her plan. The father attends a community college 2 nights each week. The parents state that they have a good marriage.

INDEX TERMS. maternal-infant attachment, colic, maternal depression, infant social development.

Dr Martin T. Stein

My interest in this case was initiated by a telephone consultation with a primary care pediatrician in our community. The pediatrician was perplexed and concerned when she observed Julie’s differential facial expressions in response to her mother and father. During more than 10 years in a general practice, she had never seen such a dramatic change in the baby in the presence of her mother. I invited 2 developmental-behavioral pediatricians to comment on the case. Dr Constance Keefer directs the Newborn Nursery at Brigham and Woman’s Hospital in Boston, Massachusetts. She has conducted numerous studies on early infant development as a member of Dr T. Berry Brazelton’s child development unit at Boston Children’s Hospital. Dr Daniel Kessler is Director of Developmental and Behavioral Pediatrics at the Children’s Health Center of St Joseph’s Hospital and Medical Center in Phoenix, Arizona. He is the co-editor of a scholarly clinical textbook, Failure to Thrive and Pediatric Undernutrition: A Transdisciplinary Approach.

Dr Constance H. Keefer

Persistent and uncontrollable crying and frequent night wakening with cry are a familiar presentation to pediatric primary care clinicians. These problems can sap time and energy from pediatric efforts, often without success, possibly because only 5% of them are associated with organic disease.1,2 Once organic disease is ruled out, the infant’s “diminished capacity to regulate crying duration,”3 is at the root of problematic crying. That diminished capacity may not, however, be sufficient explanation for the crying, nor sufficient guidance for its resolution.

Problematic crying may best be considered devel-

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opment and relational, as well as rooted in the child’s temperament and physiology. Parents’ temperament and psychology are also involved. In addition, these problematic behaviors are not trivial. They may signal significant psychological disturbance in the parent and increase the probability of mental health problems for the child. As in the case of Julie, the change in behavior toward her mother confirms the element of a relational problem.

A developmental framework and a relational model of care make many of these presentations an opportunity for real change. Not only may the problematic behavior resolve, but parents understand the infant’s behavior and grow in their relationship with the infant.

Much of our understanding about these behaviors comes from the field of infant mental health, an outgrowth from child psychiatry. The knowledge and skills derived from this discipline are available to behavioral pediatricians. The specialized knowledge and experience of pediatricians about the physiology and biology of infants enhance their effectiveness in the management of these problems.

Of the many rich resources that exist for working with families on this problem, I find the following applicable to early relational problems: the “Touchpoints model,”4,5 the “motherhood constellation,”6,7 the characterization of “affective and attentional regulation” in parent-infant communication,8 and the findings from the Adult Attachment Interview and the “strange situation.”9,10

When presented with an infant like Julie at 6 months of age, I create a broad-stroke picture of the situation with the family. These 4 models guide my history-taking and my observations for that picture.

**Touchpoints**

The Touchpoints model provides (a) a developmental explanatory model, (b) a vocabulary of the infant’s behavior as language, and (c) guidelines for a relational approach to families. Briefly, touchpoints are periods of disorganized behavior in an infant that are associated with imminent developmental change and that can disrupt the established parent-infant relationship. Touchpoints are predictable, as they arise out of well-known changes in any area of development. For example, language skills may seem lost as an infant begins to walk or a 4-month-old disrupts nursing to look across the room as focal length extends. Each change in behavior reflects the infant’s increasing organization, self-regulation of internal physiological states, perceptual skill, and cognitive understanding. Organization and regulation of social-emotional skill build upon these developments, in the context of communication.

The Touchpoints model allows me to consider a behavior problem in terms of a “developmental agenda” for the infant and for the usual relational issues that confront parents and infants. Table 1 displays the themes for the touchpoints that Julie and her parents have passed through, although not resolved, and that I would use as probes in our discussion. For example, in reviewing the birth and early weeks, I would ask the parents to tell me about Julie as a newborn and how that compared to the baby they had imagined before delivery. I would ask about their emotional responses to the birth and to Julie and for a description of Julie’s behavior as a newborn that would include her consolability and pattern of state change through the day. I would want to hear the parents describe the experience at 2 to 3 weeks. Was Julie’s individuality taking shape, and how had the exhaustion affected their reading of her behavior? By 2 months, had Julie become a rewarding baby, giving pleasure in her social responses to her parents, making them feel confident or competent as parents? Around 4 months of age, had Julie begun to turn outward, orienting away from her parents during feedings? Was she reaching out with hands and eyes to things in the world?

The Touchpoints model provides the “dictionaries” for using the infant’s behavior as the language for parent-infant and parent-clinician communication. The dictionaries include (a) the infant’s developmental agenda, (b) the infant’s temperament, (c) the infant’s history in the family, and (d) the infant’s immediate needs and wants.

The relational component of Touchpoints reflects a strength-based collaborative approach. For example, Touchpoints forces the practitioner to find and acknowledge strengths as well as problems in the family and to value passion, even negative passion, as a communication and a fuel for change.

**Motherhood Constellation**

Daniel Stern developed the motherhood constellation as a theory of maternal identity development, in contrast to and correction for the Oedipal theory used by psychiatry. The theory is also useful for a critique of the effect of medical care on the well-being of postpartum women and their infants. Guided by these themes, a clinician may efficiently

<table>
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<th>Age</th>
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<tr>
<td>Newborn</td>
<td>“Real baby”: health/survival; parent emotions; real baby; attachment; physiological regulation</td>
<td>“Life growth”</td>
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<tr>
<td>2 wk</td>
<td>“Energy sink”: parent expectations/exhaustion; feeding; individuality; family relationships</td>
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<td>2 mo</td>
<td>“Rewarding baby”: sociability; parent self-confidence; relationships; increased skill and control; social/emotional regulation</td>
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<td>4 mo</td>
<td>“Looking outward”: attachment; interest in outside world; orientation away from mother; patterns of care/routines; baby’s demands; father’s engagement; child care</td>
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gathering relevant history to understand the level and direction of a mother’s development of a maternal identity. That identity will have an effect on the infant’s social-emotional development. In Table 1, motherhood constellation themes are juxtaposed to Touchpoints themes that may be occurring in the same developmental phases. The 4 phases in the development of the motherhood constellation are as follows:

1. “Life growth” theme: Can she maintain the life and growth of the baby?
2. “Primary relatedness” theme: Can she emotionally engage with the baby in her own authentic manner, and will that engagement ensure the baby’s psychic development toward the baby she wants?
3. “Supporting matrix” theme: Will she know how to create and permit the necessary support systems to fulfill these functions?
4. “Identity reorganization” theme: Will she be able to transform her self-identity to permit and facilitate these functions?

Julie’s mother seems to have mastered the life growth theme. Was she comfortable enough with herself to present an authentic self to the baby, to emotionally engage? If not, why not? Had she a secure enough relationship with her own mother to acknowledge her need for the supporting maternal matrix? Was she able to tolerate the disorganization of identity in order to reorganize into the new form?

Parent-Infant Affective Regulation and Communication

Parents provide a dynamic social-emotional template against which the infant tests his or her own social-emotional behavior and within which those behaviors can be shaped as skills. Subtle behaviors in face-to-face interaction seem to be the basis for learning self-efficacy in a 6-month-old; cognition and language are embedded in social-emotional interaction. When a mother is depressed, subtle unavailability and dysregulation are seen in her behavior. Infants of only 3 months of age reflect that dysregulation in their behavior with mother and with others.

Subtle as they are, these behaviors are observable in real time to the trained eye. Part of my history-gathering is the observation of Julie that I begin making from the first moment that I see her. Eventually I will make direct observation of those behaviors as a part of an interaction with her. In this case I would be looking for behavioral cues that may be misread by her mother, for autonomic and motor behaviors that may be a subtext for understanding the social behaviors. Particularly, what is the optimal distance for social-emotional communication with Julie? How much direct versus indirect eye contact does Julie maintain? How does Julie signal overload? Can I find behaviors or behavioral cues with which Julie can sustain a more comfortable interaction, behaviors that could be captured and still allow Julie to maintain some control?

Adult Attachment Interview

Julie is too young to demonstrate the classic behaviors associated with the attachment classification, and I do not administer an Adult Attachment Interview. I will, however, listen for references by Julie’s mother to her own mother. Is the grandmother present at the visit, the same one who provides some child care and whom Julie has not turned away from, as she does her mother? In addition, I will ask about psychological trauma in the mother’s early years or about any loss of significant relationship. That information may help to answer the following questions: What is baby saying to her mother with her cry? Is there another interpretation? Who is crying? A child within the mother? The mother for other losses?

Reaching those answers in the mother may not happen in a first encounter, but reaching them can be a turning point in discovery for the parents and, simultaneously, a dissolution of the problematic behaviors. Julie is young, and her problematic behavior has not generalized to her interactions with her father and grandmother. This is truly an opportunity for preventive mental health in primary care.

REFERENCES


Dr Daniel B. Kessler

We are presented with a young couple in their early thirties with their first child. Based on the available information, we can assume that the mother’s income is important to the family and that her inability to return to work when her baby is 3 months old may be a source of difficulty, if not conflict, although none is indicated in the available history. The maternal grandmother has been available to the young family and helps provide child care. We know that the problem of persistent fussy crying began at 2
weeks of age and has persisted despite information provided by the pediatrician at each health-supervision visit about “various soothing techniques.” We don’t know enough about the pattern, frequency, and duration of the breastfeeding or how comfortable it has been for Julie or her mother. We also don’t know about Julie’s general health, especially her current weight or weight gain. All of this is important information.

We know very little about the life of this family between the time Julie was seen at 2 weeks of age and her presentation at 6 months of age. We know less about the parents’ lives before Julie’s birth. We know very little about the relationship between Julie’s parents, though it is described as a “good marriage.” We know very little about the role of the maternal grandmother or her relationship with her daughter, though she does help with child care. Apparently, the parents found little actual benefit from the discussion of soothing techniques. We know that they sought help from a book on sleep problems in infants and followed that advice rather than speak to their child’s primary care provider. We do not know if other reasons for the crying have been explored.

“Colic” is a description for intermittent, intense fussiness during the first 3 months of life. It is not generally seen as a cause for persistent crying at 6 months of age. At that point, and perhaps sooner, other causes for the infant’s crying should be considered. Perhaps another physiological reason such as gastroesophageal reflux (GERD) may be present, though little clinical information is provided in this regard. Though most often associated with episodes of regurgitation, we now know that GERD may occur without any regurgitation even in infancy.1 Pain related to esophagitis may present as irritable crying in young infants, and it should be considered in the differential diagnosis of the crying infant.2 Although most often postprandial, some symptoms related to GERD may be delayed by as much as 1 or 2 hours after feedings.3

We know that the pediatrician, when presented with this persistent symptom complex, further explored the family and home environment. This is appropriate. However, we do not know whether she explored in any depth the nature of the mother’s ambivalence toward Julie and her intense feelings. We do not know, for example, if Julie’s mother has had any difficulty since the birth of her infant that could be characterized as postpartum depression. We know that postpartum depression is quite common (10%–20% in most studies) during the first postpartum year. We know that postpartum-depressed women often express intense negative feelings about their infants4 and that it is uncommon for mothers to recognize their symptoms as depression.5 Unfortunately, it is also true that pediatric health care providers often do not recognize mothers with high levels of self-reported depressive symptoms.6

What we do know is that approximately 1 month before this most recent visit to the pediatricians office both parents observed Julie becoming more anxious and tense when looking at her mother. In addition, the pediatrician observed that Julie’s facial features became tense and that she took a longer time to settle when in her mother’s arms. I have observed over the years that infants are wonderful “barometers” of the emotional tone of the home in general and often quite capable of providing an accurate reflection of the affective relationship they share with a caregiving adult. They can do this quite selectively.7 It is very possible that the infant is simply reflecting back to the mother her own feelings of depression or her anxiety regarding the feeding situation. Depressed mothers are much more likely to consider their children as difficult to feed and to feel inadequate in caring for them.8 The lack of efficacy the mother might be feeling regarding her own maternal competence, conflict in the family relationship, her own relationship with her mother, or any combination of these factors can contribute to the affective communication between infant and caregiver. The importance of mutual regulatory processes between infant and caregiver is now well recognized.9 It is also understood that patterns of parental behavior can transcend generations.

Even if the crying began as a case of typical colic, it could have interacted with a host of other environmental, social, and family factors to create the current family situation. Baby blues can occur during the first 2 weeks postpartum in 50% to 80% of mothers. This normal condition of heightened emotions and frequent tearfulness should not last beyond the third week postpartum but may have interacted with other family stressors and resulted in a more stable pattern of negative feedback between mother and infant.

All of these factors could and should be explored further, if not by the pediatrician then through a competent mental health referral made by the pediatrician. A provider located in the same practice would be ideal. The referral should be framed as an understanding that the symptom is complex and deserving of careful and thorough consideration. Although most infants with “colic” should be expected to do quite well, for a subgroup of infants and parents, especially those with substantial risk factors, early excessive crying may not resolve, but rather evolve into a more generalized infant distress syndrome that requires thoughtful family intervention.10

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Web Site Discussion

The case summary for the Challenging Case was posted on the Developmental and Behavioral Pediatrics Web site (www.dbpeds.org.list) and the Journal’s Web site (www.lww.com/DBP). Comments were solicited.

Linda Nathanson Lippitt, MD

What foods is the mother eating? Has the child been growing well? Could the milk supply be insufficient? How about pumping and having other people feed the child for a few nights? It seems, if all else fails, that some family dialogue with a good referee, ie, therapist, might help to resolve both parents’ ideas of priorities. Was this woman a career-oriented person who now sees her life severely truncated by this child? How much is the father willing to do in the way of active parenting? Can his work hours be modified to permit the mother to begin to work again? Teaching the mother some “centering” activities like yoga or meditation might also reduce the overall stress level. T.B. Brazelton’s classic book, Infants and Mothers: Individual Differences in Development (New York, NY: Delacourt; 1969), could be very supportive.

Meg Zweiback, RN, CPNP

Julie’s mother is so sleep-deprived that she is not likely to be able to engage responsively to her baby at all times. Her fatigue is caused by being awakened throughout the night and the substantial energy drain of breastfeeding a 6-month-old. The first step toward solving the problem should be to address these issues.

A 6-month-old baby who is awakening every 3 hours during the night is virtually always doing so because of (a) a sleep association habit that takes the form of being rocked or nursed to sleep at bedtime and needing the same help during the night to settle again and/or (b) hunger. Babies who are hungry often get a worried look on their faces. I think that parents should first try to feed Julie more during the day and then, if necessary, change her pattern of falling asleep at bedtime. I would not want Julie to be deprived of middle-of-the-night feeding until I was certain she was getting enough during the day.

I would like to know if mom is able to nurse Julie to satiety or if she or Julie is ending the feeding before both breasts are totally emptied. The “hind milk” is higher in fat and leads to longer intervals between feedings and a higher caloric density of breast milk. If mom is chronically fatigued, her ability to make milk may be affected. If Julie is continuously feeling dissatisfaction at the amount of milk she receives at each feeding, she might well look anxious. Julie can be supplemented now with rice cereal mixed with breast milk or formula. Unless Julie’s mother has strong resistance, I would ask her to add formula to this baby’s diet in 1 or 2 “topping-off” feedings per day, which would not interfere with the baby’s interest in nursing.

Increasing feeding is both therapeutic and diagnostic. If hunger was the problem, Julie will be happier and sleep longer and the family stress will decrease. Dad can feed the baby during the night and mom can sleep more and get a break from time with baby.

The next step, which could begin within a few days, would be to help Julie learn to fall asleep at bedtime without a parent’s help. That would solve the habitual night-waking aspect of the sleep situation. At that point the frequent awakening for nursing would probably decrease, although it would be reasonable to expect at least 1 night feeding in a breastfeeding infant.

Until these steps were taken, I would offer this mother unconditional support and refrain from further exploration of the mother-baby relationship. She would feel even more to blame for Julie’s colicky behavior. I’d ask parents to keep a log of feeding/sleeping/crying/alert times to look for patterns and to measure how many hours the baby is really crying. After the changes in feeding and sleep were implemented, I would explore with the mother how she is feeling about herself and her baby and how being a mother has been different than her expectations. I’d try to get her hooked up with a new-mother support group. Her feelings of ambivalence sound pretty normal, given the circumstances, and other new mothers could help her cope with her new life.

Morris Wessel, MD

Regarding the difficulty the mother and baby had in constructive connections while the father and baby did better: My early observations on colic convinced me that there are some human beings who in stressful moments develop a bodily tension that, as in this case, is felt by some babies who are “highly perceptive,” receive the tensions, and become irritable.

I always felt that there are many comparable situations. Why are many race horses “impossible” with a strange rider and do beautifully with an experienced rider? How do dogs sense, even without tactile comment, that some people are “bad news?” And when a person unfamiliar with a car takes over, the
car often stalls and the wheels screech. I think, in all these instances, there is in the adult some way in which anxiety or fear is accompanied by muscular tension which the dog, horse, car, and, in this case, the baby senses. Being highly perceptive, many colicky babies react with crying. As the mother “fails,” her muscular tension increases and the pattern is in full swing. I believe Bill Carey has some of the same feelings in his studies of temperament in infants (see the Challenging Case “Is This a Behavior Problem or Normal Temperament?” on page 1400 of this supplement).

The highly perceptive infant I also think reacts to his or her own bodily feelings more intensively than some other babies. I hope some of our colleagues will “hang on to the colicky infants’ names” and follow them for a few decades.

Nancy Segall, LCSW

I have a private practice utilizing a home visiting model in which I see a number of mothers with very similar complaints and issues. I have found that a several-month period of “kitchen table” psychotherapy with a strong psychoeducational thrust is very helpful in these situations. These mothers are feeling so vulnerable, unsuccessful, and overwhelmed that they need an empathic, hands-on intervention that focuses on a thorough history from conception to the current time; the nature of the specific interactions between mother and baby; close observation of the baby’s behavior and responses; and encouragement that the problems are solvable and that things will get better over time. When these mothers feel heard, when their anger and resentment are reinterpreted as reasonable responses to a very difficult situation, they start to relax, and then we can really get to work looking at who this baby is, what she is asking for, and what mom can do to shift her responses to ones that are more gratifying to both of them [editor’s italics]. I put a lot of emphasis on finding areas of mutual pleasure in the relationship, even though lots of rough spots may remain. We look at every possible factor in their lives that could be contributing to the difficulties baby, mother, and family are experiencing and try to tackle them one by one. The use of a babysitter will give the mother a well-deserved break, but it won’t resolve the mismatched responses between mother and baby. They need some intensive help for a period of time, probably a number of weeks, and then some regular follow-ups until they are back on track.

David M. Snyder, MD

Normal breastfed infants do experience days with more frequent awakening during the first weeks after birth. In my experience, this occurs every 7 to 10 days for the first 6 to 8 weeks. This disruption in the baby’s usual hunger and sleep patterns seems to be associated with growth spurts, with the more frequent feedings resulting in increased breast milk production. Awakening every 2 to 3 hours for feedings on these days would be quite typical.

The unfortunate parent who perceives this as colic or “a sleep problem” might “just let the baby cry,” resulting in an unsatisfied, hungry infant. The case report indicates the parents tried the “just let her cry” approach for 1 week. It seems that, following that week, the baby continued to awaken every 2 to 3 hours, crying intensely. Her mother fed her, and the baby seemed satisfied. However, the mother continued to suffer disrupted sleep and ambivalent feelings toward the baby.

The effect on the parent, particularly the breastfeeding mother, must be an erosion of her sense of competence as a parent. And the infant’s continued, inconsolable crying must seem to the mother an unrelenting accusation of inadequacy. The effect on the infant is most intriguing. Is the infant receiving adequate nutrition, or has the mother’s anxiety inhibited milk production? Is Julie growing normally, or is she failing to thrive? Is Julie picking up on her mother’s anxiety and ambivalence? Is that the cue to which Julie is responding with “tense and anxious” facial features, as described?

As I consider the situation at the 6-month visit, the baby’s sleep, feeding, and crying behaviors seem quite normal. Her positive interactions with other family members are reassuring. The mother’s continuing sleep disruption and ambivalence is the most worrisome element. Julie’s response to her mother makes most sense as a reaction to her mother’s affect. I wonder what prior experiences might have made the mother so vulnerable to Julie’s crying. What was her own early childhood like? What is her present relationship with her own mother? Is it really as “supportive” as it seems?

In light of these concerns, I would first attempt a therapeutic trial of reassurance. I would explain the normality of Julie’s increased demand for frequent feedings early on and empathize with the parents’ concerns at that time and attempts to do the right thing. I would present this as “good news” that Julie is a “normal child.” I would also frame Julie’s behavior toward her mother positively, as an indication of her sensitivity to her mother’s distress.

I would recommend ad lib feedings and foster the expectation that Julie’s sleep and hunger cycles would become more regular and predictable. I would encourage the parents to call with any questions or concerns and have them return in 1 to 2 weeks. The mother’s ability to accept reassurance, as measured by a more positive affect, is diagnostically important. If, on the return visit, the mother’s sleep disturbance has not improved and the mother-infant interaction has not become more positive, the meaning Julie’s behavior has for the mother must be explored in more depth.

Dr Martin T. Stein

A clinical approach to behavioral problems benefits from the same rigorous diagnostic process that we use in all areas of medical practice. This Challenging Case illustrates the value in teasing apart the major issues and thinking about them from different perspectives.

My initial response to Julie’s pediatrician was focused on the remarkable change in facial expression Julie demonstrated repeatedly when viewing her mother and father. The intensity of the selective af-
fective response suggested a severe mother-child communication problem. Was this the onset of an infantile, anaclitic depression precipitated by a loss of trust? Without an immediate intervention, were we witnessing a permanent alteration of synaptogenesis in a developing brain that might result in persistence of an emotional deficit in future interactions between Julie and her mother?

The commentaries on this case point out the importance of considering all of the behaviors in the context of Julie’s developmental history and her family. Collectively, they provide us with 5 behavioral/developmental problems: (1) persistent crying lasting beyond the period of 3-month colic; (2) a feeding problem related to Julie’s irritability and exacerbated by night awakenings and possibly an inadequate supply of breast milk; (3) a disordered sleep pattern for Julie; (4) probable maternal depression associated with sleep deprivation and a feeling of diminished maternal competency; and (5) Julie’s dramatic change in her facial expression when looking at her mother.

Taken together, the commentaries by Drs Keefer and Kessler and the discussions from the Developmental-Behavioral Pediatric Web site provide an example of the value of a biopsychosocial approach to a clinical problem. Dr Keefer emphasizes the potential effects of persistent crying and irritability during infancy on the evolving relationship between a child and her parents, the development of maternal identity, a sense of competency, and attachment. It is these factors that affect an infant’s social and cognitive development. She also shows us how the Touchpoint model may provide “a vocabulary of an infant’s behavior as language and guidelines for a relational approach.” Dr Kessler also recognized the psychosocial effect of persistent crying. He highlighted the importance of framing persistent irritability as both a possible cause for or expression of maternal postpartum depression. He correctly pointed out that postpartum depression is both common and underrecognized by pediatricians. It is an opportunity for the pediatrician who recognizes, in the words of Bayard Allmond and Lane Tanner, that “the family is the patient.” Dr Morris Wessel observed that in some babies who develop bodily tension in stressful moments during interactions between mother and baby, it appears that the highly perceptive baby receives the feelings of tension and becomes irritable.

Other commentaries focused on the consideration of “biological” causes for Julie’s irritability, including GERD associated with peptic esophagitis, insufficient amount of breast milk, the mother’s specific food intake, and the baby’s growth pattern. I would add to the list urinary tract infection, constipation, chronic or recurrent otitis media, corneal abrasion from recurrent scratching of the cornea, inguinal hernia, and child abuse (undetected fractures and subdural hematoma). Meg Zweiback reminded us that babies who end a feeding before both breasts are totally emptied may not receive the hind milk that is higher in fat and caloric density. These babies are not satisfied sufficiently, may become irritable, and not grow as expected.

The strength of developmental-behavioral pediatrics as an evolving subspecialty is dependent on framing diagnostic models and treatment strategies in the context of the interaction between biology and psychosocial conditions in the life of the child and family. This challenging case demonstrates the effectiveness of the biopsychosocial model.

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/content/114/Supplement_6/1407.full.html