

Living and coping with excessive infantile crying

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Aim. The aim of the study was to elicit from parents how they lived and coped with a baby who cries excessively. It sought to identify factors which made coping more difficult, as well as interventions perceived by parents to be effective in improving the situation.

Background. The excessive crying of a baby can be one of the most trying aspects of parenthood. Although there have been many studies into the cause and treatment of the problem, these have produced little convincing evidence and even less agreement among investigators. In the light of this an alternative approach is to provide effective support to enhance coping until the crying abates.

Design. This study was based in pragmatic ethnography and followed an adapted grounded theory approach. A total of 25 adults from 14 families participated, recounting their experiences with 20 babies who either were currently crying excessively or had done so previously while less than 1 year old. Data was collected by a factual questionnaire and tape-recorded focused interviews conducted in the family home augmented by periods of participant observation.

Outcomes. Almost every aspect of family life was disrupted, resulting in strained relationships, feelings of guilt, and concerns about losing control. Repeated attempts had to be made to establish a diagnosis and to find a cure. Such attempts failed, leading to a repeated cycle of hope and disappointment. The greatest potential to effect a positive impact lay in the supportive role of health visitors. They needed to visit frequently; stay for a prolonged period; demonstrate engagement with the family and its difficulties; and impart specific messages with conviction and sincerity.

Conclusion. A specific, vital role was found for the health visitor in supporting parents through this problem, and aspects of the role were identified in which further study is indicated.

Keywords: community health nursing, ethnography, health policy, health visiting parental support, infant colic, infant crying

Introduction

Although all babies cry, some cry more than others, and some continue to cry despite all the efforts of their parents

and colleagues to pacify them. Such crying exerts a powerful effect on the family, disrupting the lives of the parents, provoking feelings of anger, guilt and despair, and significantly increasing the risk of nonaccidental injury to the

baby (Frodi 1985, Crowe & Zeskind 1992). From Illingworth's (1954) description of '3 months colic' and 'rule of threes' by Wessel *et al.* (1954), a mixture of arbitrary criteria of duration of crying and vague notions of intensity has characterized attempts to define and investigate excessive crying. The problem presents a major challenge. It has been estimated that nearly 17% of families in the United Kingdom (UK) seek professional help with a baby exhibiting excessive crying (St James-Roberts & Halil 1991), although estimates of international prevalence vary wildly, perhaps as much as from 9% to 26% (Cernik 1991). The multitude of estimates is clearly as much a result of divergent definitions, varying samples, and differing methodological approaches as any clinical or epidemiological factor. Van der Wal *et al.* (1998) found in a large study of 1826 families in Amsterdam that 7.6% of babies were reported to cry for three or more hours per day, while crying was reported to be a problem, however, by 20.3% of mothers. The researchers' conclusion that intervention should be based on parents' perceptions of the crying, also supported by St James-Roberts (1993a) and Barr *et al.* (1992), was adopted in this study. In other words, rather than drawing an arbitrary threshold of hours spent crying above which the crying is to be considered excessive or abnormal, it was accepted that if the crying was perceived to be excessive and problematic by parents, then their inclusion in the study was appropriate.

This study was intended to ascertain from the families' perspective what was problematic about excessive crying and what, if anything, impeded or facilitated coping. A wealth of literature addresses explanations of excessive crying, focusing on three main possibilities: physiological disturbance; infant temperament and maternal response; and deficiencies in parenting practices. Inexplicably, studies in the first of these categories appear to be beset by poor method and inadequate sampling: Wolke's review providing a telling critique (Wolke 1993). Notions that crying babies demonstrate irritable temperaments are common in the literature, but there is as yet no evidence of a causal relationship (Medoff-Cooper 1995). Inadequate or unresponsive parental care has also been held responsible. In contrast, there is convincing evidence that parents of crying babies make more effort than other parents to soothe their babies (St James-Roberts 1989, 1993b). In summary, there is little agreement in the literature on the definition, prevalence, cause, or effective treatment of excessive crying. Some progress has been made in recognizing the general pattern of normal crying (St James-Roberts & Halil 1991), but, largely because of divergent definitions and inadequate sampling, other areas of knowledge in this topic remain

unclear, contradictory and unconvincing. In this study, the following research questions were addressed:

- What constitutes excessive crying as reported by parents?
- What factors contribute to the crying being identified as a problem?
- What consequences of the crying are problematic for the family as individuals or as a group?
- What pertinent advice is received and from what sources?
- What interventions are perceived by parents to be effective in improving the situation?

The study

Method

The study was approached from an interpretive perspective compatible with the pragmatist ethnography discussed by Hammersley and Atkinson (1995, pp. 1–2) and was undertaken in rural, urban and inner-city areas of West Yorkshire, including households from areas of relative affluence and poverty.

Participants

A total of 25 individuals from 14 families participated, and in addition to the 13 babies who were currently crying excessively, another baby and a further five siblings who had cried previously were discussed. The sample included the mother of every baby and six of the fathers. Nine siblings were also present. Initially, health visitors identified likely candidates from their own caseloads and provided them with written details of the study and an invitation to return a questionnaire. However, once the health visitor's role emerged as a crucial factor in coping, this mode of recruitment was substituted by the use of posters displayed in baby clinics and other suitable locations. It was a limitation of the sample and of the study that, despite specific efforts in theoretical sampling to redress the problem, ethnic minorities were almost absent from the sample. Failure to recruit from such groups is common even to large, funded projects (Barr *et al.* 1988, St James-Roberts *et al.* 1996, Van der Wal *et al.* 1998). Of the 14 mothers included, one had no current partner and four others were alone for long periods (weeks) because of their partner working away from home.

Data collection

Data collection was spread over a period of slightly less than 12 months and was pursued through a questionnaire, semi-structured interviews and informal participant observation. The questionnaire comprised 40 questions addressing issues about the baby, the rest of the family, and professional help,

and was designed primarily to save time at the interview. The completed questionnaires were scrutinized before each interview and reviewed in a cumulative manner as the study progressed. The latter proved useful in evaluation of the nature of the sample. A single visit was made to each household lasting from 1½ hours to a little more than 3 hours and anyone involved in caring for the infant was invited to participate. Part of the encounter (ranging from 45 to 90 minutes) was tape-recorded using two small recorders; discreet devices which nevertheless proved to be an irresistible attraction for several siblings. The researcher was commonly invited to stay and spend more time with the family to observe the baby's behaviour, indulging in various aspects of child care or simply 'hanging around' in the lounge or kitchen with the family. Field notes were made discreetly (rather than secretly) so as not to dispel the informal, relaxed atmosphere. No field notes were taken during the taped time. The extended visit helped to promote trust and a relaxed atmosphere and made reversion to normal patterns of behaviour more likely. Simply being in the respondent's environment enhances the likelihood of their meaning emerging and being recognized and is a means to enhance validity.

Data analysis

Data analysis followed an iterative process making use of the grounded theory techniques of open coding, constant comparison and theoretical sampling, and utilizing the software package QSR NUD*IST® 4. Preliminary analysis was undertaken of each interview as it was concluded and transcribed, together with the corresponding questionnaire answers and any field notes, amending the emerging understanding of the issues, and used to inform subsequent interviews. Axial coding was pursued in a novel manner through the use of concept maps, continually adjusting and amending these as the interviews progressed and the emerging theory developed. (This aspect of the study is to be reported elsewhere).

Ethical issues

There were no physical risks to participants, although there were numerous episodes of animated, plaintive, or tearful recounting of experiences. Several participants declared explicitly that it helped to talk about the experience. Written consent was gained following both verbal and written information which emphasized the voluntary nature of participation and the absolute right to withdraw from the study at any time. At least 7 days were allowed for written details to be digested and for further information to be sought if required. Approval was gained from a Local Research Ethics Committee. Confidentiality was assured by the anon-

ymizing of the transcripts, questionnaire responses, and report, while contact details of the participants were recorded manually on paper and stored separated from the data. Each informant was also given the choice to have the tape recording erased on completion of data analysis.

Outcomes

What follows is an outline of the outcomes of the study and a discussion of probable implications which should be explored on a wider basis in future. Four constructs will be addressed: disrupted lives, search for a diagnosis, coping and the response from professionals.

Disrupted lives

The lives of the families in the study were characterized by pervasive disruption, and daily life became a chaotic rush: running just to keep up. Relationships between parents grew strained. One mother admitted that 'it's a loveless marriage with a relationship that won't exist until the crying stops, if even then, and we argue about it all the time'. Siblings suffered, too, and this contributed significantly to the guilt felt by parents. Sarah remarked on a tendency which she had noticed in her son, Francis (aged 3).

Sometimes when Patrick's having a really bad screaming do he (Francis) will sit on the floor near me: silent. I think it does affect him, really. Deep down it does register. It's like he's thinking 'My Mum's not shutting him up. She looks like she doesn't know what she's doing.' I wish I knew what was going on in his head.

A number of factors combined to promote social isolation, a gradual introversion with the focus of life becoming the crying. Michael cried uncontrollably from 2 weeks after birth until about 5 months. His mother, Helen, recalled that:

I didn't go anywhere. I didn't go shopping. I didn't go to see friends. I didn't go for walks. I didn't do anything. Everything just completely stopped. Certainly the social isolation thing was really significant. And it was more profound than you might think. I couldn't see any end to it. I mean, it was three months solid when I couldn't go out.

Similar stories were told by other families. Even when friends visited, interaction with them would be difficult: the continuous crying stilted any conversation. Others found that their reluctance to inflict the crying on others distanced them from their family and friends. Interestingly, such factors are discussed by Bradford (1997) and Dale (1997) with regard to the parents of children with chronic illness. The absence of any period of relief eventually caused exhaustion and loss of control, and the repetitive nature of disturbed nights often

exerted a cumulative effect. Melanie was unequivocal about the problem of day-time crying, too:

What! I didn't have any time at all. I couldn't get anything done. I never had any time of my own. It was all trying to stop her crying, and trying to feed her or play with her or whatever. I never got over it.

The most significant fear for parents from this was the danger of nonaccidental injury to the baby. Such fears, exhaustion, and the occurrence of intermittent periods of especially heightened tension, led to a pattern of approaching and withdrawing from a point of total loss of control: living on the edge. Most participants remarked openly upon this phenomenon, and Joanne, for example, explained:

I think you get used to a level, even though it's a very low level. Then, when you get too much aches and pains, and the pressure is too much, it takes you over the edge. And it might not take much to send you over that edge, either... You start thinking 'I shouldn't be picking the baby up because I'm starting to lose control'.

Acknowledgements of the intermittent proximity to a regretful incident further fed the guilt, stress and desperation of parents. As the risk of nonaccidental injury had already been suggested as a significant risk in excessive crying (Frodi 1985, Crowe & Zeskind 1992), it was a condition of participation that revelations or observations which caused the researcher concern would be discussed with the relevant health visitor. In practice, there were no reports of actual incidents, and episodes otherwise of concern were already known to the health visitor.

This disruption was too severe and prolonged simply to be tolerated so active efforts had to be made to secure an improvement. Indeed, a significant part of the guilt experienced by parents arose from their own interpretation of their inability to solve the problem as inadequate parenting and culpable ignorance.

For as long as he carries on crying I can't help feeling that I ought to be trying something else. I'm sure it's all to do with being a mother. A mother ought to be able to make things better. But you can't. There's nothing to be done. I do know it, inside. But that doesn't stop the guilt (Elaine).

Such feelings, also found by St James-Roberts *et al.* (1996), always led to a determined search for a diagnosis.

Search for a diagnosis

The quest for an explanation and a cure came to be all-important. 'It rules my life!' concluded Roisin. 'It takes over my life.' Claire, too, found that 'there have been times when my whole life has revolved around seeking explanations for

the crying'. As more medical consultations were attended and the desired result was not attained the sense of disappointment and despondency grew. Options were seen to be used up and a final stalemate foreseen. When it became clear that traditional medicine held no solution, or even a convincing explanation for the crying, parents would often turn to alternative therapies; however, no relief was to be found in this part of their quest for a cure either.

I suppose, really, because I knew that nobody could help him, because there was nothing, we thought we'd try it (osteopathy). For the first treatment Patrick seemed to be better for two to three weeks. I don't really know whether he actually cried less or whether I just coped better, now. Richard thinks there was no difference at all, but, well... Like he says, I felt better about things. The second time we went, the crying seemed better just for a few days but then was as bad again. And the last time it didn't really have any effect at all that I could see. Not really, now that I'm honest about it. So that was a blow, another disappointment (Sarah).

So the search for a diagnosis and consequent cure was doomed to failure but attempts to find a cause could not be abandoned. Life and morale spiralled through a repetitive sequence of hope, active search, and disappointment. There were varying periods of resigned acceptance that a cure would not be found and life settled down (comparatively) to a steady, resigned plod. Little stimulation was needed, however, for the peace to be shattered and the pursuit of ever-more dubious causes or unlikely strategies to be resumed.

As Muriel, Susan's mother and Malachy's grandmother, recounted:

You try anything. If anybody can give you a bit of advice that you think you can use, anything at all, you do it. Problem is, of course, none of it works and you're left no better off, maybe a bit poorer, and sometimes it may even seem worse than before. It, like, knocks you back when you build up your hopes and then it doesn't work.

The revolutions of hope, active search, and disappointment were recurrent, and for some this cycle endured until the problem eventually ran its course, the baby grew older, and the crying gradually subsided. This could take as long as a year, and behavioural problems could persist for a further year or more. Looking back on her experience, Helen, who was pregnant again, pondered:

I think that's probably where I got it wrong, though, or at least where I made it worse for myself. I couldn't stop trying to find the cause. I mean, you don't stop until... well, in my case until he'd grown out of it. Doing it again makes you really think hard. I'm already looking for the cure before he's even born.

This spoke volumes of the intensity of the urge to discover the cause and establish a diagnosis and of the longevity of the effects on the parents.

Coping

An alternative strategic approach was to seek support with coping until the crying resolved of its own accord. Coping was to be found in both problem- and emotion-focused activities (Lazarus & Folkman 1984, Carver *et al.* 1989) aimed at reducing the threat to family life. Planning ahead and establishing a routine in order to regain control was counterpoised by the need to break out of the enforced boundaries of life focused on the crying. Distraction and occasional relief from the crying through various means helped to bolster coping. Helen had a friend who would take Michael out to the park for an hour or so while she attended to the housework that had built up:

That little break was really important. I think probably one of the most important things was my friend coming round to give me those few precious, and, it seemed, very brief moments to myself. That little bit of relief and the chance to catch your breath. That mattered.

Varying risks could be seen as being temporarily acceptable in order to secure such a break. For example, Peter recognized the risks involved in driving while exhausted and suffering from chronic shortage of sleep.

If you're that tired you shouldn't be driving a car. People do, I know they do. They take them out in the middle of the night to get them to sleep. You can't concentrate when you're that tired. It's the baby's life as well as your own that you're risking. You could nod off at the wheel. Fortunately, I've only had to do it twice.

Understandably, parents looked primarily to each other for practical and psychological support, and sharing the load between them was a vital part of their survival tactics. This might be a matter of sharing the physical tasks but also an issue of allowing a release of pressure. Waiting for a husband to come home from work in order to 'scream at him and thrust a crying bundle into his face' was a common activity, and it helped to vent pent-up feelings in this manner: a negative feedback mechanism found to be effective by Whyte (1997, p. 8).

Parents experienced alternating periods of peaks and troughs of coping, with few predictable factors to account for the switch from one to the other. However, the recognition of minor victories and up-lifts of mood for whatever reason could often stimulate an improvement. An accumulation of negative experiences or factors often provoked a

reduction in coping. There were periods of relative stability which were characterized by resignation and re-adjustment of expectations. However, the inevitability of an end to the crying usually could not be accepted while coping was in a trough and while more immediate demands and fatigue obliterated such optimistic assertion. Elaine admitted that she needed...

...reminding that it will come right some time. It is difficult to even think about the future when you're coping with today and this feed, or its four o'clock in the morning and you've been woken up again. I think you go through periods of just not being able to see beyond today.

The repeated disappointments of failed potential cures added to this and often prevented recognition of the minor or gradual improvements that heralded eventual resolution of the problem. Findings by Gibson (1995) and Canam (1993) concur with these processes.

The response from professionals

Parents expressed four specific needs which required attention:

- The need for people to listen and to try to understand.
- The need to be believed.
- The need for someone to visit and to 'be there'.
- The need for reassurance that the parents are not to blame and that the crying will stop eventually.

Demonstration of belief in the parents' story was a vital element of establishing rapport and gaining trust. Explicit verbal confirmation of belief was essential, but more active, persistent reinforcement was necessary; a visible commitment to trying to understand the parents' difficulties.

They don't know how it is. They don't know how it is. 'It's hard', said Julie. 'Unless you're a mother who's had the same, no-one can understand what you've been through'. You'll never know how awful it can be... But you could try. I wanted someone to see what was going on and then recognize how awful it was for me.

The same sentiment was expressed by Helen and Joyce who each appreciated the health visitor's attempt to meet this need to listen and to try to understand.

You see, I don't think you could ever really understand what it's like until you've had one yourself, but it seemed to me that people weren't even trying to understand. Except for the health visitor (Helen).

My health visitor was brilliant. I mean, as far as they can do. They can only offer to listen to you, but that made such a change. She would listen all day if I carried on (Joyce).

Perhaps surprisingly, of the families in the study, only three had heard of CRY-SIS, a voluntary group which offers local support usually from a mother who has also experienced coping with excessive infantile crying, and only one had made contact. There is sufficient evidence that those who complain to professionals that their baby cries excessively do, indeed, have a baby who cries more often and for longer than most (St James-Roberts *et al.* 1993, Baildam *et al.* 1995). Belief in this, and in the pervasive effects that the crying exerts on the whole family, was the basic requirement for a professional to be accepted and trusted to proceed further into the depths of the parents' world.

Having established a relationship with parents the next issue to be addressed was the perception of guilt, that the crying was attributable to acts or omissions on the parents' part. Most parents needed to be told repeatedly, convincingly, and with sincerity that they were not to blame. Although there were examples of parents being explicitly accused of poor parenting practice, more often the feelings of guilt resulted from self-recrimination or perhaps from perceptions of external criticism. It seems that even though parents may have known that they had acted in a proper and responsible manner, exhausting every opportunity to help the baby, they could not rid themselves of thoughts of having failed. Overall, the weight of evidence is that inadequate parental care is unlikely to cause excessive crying, and excessive crying is more likely to provoke greater efforts on the part of parents to deal with the problem (St James-Roberts 1993b, 1989). Such self-doubt could not easily be countered. It demanded repeated confirmation from someone with the authority of professional knowledge who had already established their commitment to the family that no potential solutions had been missed and an explicit assertion that the crying was not the fault of the parents. Hearing such reassuring messages and being convinced was clearly therapeutic, and the therapy was needed in frequent, repeated doses, Melanie recognized her need for help particularly because of her inexperience in child care.

I think probably it was reassurance. (Thinking) Yes. That was it: reassurance. Because I was a first-time mother I needed things explaining and I always thought it was just me. But (named health visitor) kept telling me it wasn't my fault. That was good. I needed that.

Self-recrimination might be expected to peak when parents felt 'close to the edge' and to wane as life returned to a more settled routine, but it was always present, persisting long after the crying had abated.

Both of these issues responded better to intervention which was prolonged and situated in the home. Parental dissatis-

faction with medical consultation has been found in a number of studies (for example, Ley 1988, Bradford 1997) and this dissatisfaction was a recurrent feature of the interviews in this study, too. Mike told me of numerous visits to the surgery.

A lot of the time they all said the same thing. It's just like a fob-off isn't it? To me, that's an easy way out for them... I don't think that they're interested, really. They don't believe what you say. They think you're exaggerating.

This was echoed by Eileen (and most others) whose judgement was that 'It's because they don't know. They just fob you off. The doctor was a waste of time'. Discounting the occasional incidence of inappropriate attitude and deliberate obtuseness, however, the GPs and paediatricians appeared mostly to have fulfilled their basic function of diagnosis and prescription as far as circumstances allowed. Yet this was all, perhaps, inevitable. A major part of the reason for the perceived failure of the medical response was its location distant from the scene of the problem and the unavoidable brevity of consultations. Parents felt a need for someone to address their problems in the home, taking time to experience a greater breadth of the difficulties being faced, and giving further evidence of a commitment to see the problem through to the end. Elaine appeared to be clarifying the issues for herself as she spoke.

You feel helpless. So with that and the guilt you can end up feeling fairly bad about the whole thing. So if other people don't or perhaps won't understand that makes it all the harder to cope. Maybe that's why it's still good for people to come: the health visitor and the breast-feeding counsellor. Just so someone understands or at least tries to. Someone who will not judge you, but will sympathise and support you and help you through it. If they just take the time and be there for you, at home, and give you the time that you need. I don't even know what they would do. But it still seems important for them to come and be there.

While acknowledging the current impossibility of their demands, parents expressed in unambiguous terms their need for visits to occur perhaps three times per week, or even daily, and to last for 2 or 3 hours each time. Periods of feeling close to the edge provoked greater need for this prolonged professional presence, but this was less pronounced during less traumatic periods. The linkage between this requirement of prolonged domiciliary contact and those of being believed and reassured about lack of guilt was an intimate one. Each necessitated a major allocation of time and emotional effort. 'Being there' was a way of confirming commitment to the family; it increased the chances of coming to understand the situation better; and it enhanced the credibility of reassuring assertions.

The final need was for the message to be driven home that the crying would stop in time. Although logically this may seem superfluous, in the unceasing grind of coping with excessive crying it could be remarkably difficult to accept or draw comfort from the inevitability of an ultimate resolution; to project forward to a time when life would be normal and more enjoyable. This assurance could not be adequately provided in a brief consultation, however knowledgeable and authoritative the professional might be. Successful intervention in this key area demanded attention first to the previous three aspects of need.

The families in this study experienced chaos and disruption in their lives, expending time and energy in fruitless search for a solution. Eventually, they came to accept that support through the problem was a more effective strategy and in this they identified specific needs and desired responses. The most important implications that arise from the participants' comments, and certainly the most explicit on their agenda, related to the desired intervention by health visitors. They include consideration of the ability to address social isolation and the fear of losing control, and to provide support in the home at times of more intensive need.

Implications for practice

Addressing the needs of families, particularly with children under five years, is recognized as being a crucial part of the health visitor's role (Botes 1998). Chalmers and Luker (1991) explain that health visitors promote and develop relationships with such clients over long periods, often years, while Cody (1999) notes the importance of active listening and efforts to support parents in re-establishing self-esteem and control in their lives. The search for health needs is another fundamental principle of health visiting practice (Community Practitioners' and Health Visitors' Association 1997). Cody (1999) highlights the provision of a service within the client's own environment as being a key factor in the therapeutic effect of health visiting, but reducing the number of home visits has been a consistent recommendation of the Hall Report (Hall 1996). Reassuringly, the consultation document 'Supporting Families' (Home Office 1998) allows for extra funding for an enhanced health visitor role which would include more frequent visits to specified groups. Sure Start (Department For Education and Employment 1998), too, recommends the application of resources to provide for additional health visitor sessions in the home (although admittedly not specifically for this problem). Theoretically, the needs discussed here could be equally well met by other professionals or perhaps ancillary workers provided that they were able to satisfy the specific requirements detailed above.

Pragmatically, however, health visitors currently form the sole group with the knowledge, skills and, importantly, access demanded of the role. Evidence from the Community Practitioners' and Health Visitors' Association (1998), while of varying quality, suggests that health visitors at least believe themselves ready to respond to this challenge. Although effective intervention would be costly in terms of human resources, central government has recognized this need and made some limited provision for pilot schemes. From the perspective of the parents in this study, the cost in human terms of failing to provide an effective service was much greater.

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