Whatever the etiology of colic in infancy, and multiple causes seem most likely, there is little doubt that emotional factors enter the picture. Whether these constitute one of the causes of colic or only intensify it, is at present impossible to determine.

Some investigators have found the colicky infant to be hypertonic, tense, fussy, unhappy even before the onset of specific symptoms. McGee in 1943 suggested that fetal hiccoughs were common in babies who later developed colic.

Spock has emphasized that fatigue of the infant in late afternoon may be a factor, and Gesell has pointed out that there is heightened tension and increased irritability in infants, starting at about 4 weeks of age and continuing to 2 or 3 months, as evidence by increased appetite, more frequent crying, and greater difficulty in getting to sleep.

Vessel and others have found family tensions greater and more frequent where there are colicky babies than where the infants are contented.

The mother of the infant with colic has been described as tense, anxious, uncertain, inconsistent in her handling of the baby and often rejecting him. The psychiatrist’s explanation of the reasons for this personality includes early rejection of the baby, rivalry with infant or husband, conflicts about accepting the feminine or maternal role and her dependency needs.

A simpler explanation would seem to be that as it is the mother who first responds to the infant’s needs, she feels frustrated and concerned if she is unable to satisfy them. Feeding is the focus of the first emotional relationship between the mother and child, and if this does not go well, the mother may become very upset. Further, first-born infants develop colic more often than later-born; most mothers are less sure of themselves with the first born. Because of their inexperience they become worried and may magnify the infant’s discomfort. In any family the crying of a very fussy infant can produce tenseness in the adults.

When the infant fusses and cries and appears to be in pain, a change in the feeding is usually one of the first attempts to quiet him. The mother may increase the food, believing the baby is crying from hunger. He takes the feeding eagerly but continues to cry and show evidence of discomfort. Then she may try to feed more often, but the infant still cries. In the search for some way to stop him, she may pick him up, “burp” him, walk with him, patting, jiggling, stroking, rocking. When nothing helps, she may try leaving him alone and letting him cry. She may increase the time between feedings and decrease the amount. The infant’s discomfort continues and is often increased by this inconsistent handling.

Even the pediatrician is not consistent in his advice to the mother. He may consider the colic due to overfeeding or underfeeding or to some allergic food to which the infant is reacting. So, he may suggest at one visit that the mother try one thing, and at another visit something different. This, too, increases the mother’s anxiety.

Sometimes a nurse or grandparent in the household, seeing the mother’s inability to quiet the child, becomes critical and offers suggestions; this adds still another method of handling the infant and makes the mother more uncertain and nervous. Bring into the picture a father who comes home from work in the late afternoon, just when the infant’s distress is greatest, and who gets little sleep because of the crying, and it is not difficult to believe that the mother of the colicky infant is tense, anxious, and exhausted.
This tenseness is transmitted to the infant. It has been shown by Escalona, Spitz, and others that infants respond to the emotional state of the adult in a consistent way. The infant is happy when played with, talked to and handled securely and upset by inconsistent handling, tenseness, and anxiety.

The parents may experience physical and nervous exhaustion and become upset to the point of wishing they had no baby. In order to break the circle of crying exhausted infant, and tense worried parents, a number of techniques have been tried with some success.

Anything which will make the infant happier has some chance of success. This includes change of feedings, elimination of certain foods and various medications such as atropine, sedatives, and antihistamine drugs. The pacifier has helped in many instances. Rocking, patting, and walking the infant may quiet him. Wessel puts this first in his list, as benefiting over half the infants with colic.

Having someone else care for the baby is sometimes successful in decreasing the periods of fussing. It has often been found that colic will stop within a few days after the infant's admission to a hospital. Studies have been made showing how infrequent is colic in an infant ward or an institution. Levin reviewed the charts of 645 infants between birth and 3 months of age, in the New York Foundling Hospital (1944-47), and found not one case of colic reported by the medical staff and only 8 possible cases on closer scrutiny of the charts. This contrasts sharply with figures from private practice (36 per cent in Dr. Martin's patients of this age in Rochester). Whether colic occurs more often in the home because of the emotional environment, or less frequently in the hospital because nurses bother less about a crying baby, I do not know.

While treating the baby, the family must not be forgotten. Sympathy and reassurance are of great value. It is a relief to the parents to know that in most infants, the colic ceases spontaneously at about 12 or 14 weeks. The fact that in spite of his distress, the infant is actually in good physical health and will probably continue to gain normally gives some comfort. The suggestion that adult members of the family take turns in caring for the baby is often helpful as in this way the mother has an opportunity to get a little rest.

Another way for the mother to get some sleep is for her to take a sedative at night, strong enough so she is not disturbed by the baby's crying. In the morning she is fresher and more able to cope with her household and with caring for her baby. When she is not so tired and exhausted, she will not be so upset and tense.

After a few days or at most a week the majority of infants have quieted down. I do not know whether this is due to the fact that crying did not bring prompt attention, so the infant found it useless to cry continually, or whether, the mother being rested, found she could cope with the situation better and used better sense in handling the infant or whether, as seems more likely, the decrease in nervous tension was sensed by the infant who responded by less crying and perhaps by better digestion and less cramps.

Why the infant spontaneously recovers from colic at 12 or 14 weeks of age is still open to question. It is possible that an immature central nervous system is then functioning better, or a small gastric capacity may have increased so that the infant can take and digest more satisfactory quantities of food. Wessel believes that as the infant grows older, his period of fussing in late afternoon may give way to a play period, or that when he can use his eyes and hands to amuse himself he no longer needs the adult to comfort him. Spitz confirms this in part, showing by his studies that the younger the infant the greater his emotional needs, and these must be satisfied entirely by the adult in his environment, usually the mother.

It has been suggested that many of the emotional problems of later life can be
traced to this early period of unhappiness and discomfort. The idea has been put forward also that parent-child relationships may be established during the months when the infant had colic and the mother wished she could be rid of him. This has not been my experience. In the few instances where I see these children as adolescents they appear to be no different from other children in their problems or in their relation to their parents.

FAMILY TENSION AS A CAUSE OF COLIC IN INFANTS

By John C. Cobb, M.D.

A study of colic in infancy was undertaken as part of the Yale Rooming-In Project.1 The longitudinal records of 98 infants who were study subjects were analyzed with respect to incidence, duration, and severity of colic. Forty-eight of the infants were classified as fussy or colicky and 50 as contented.

Because I had formed the clinical impression that allergy was an important contributing factor in the causation of colic, careful family histories were taken for all of these infants with particular attention to allergic disease in any member of either parent's family. An adequate family history was obtained in 95 of these infants. These data were analyzed both according to the incidence of allergic disease and according to the severity of allergic disease in family members.

Among the relatives of the 45 “fussy” or “colicky” infants 7.3 per cent had severe allergy, 17.7 per cent had mild allergy and 74 per cent had little or no allergy. Among the relatives of the 50 contented infants 7.6 per cent had severe allergy, 14.7 per cent had mild allergy and 77 per cent had no allergy. The family histories included a total of 957 relatives.

The 45 families of the babies who were fussy or colicky were divided as follows as to amount of allergy among the relatives. In 7 families there was much allergy, in 30 families there was some allergy and in 8 families there was little or no allergy. The families of the 50 contented infants were divided as follows, in 7 families there was much allergy, in 33 there was some allergy and in 10 there was little or no allergy.

These figures comparing the degree and frequency of allergy in the families of the two groups are remarkably similar. There is no statistical difference.

The colicky or fussy group was similar to the contented group also as regards details of feeding, birth weight, weight gain, sex and educational level of the mother.

Of the 48 colicky or fussy infants, family tension was adjudged to be an important

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<th>TABLE I</th>
<th>Number of Known Relatives with</th>
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<td>Severe Allergy</td>
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<td>45 “Fussy” infants</td>
<td>92</td>
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<tr>
<td>7.9%</td>
<td>17.7%</td>
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<tr>
<td>50 “Contented” infants</td>
<td>40</td>
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<tr>
<td>7.6%</td>
<td>14.7%</td>
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<tr>
<td>Total</td>
<td>72</td>
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<tr>
<td>7.5%</td>
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Dr. Cobb is Assistant Professor of Maternal and Child Health, Johns Hopkins University School of Hygiene and Public Health.

<table>
<thead>
<tr>
<th>TABLE II</th>
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<tr>
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<td>7</td>
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<tr>
<td>50 “Contented” infants</td>
<td>7</td>
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<tr>
<td>Total</td>
<td>14</td>
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PSYCHOSOMATIC FACTORS WITH PARTICULAR REFERENCE TO THE PARENTS OF THE COLICKY INFANT

Ruth M. Bakwin

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