Parents' concerns and understandings around excessive infant crying: qualitative study of discussions in online forums

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Abstract

Crying is an essential behaviour in infants, occurring on a continuum, and only rarely indicates serious underlying diagnosis. Searching online for information about excessive crying has become common, using the internet to seek health information and support through forums. The aim of this study was to examine data systematically derived from discussion threads on two online parent forums to explore discussions around excessive infant crying. This study utilised two qualitative approaches; the first, a thematic analysis to explore concerns around excessive crying, and the second, discursive psychology, to explore how diagnostic labels (underlying medical cause of crying) are negotiated within an online thread. The thematic analysis identified a tension between interpreting what is 'normal' crying and when crying is a sign of an 'underlying problem' leading to a search for a diagnostic label. This tension seemed to be heightened when expectations that infancy should be a 'happy time' were threatened by excessive crying. Responses to original posts offered support for parents/caregivers to 'trust their instincts' and to explore different diagnostic labels. The discursive psychology analysis explored responders' accounts of their experiences to increase credibility and showcase expertise. Forums play an important social role, meeting needs for reassurance, validation, and empowerment. This study suggests that labels are used interchangeably, and further work is needed to understand how perceptions are developed and acted on in the community, as well as online. Furthermore, this study suggests there is a need for supporting parents/caregivers in understanding and managing common behaviours such as excessive crying.

Keywords (6) Infant crying, colic, qualitative, online forums

Introduction

Infant crying is an essential behaviour, a form of communication, expressing basic needs and events as well as being a social behaviour (Lester, 1985). Crying can be categorised as a preverbal interpersonal communication where parents/caregivers and adults use features, timings, amplitude, frequency to decipher the message in the cry (Boukydis, 1985). The message in a cry can be perceived as either a clinical sign or symptom of an underlying issue or pain or as a functional signal (Barr, 2000). Severity of infant crying occurs along a continuum with excessive crying affecting up to 12% of infants, depending on definition (Reijneveld et al., 2001). Although definitions of infant crying vary, we use the term 'excessive infant crying' to refer to behaviour that parents/caregivers report as problematic in the first 12 months of life. Parents as a term when used in this paper refers to both parents and main caregivers of infants.

Excessive infant crying commonly has no identifiable cause, but can be a symptom of constipation, injury or, rarely, more serious underlying diagnosis (Douglas & Hill, 2011). Where such causes have been ruled out there are a number of other commonly applied terms, such as infantile colic, gastrooesophageal reflux or cow's milk allergy that have overlapping symptoms and, usually, low diagnostic certainty. 'Infantile colic' is a descriptive term for when babies cry more than 3 hours a day, 3 days a week for at least 1 week (NHS, 2018). Infantile colic is described as peaking at 6-8 weeks of age, crying is particularly common in the evenings and it is generally treated symptomatically with positioning and winding approaches, or anticolic medication (NHS, 2018). Gastro‐oesophageal reflux is considered when a baby vomits or brings up milk after feeds, often associated with crying, and affects approximately 40% of infants (Katz et al., 2022; NICE, 2019; Vakil et al., 2006). Gastro‐oesophageal reflux generally resolves without treatment but can be managed with approaches around positioning, winding, or, for bottle-fed babies, use of feed thickener or avoiding over-feeding. A trial of prescription medicines can be used for gastro-oesphageal reflux with marked distress (Katz et al., 2022; NICE, 2019). Lastly, cow's milk allergy is considered where more than one system is affected in an infant consuming cow's milk, for instance low growth or treatment-resistant eczema in addition to gastro-intestinal symptoms (Fiocchi et al., 2022; Fiocchi et al., 2010; NICE, 2011).

Prescribing for both cow's milk allergy and gastro-oesophageal reflux in infants has increased in recent years, suggestive of changes in help-seeking or diagnosis (Mehta et al., 2022; NHS Digital, 2018). Some have suggested that the increase in prescribing for cow's milk allergy is the result of overdiagnosis and industry influence on parents' and health professionals' responses to commonly experienced infant symptoms, such as crying (van Tulleken, 2018). Little is known about how parents reach decisions about whether their infant's crying is excessive or what types of information or support they draw on when deciding how to act or whether to consult for such symptoms. Previous work has mostly focused on the impact of excessive crying on parental wellbeing (Muller et al., under review). Qualitative research methods would be valuable in starting to explore these common dilemmas for parents.

The Internet is increasingly used to seek health information and support by communication with others who have similar health issues via personal blogs, online forums, and social media platforms (Mazanderani & Powell, 2013). Online forums are discussion sites that allow users to communicate their personal experiences and engage in supportive interaction with other individuals facing similar challenges, through the medium of asynchronous written communication. In many forums, postings and discussions can be viewed by every Internet user, although to be able to post a message, users have to register and log in. Such forums may provide researchers with a rich and valuable source of primary data about users' perspectives and experiences of a particular health issue and enable analysis of discourses taking place within the online setting (Holtz et al., 2012; Robinson, 2001). Therefore, online forums may provide us insight into what information parents are seeking and sharing about excessive infant crying.

The aims of the current study were to explore: (1) parents'/caregivers' understandings and concerns about perceived excessive infant crying expressed in online discussion forums;(2) what advice and support is shared in online discussions around excessive infant crying; and (3) how parents/caregivers negotiate and discuss labels that are associated with excessive infant crying.

Methods

Data Retrieval

Stage 1: Identifying forums and search terms

A scoping review was conducted in November 2019 by DG, an experienced qualitative researcher, to identify relevant online discussion forums and most efficient phrases to identify discussion threads relating to concerns regarding excessive infant crying. Terms such as 'baby won't stop crying' and 'baby suddenly crying inconsolably' and related terms that came up on two search engines (Google and Bing) were evaluated. These searches were completed in 'incognito' and 'private' browser tabs to remove algorithm biases. This step helped identify potential forums and phrases needed to use within the selected forums in our next stage. To then identify discussion forums in every search conducted within the selected forums, the first five pages (50 results) were included in the evaluation. This process overall identified 5 different forums and two were included in the study on the basis that they were frequently used, were not private (i.e. no password required) and were from the UK. DG familiarised herself with these forums and then DG and MS developed a search strategy within the two identified forums. MS has previous experience in forum studies and worked with DG through the data collection and analysis, DG has not had previous experience working with forum data but has previously used secondary data. The analysis plan was driven through the familiarisation of the data, and as DG does not share the experiences of the data, the analysis was checked with the Patient Representative, KS who is a mother of a child who had experience of excessive crying and allergies.

Stage 2: Identifying relevant threads within selected forums

In order to identify relevant threads within these forums, DG used the internal search function with terms 'excessive crying' which yielded 4,350 threads, 'fussy crying' which yielded 6,970, 'inconsolable crying' yielded 1,450 threads. The first 5 pages of results (10 per page) were reviewed, and 117 threads were evaluated further, from these 56 discussion threads were excluded, covering topics such as sleep problems, discussing older children, neighbour issues, therefore 61 were included for analysis and were copied into Microsoft word and then exported into qualitative data management software NVivo V.12.

Ethical considerations

This study received ethical approval from the University of Southampton Faculty of Medicine in October 2019 (ERGO 51811.R3). It was not possible to paraphrase quotes for the discursive psychology analysis, so we ensured that the analysis and the reporting of findings stayed within the

focus of the research question in understanding the role of discourse rather than about personal circumstances or characteristics of the individuals who wrote the posts. This followed a similar approach found in published discursive psychology analysis with public forums (Wiggins et al., 2016). Any identifying information was removed and the use of more than one online forum and not identifying these in publications further protects anonymity of the participants. Use of multiple sources is also outlined in the updated British Psychological Society Ethics Guidelines for InternetMediated Research (2021). Only websites that have public discussion forums (i.e. researchers did not need to register in order to view the messages) have been considered for this study in accordance with the British Psychological Society guidelines that consider forum messages to be within the public domain (British Psychological Society, 2021). Pseudonyms have been used for the quotes reported in the manuscript. It is likely that the online parent forums are used by mothers, we did not have access to data such as gender or ethnicity therefore gender-neutral pseudonyms were given to the quotes.

Data analysis

To address the different aims of exploring concerns and perceptions and the negotiation of labels, data were analysed using qualitative mixed-methods: reflexive thematic analysis (Braun & Clarke, 2014, 2019) was conducted to develop themes around understanding and concerns about perceived excessive crying (Aim 1 and 2), whilst discursive psychology analysis (Edwards & Potter, 2005; Potter & Wetherell, 1987; Wiggins & Potter, 2017) was used to understand how 'diagnostic labels' were negotiated (Aim 3). These two different analysis approaches (thematic analysis and discursive psychology) were utilised through a pragmatist perspective in scientific inquiry to understand both the content of posts about understanding and concerns of excessive crying but also the dynamic relationship that is happening within a thread, around diagnostic labels, and advice regarding excessive crying.

Reflective Thematic Analysis

For the thematic analysis, the phases as outlined by Braun and Clarke (2014, 2019) were followed for reflective thematic analysis. Coding was approached using inductive methodology to derive all codes directly from the data using a “bottom-up” approach. One author (DG) developed the dataset by going through the search results within the forums, each post in threads were coded. The coding was discussed with the team with examples and ensuring clear definitions for each code. To increase credibility, three authors (DG, MS, CM) coded four of the same discussion threads and this helped build discussions around the threads and codes. Three authors (DG, MS, CM) read the rest of the discussion threads and coded line by line. Regular meetings allowed critical discussion of the coding, so an iterative process was followed for coding and analysis. This was followed by discussions with the wider team, which enabled themes to be refined and coding reorganised (allowing for a quality control). A thematic map with sub-themes was developed iteratively until the discussions evolved to central ideas about concerns and perceptions of excessive crying.

Discursive Psychology Analysis

A discursive psychology analysis was conducted to explore how people on forums negotiated labels around excessive infant crying, developing our ideas further from the thematic analysis. For the discursive psychology analysis, we included threads where a discourse in the data was developed around labels and underlying cause throughout (where the replies are referring to each other and building a narrative around labels) and threads where the original poster came back with responses were included. Deviant cases were brought forward for further analysis using discursive psychology analysis. This helped the team to understand the mechanisms original posters use to elicit advice around labels, and the mechanisms employed to validate or reassure the original post's concerns or suspicions. In total, there were 26 threads that were included in the analysis. Discursive psychology is an approach that treats the text as social action in which it is recognised that people use language for certain purposes (Potter & Wetherell, 1987). In this current scenario, we focused on two social actions, the first in the original post which elicited concern about excessive crying, and the second in the response posts that either validated or reassured the original poster's concerns. This was achieved through the use and negotiation of labels and shared experiences. Analysis focused on the original post provided the rationale for identifying crying as 'in need of a label' and then examined the responses on how this was either disputed or supported. Summaries of the threads were developed by three authors (DG, MS, CM) to put together a dataset for the discursive psychology analysis. These summaries provided indicators of techniques of voicing concerns. We analysed techniques the original post would use to steer the advice, and how and when responders negotiated or offered labels. This helped focus the concept (building a case), allowing familiarisation with the data and how this was invoked in the threads of both the original post and the responses. Our analysis of negotiating labels then was used to develop a separate coding of techniques identification of discursive constructions for the discursive psychology analysis and collecting other instances of these techniques in the dataset.

Findings

In total there were 61 threads included for analysis, with 30 threads included from forum 1, and 31 threads from forum 2. These discussion threads involved 644 total users (range 2 to 44 users per thread) with 386 users in forum 1 and 258 users from forum 2. There was a total of 963 posts (range 2 to 74 posts per thread) with 616 posts from forum 1 and 347 posts from forum 2. The posts from moderators (a user who responds to some of the comments or removes spam) in the threads were marked when transferred to the word documents and it was noted that there were more moderators replies in response to posts about the parent's emotional wellbeing. However, these moderators' posts were not included in the analyses reported below to be able to address the aims of exploring understanding and concerns of parent/caregivers in online discussion forums and how they negotiate diagnostic labels for excessive infant crying.

Findings– thematic analysis

Three themes were developed to address aims 1 and 2, through thematic analysis in trying to understand the contents of the forums, and these centred around “making a case for a label”, related to an underlying question around whether this excessive crying was normal or a sign that there was something wrong. See Figure 1 for the thematic map outlining the themes and sub-themes. As a team we found there were certain patterns in the use of language and techniques to encourage the original poster that the crying was either normal or in need of a diagnostic label. Related to this, there was also encouragement and validation that the original poster should trust their instinct, and lastly suggestions for consideration.

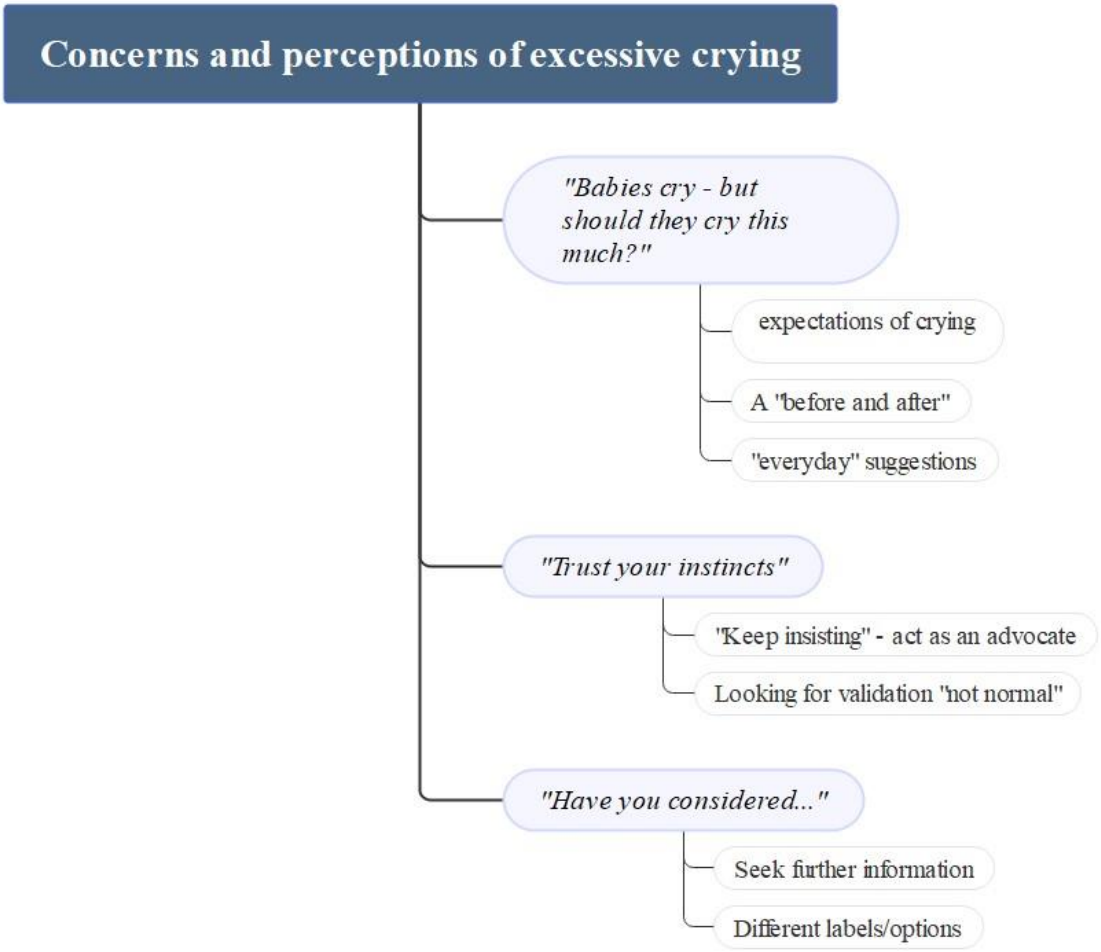

Figure 1: Thematic Map with sub-themes

"Babies cry – but should they cry this much?"

There was a general acceptance that crying is 'normal' for babies but with underlying (implicit or explicit) questions or concerns regarding when crying could be classified as excessive or that their current experience was not in line with their expectations of crying. This was evident from the ways that both the original poster would differentiate between what they would consider to be normal crying and what they would consider to be excessive crying. The original posters referred to their expectations of crying through a number of means, including comparing to other children or siblings.

> *The crying just makes me so anxious but I know I have to push through and leave the house eventually! My daughter was the complete opposite she never cried, total angel so this is new territory for me* 😟
> Charlie (Thread 1, Forum 1; Original Post (OP))

In other instances, the original poster would compare their baby's current behaviour to past behaviours, suggesting a change as a cause for concern, for instance a change in the type of cry, behaviour in the

context of the crying (e.g. clingy) or duration of crying. Some provided more examples of changes including other behaviours such as eating or sleeping or breaks in routines. These were provided by original posters as examples and justifications for asking if this was normal or was there an underlying cause for the change this increase in crying.

> *My LO* (Little One) *has been great settling and having quiet awake time in his bouncy chair while I do laundry etc but over the last week he has been screaming rather than crying and suddenly very clingy, wants to be held all the time or suck on my pinkie and screams if i put him down so I can go to the loo, eat etc! He is also taking less milk and its taking longer for him to take it as he struggles and cries during the feed which he has never done before.* Frankie (Thread 2, Forum 2: OP)

Alongside expectations about crying and the amount of crying there were also expectations about infancy being a 'happy time' with a baby that was hindered through excessive crying. There seemed to be a sense in which the early baby stage was finite but was being consumed by crying or trying to reduce the crying. Part of the responses included reassurance that this time will be missed despite the crying and that it will get better.

The response threads appeared to seek to provide reassurance to concerns about excessive crying, suggesting similar experiences and providing hope regarding finite timelines for this behaviour (e.g. "they will grow out of this phase") as highlighted in the quote below.

> *feel free to vent on here - those first two months of screaming were the hardest of my life and I was genuinely getting depressed- but it does get better o promise. And the main thing is, don't blame yourself. I was constantly comparing my baby to my NCT friends' happy, easy, contended babies but that was unfair to myself and my son!* Taylor (Thread 3, Forum 1: Response)

In addition to reassurance, the responses tended to include a variety of advice that could be classified as "everyday" or 'common-sense' solutions to either soothe or comfort both the infant and the original poster such as rocking/swinging, sling, baby massages/cuddles, dummy, feed frequency, sleep routines. Such responses seemed to implicitly suggest that the crying could be normal – using a checklist of common causes of crying (hunger, sleep, wind, hot/cold) without explicitly suggesting that this is just 'normal' baby crying.

> Sounds like colic.
> Try a sling.
> There's a growth spurt at around 8 weeks as well so you might find you have to offer milk more regularly for a little bit.
> I always work through the list:
> Are they hungry- *offer milk see if that works*
> If they aren't hungry do they have wind- *leap around the house trying to wind the baby*

> If they aren't hungry and they don't seem to be windy are they tired? *Furiously attempt to rock baby to sleep or sway aimlessly with them in the sling*
> Baby still clawing at me and screaming, perhaps they are bored? *puts Cbeebies on, baby cheers up immediately and I rock in a corner sobbing and eating a twix*
> You won't believe me now but after having two babies that did this from 6 weeks through to about 12 weeks I promise things do usually start to improve drastically between 10-12 weeks. *stares at 12 week old and dares them not to prove me wrong* Alex (Forum 1, Thread 2, Response)

The key message around "this is a phase" was that there was a clear timeline to focus on, suggesting that there may not be a quick solution but also implying excessive crying could be part of 'normal' infant behaviour, so there was also advice about self-care and support and encouragement as part of the responses throughout the threads.

"Trust your instincts"

The message of trusting instincts was present in both the original post and in the responses, suggesting that if a parent is concerned about a change or excessive crying there is likely an underlying health reason. This usually transpired when talking about advice from the General Practitioner (GP) or Health Visitor where they did not provide what they would perceive as the right or satisfying answer.

> *He told me that as long as the baby is gaining weight and growing, peeing normally and there is nothing different with his poop, I have nothing to worry about. It was not what I wanted to hear, because my baby is in pain and I want him to feel better asap. Anyway, he told me to take him to the GP tomorrow and have him checked again. Will do. As many times as I need!* Jesse (Forum 2, Thread 4, OP)

There was discussion around having a gut feeling, suggesting that there must be an underlying health condition. In some posts, being offered the label 'colic' by a healthcare professional (HCP) was perceived as being *'fobbed off'* rather than receiving an investigation into the cause of excessive crying, and responders encouraged further investigation.

> *My DD* [darling daughter] *is on meds for it, but that was after paediatrician diagnosis at hospital. Go to your GP if you do think its reflux. The first thing they prescribe is non medicinal infant gaviscon to see how that helps keep the stomach contents down and therefore the LO* [little one] *happy. Good luck, its horrible to see your baby suffering and not be able to help.* Max (Forum 2, Thread 31, Response)

Satisfaction with responses from HCPs seemed to be centred around whether or not the HCP appeared to 'believe' there was an underlying health condition, related to a feeling that if no underlying health

condition was diagnosed then they were just being told ‘to get on with it.’ This reaction was seen in both the original posters’ description of interaction with the HCPs and within the responders.

> *Our two week old little girl is suffering badly from what we think is colic. We have been to the doctors but haven't got any decent advice yet.* Rudy (Forum 1, Thread 4)

In these threads, responses included encouragement that the original poster (OP) should go back again, seek further assessment and advice and 'fight' for the infant, enforcing this belief that parents should trust their instincts as suggested by one original poster: “*mother’s instinct is nearly always right”* (Jules). Some of the posts recounted experiences of seeking to 'convince' a Healthcare Provider (HCP), either a health visitor of GP to take the crying seriously, raising concerns that the HCP may perceive the parent/carer as anxious or overprotective. Therefore, the forum and threads seemed to be sought as sources for empowerment, through reassurance and validation of concerns about the excessive crying.

> *It's such a hard time. My lo* [little one] *came 10 weeks early so all these things were spotted quickly for us as he was having so many appointments but for most they don't get answers so you need to push for them; it's not normal for babies to cry all the time and it's so hard for parents when they do. It will get easier I promise but you need to get the right medication and the right healthcare. Xxx* Morgan (Forum 2, Thread 6)

This was a common narrative across many threads, suggesting that caregivers perceive themselves as advocates for the crying infant. It felt as though parents perceived themselves responsible completely, and therefore should know and understand the meaning behind every move and sound the infant makes, thereby knowing when something is wrong.

“Have you considered…?”

Throughout the threads there were a variety of diagnostic labels, or possible causes of crying, mentioned ranging from ‘normal’, trapped wind, teething, sleep issues, reflux, colic, allergies, intolerance or cow’s milk allergy. These labels arose both in original posts and in responses, but where they arose in responses they were often offered as a possible cause for the original poster to consider. These labels tended to be paired with advice recommendations, ranging from routines (sleep or feeding), cuddles, movement, seeking emotional and practical support, diet changes, gripe water, comfort milk, cranial osteopathy, and medications.

For many of the diagnostic labels discussed, there seemed to be confusion or variation in the meanings, either perceiving them as a 'diagnostic label' or an associated symptom for another label. For instance, at times, reflux was not described as a label but as a symptom indicating that the baby had an allergy. 'Colic' sometimes seemed to be viewed as a label itself but most times colic was perceived as a 'gateway' to another label, such as allergy or reflux. The term 'reflux' appeared to be used

interchangeably with labels such as ‘silent reflux’ or ‘acid reflux.’ Terms such as allergy, intolerance or 'lactose overload' were used interchangeably, occasionally presented together, paired with suggestions of diet changes for the mother if breastfeeding or formula changes where bottle feeding. This was especially evident in the use of lactose intolerance and CMPA.

> *Could it be a dairy allergy? My lo* [little one] *had reflux and it was caused by an allergy to dairy and soy. The crying was one of our first clues. You will be prescribed special formula if you're bottle feeding (although they come in stages with neocate being the most effective amd they will likely try you on a cheaper one first) if you are breast feeding cut dairy and soy out of your diet. It will take about 2 weeks for the dairy and soy to come out of their system so won't work straight away. Very common to be allergic to both. Good luck!* Daryl (Forum 1, Thread 8 Response)

These findings suggest that some of the confusion stems from how people are conceptualising excessive crying, if perceived as either a sign (indicator of state) or symptom (underlying health reason). When excessive crying was perceived as a symptom, there tended to also be advice for seeking further information, reassurance that exploration is necessary to differentiate between signs and symptoms.

> *if it doesn't get any better, do take her to your doctor as there may be an underlying medical reason as they might spot it straightaway and save you weeks of stress!*
> Stevie (Forum 2, Thread 12)

Although there seems to be uncertainty around defining excessive crying and what it represents, there were strategies employed in directing the threads to be taken seriously by the original poster (e.g. in theme 1 providing a before/after description), and strategies taken by the responders so that the labels and advice provided are trustworthy. These were strategies of interest in the discursive psychology analysis to understand how these diagnostic labels and excessive crying are negotiated online.

Findings – Discursive Psychology Analysis

The use of shared experiences was of interest in the analysis to address aim 3, especially in how discussions of these experiences performed different functions in the forums. The use of shared experiences can a be a tool in discourse that increases a sense of membership of a group (Lamerichs & Molder, 2003; te Molder & Potter, 2005) in this case, it would be parenting a child with excessive crying. By increasing a sense of membership, through establishing shared experiences, this can showcase expertise, and increase credibility in advice, as showcased in Figure 2. Sharing similar

experiences provided context around medical labels (e.g., there is a medical underlying reason for excessive crying) or to normalise excessive crying on the continuum of crying. In these forums, the shared experiences could either be their own or the experiences of others in their social circle that they reported and described in their posts.

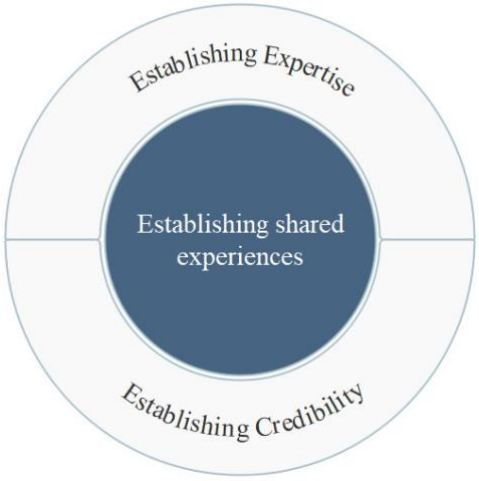

Figure 2: Outline of Discursive Psychology Analysis, by establishing shared experiences, one can establish expertise and credibility

Establishing shared experiences

The establishment of shared experiences can be seen to be begin with the original post, the original posters used implicit and explicit strategies to direct the subsequent discussion. Some original posters directly asked for what they want to see or not see in the replies (e.g. *"And please no 'it's all worth it and it will pass' comments"* Jesse). Some original posters would also provide information on already tried and tested methods as though to move the conversation on or to provide an indication that they have eliminated their options (e.g. "*nothing I do works"* Kyle*).* This use of details is a discursive device that allows for further questions (avoiding the pre-empted questions) but also allows for perceptions of identity and skills (Wiggins, 2016). This was useful for responders to identify the criteria of the membership in this parenting group and to identify themselves and their experiences in the post.

Another strategy was to frame the thread by providing diagnostic labels in the original post, either as a label already applied to the infant or within a question as shown in extract 1 line 6, where the original poster is asking for "something else", framing concerns that there is a serious underlying cause for the change in their infant. Such a narrative structure (Wiggins, 2016) allows for a scene-setting seen in illness narrative (Horton-Salway, 2001).

2 My baby has been crying since 10 this morning. It's very unusual for him. 3
He's sleeping for 5-10 mins after feeds or -if we are lucky- after rocking 4

or bouncing him off to sleep. He cried through his bath, which he usually 5
loves and cries in his sleep.
6 Is this colic or something else? I tried winding him, but nothing happens. 7
Please help! Suggestions very welcome!

Ashley: OP (Extract 1; lines 1 -6)

In extract 2, the original poster listed the usual checks, and methods have been made (in line 1 – 2) therefore, asking indirectly to not suggest these in their responses. Whilst listing the usual checks can also demonstrate capability, as they have already tried/checked the usual checks and methods. However, the use of emotion categories (Wiggins, 2017) in line 3 and 5 of extract 2, sets up a distinction that the original poster is in need of acknowledgement and emotionally supporting the credibility of the claim that it is indeed excessive crying.

1 He has been crying all day. He has been changed, breastfed,
formula 2 fed, winded.
3 I cannot bear it. I cuddle him he cries, I put him down he cries.
Please, 4 any ideas? I have danced around the kitchen, i have left
him to cry, 5 I just am at my wit's end.

Sam: OP (Extract 2 line 1 -5)

The responses to emotions presented in the original post (e.g. Sam in extract 2, line 5) was empathic (acknowledgement), and provides recognition of the state of the original poster because of the excessive crying. The responders positioned themselves as knowledgeable because of their own experiences, using statements such as *"sounds similar"* offering these shared experiences before providing the advice/suggestions establishes the shared membership. This was especially evident when one responder to extract 2 referred to themselves as *"One Who Has Gone Before"* in line 154, by providing this category entitlement (Potter, 1996) they were increasing the likeliness of trusting their proposed non-medical labels of "growth spurt".

154. Some thoughts from One Who Has Gone Before:
155. 3 weeks is a classic age for a growth spurt (others are: 6, 8, 12 and 19 weeks).
156. Basically he will want to feed loads to increase milk supply and will be
more fussy 157. (ha! good euphemism...) during the day.
158. If he's only slept for 10 minutes at a time, he will be massively overtired and
159. need (though he may, obviously, resist) a nap. A good rule of thumb is that
160. babies can't stay awake for longer than 2 hours without needing a sleep. For
161. both of my sensitive little souls at that age it was more like 45 minutes
162. including feeding before they would need to go down again. Just observe
163. your baby, get to know his tired signs (eye rubbing, fussy, irritable, nothing
164. calms them all of a sudden) and start to put them down for a nap. Don't
165. worry about how long they have been up (as long as it's not past 2 hours,
166. that really does seem to be a golden rule) just start settling them down
to 167. sleep as soon as they look tired.

168. Oh, and swaddle and sling away! DS [darling son] **only** slept on me in a sling
169. for the first 16 weeks and then we started training him to actually sleep on a
170. flat surface 😁. Don't worry about bad habits/that it will be like this forever – it
171. won't! - just do whatever you can do sleep your baby frequently throughout 172.
the day, whereever they look as if they'll sleep!
173. And May the Force be With you... it's so, so hard this stage, it really is....

Quinn: Response to Sam (Extract 3; line 154 – 173)

Establishing Expertise

In the same thread as extract 2 and extract 3, the first responder of the thread (Logan in extract 4) comes back to the discussion after Quinn (extract 3) and backs up the claim of growth spurt making it more credible as a label. This emphasis from other members of the thread included the advice of swaddling allowed for a shared expertise in managing excessive crying that was not related to hunger, wind, or in need of a change. Furthermore, Logan (extract 4) use the strikeout feature to keep exaggerations (e.g. line 177: *weeks* vs *days*) and differentiating by how they felt and what happened (e.g. line 181: *set fire* to vs *scowled*). This also added humour and a shared understanding that the 'growth spurt' can feel like it is a fobbing off label but showing expertise through experience that it is a 'phase'. Whilst humour added credibility regarding the responses, it also built rapport and emphasised membership to the group. The strikeout function can also neutralise the rest of the statements implying that what is not retracted is not an exaggeration, adding to the credibility to the post.

175. **Logan**: excellent post, **[Quinn]** 🙂 176.
177. **Quinn**: Thanks, **[Logan]**! I like to feel that my ~~weeks~~ days
of doom
178. and gloom with DS weren't entirely in vain 😁 179.
180. **Logan:** I remember the hellish growth spurt thing - I would happily
181. have ~~set fire to~~ scowled at the next person to say that, but it's so true.
182.
183. [**Sam] -** this bit is true true hell, I remember it well.. argh, horrible.
184. Thing is, you're through the worst of it and it will get better soon,
185. promise 🙂

Logan and Quinn: responses to Sam (Extract 4 line 175 – 188)

At the end of the thread from Sam (extract 2), Sam; the original poster returns to feedback, providing further evidence of trust to the claims given in the thread, especially in line 220-221 where Sam showcased checking the legitimisation of the growth spurt label with their Midwife (MW) and disregarded the negative response that '*it was unlikely'* with a disclaimer using *"but I feel like I can see him growing before my eyes*!" (Line 222).

209. Brilliant advice, [**Logan**], [**Quinn**]. Thank you so much. Not too bad last 210. night, up at 1, 3 and 6. He HAD been sleeping in 4 and a half hour blocks so I 211. was spoiled!
212.
213. Overstimulation may well be a part of it, as I was using musical mobiles to try 214. and distract him from crying.
215.
216. Will try leg cycling, also. Interesting also what you say about combined
217. feeding making them windy, Jareth. I am aiming to buildup the BM *(breastmilk)* and 218. ditch the FF *(formula feed)*. Due (I believe) to a fairly traumatic delivery my milk 219. was delayed.
220. Oh, and thanks [**Quinn**] about the growth spurt timeline.... I had asked the 221. MW [midwife] on Monday if he could be going thru one, she said it was 222. unlikely, but I feel like I can see him growing before my eyes!

Sam: OP responding to responders Quinn and Logan (Extract 5; line 209 – 222)

Responses that proposed possible medical underlying causes (e.g. diagnostic labels) made use of questions. Using the shared experiences in these instances were a tool to present knowledge known to those within the category/membership group (Potter, 1996). In response to extract 1, a diagnostic label is provided (dairy allergy) as shown in Extract 6, Avery is asking if Ashley (the original poster) should cut out dairy to see if it helps, framing the advice following a question.

49. I had similar with my ds and turned out he had a dairy allergy. If you
50. bf [breastfeeding] it could be worth cutting it out to see if it helps? It 51. takes 3 weeks to leave your system completely but you should see an
52. improvement in a couple of days if it's that.

Avery; Responder to Ashley (Extract 6; line 49 - 52)

This position is further emphasised by using modal verb "*should*" in line 51, moving the responsibilities (Wiggins, 2016) to cut dairy from the diet and checking if it is a dairy allergy on the original post. The use of "could" can also be seen throughout the responses (emphasised in our third theme) this use allows for a variety of suggestions within individual posts or throughout the threads. There was no evidence of confrontation or direct disagreements throughout the threads. If responders came back to the thread it was either to provide more information or agreement and support for each other. Questions, and the use of experiences (primary or secondary), allowed a responder to provide alternative suggestions and add to the advice throughout the threads.

Establishing credibility

The use of experience, which related and combined symptoms that the original poster may mention were also combined with further information. Although there were also instances where the experience was not directly personal but were second hand (from other people's babies, or their own). These

experiences at times or occasionally were combined with links and other sources to provide further evidence, especially when framing a symptom checklist. For example, in extract 7, following a reflection on the awake/crying comment from the original poster (Stevie), Ellis added other symptoms as a checklist (line 24 – 36) to help Stevie identify with the other related symptoms besides the screaming and excessive crying (line 22).

20. My money is on reflux, or more likely CMPA. Reflux is often a 21.
symptom of CMPA.
22. My son is severely allergic to cows milk. When he was born, if he was
23. awake, he was screaming an awful, heart wrenching scream
24. Other symptoms include:
25. - A rash (usually around the head, face and neck, but can be anywhere
26. on the body)
27. – Reflux
28. – Vomiting
29. Frequent mucousy poo or constipation (both are common, my son had
30. the runny mucous poo)
31. – Bloating
32. - Rubbing eyes a lot
33. - Runny nose and weepy eyes
34. - Struggling to pass wind, or passing frequent, offensive smelling wind
35. - Frequent bouts of hiccups or coughing 36. - A frequent pained cry
37.
38. You could try removing all forms of dairy from your diet and continue
39. breastfeeding. It can take a few weeks for the proteins to completely
40. leave your system, but you will usually notice an improvement within a 41.
few days

Ellis; Responder to Stevie (Extract 7; line 20 - 41)

Checklists were used as a way of providing a tool for collective thinking about an underlying cause for excessive crying, mapping back to personal experience as shown in extract 7, the personal experience was presented interspersed with the list of symptoms. The poster puts forward a claim that reflux is often a symptom rather than a cause (line 20 – 21) which is further emphasised by also listing it in the symptom list that followed. Presenting the information as a list can add credibility to the information, as this imitates how health-related information tends to be presented in credible sources/websites. This can indirectly increase trustworthiness whilst the added personal experiences position the poster as an expert as well as providing evidence for the health-related information.

Discussion

Whilst crying is a normal behaviour during infancy, it can also be indicative of underlying health conditions. Parents/Caregivers who utilise online discussion forums have fundamental questions about

defining excessive crying to determine 'what is normal?' and when to suspect possible underlying medical cause. They receive advice that presents multiple labels, occasionally contradictory, confusing, or interchangeable (for example 'colic' sometimes falling within a 'medical' label and sometimes 'normal' label). A further discursive psychology analysis of the dataset to address aim 3, determined action-oriented strategies in how personal and shared experiences are utilised in forums, these are to establish membership to a group of parenting a child with excessive crying, establish expertise, and establish credibility in the advice or information provided.

Our thematic analysis demonstrated that there are expectations related to crying and to parenthood in the early days. This could either have come from previous experiences (e.g. their other children) or from expectations of an idealistic parenthood where time with a new-born is anticipated as a 'happy time'. Due to these expectations, it may be harder to distinguish whether or not the excessive crying is normal or a sign of an underlying diagnostic label, and/or emotional consequences of the parent's wellbeing. Infant feeding research to date often focusses on mothers, and in the literature about emerging feeding practices there is a move towards what is being described as unattainable expectations and pressures for motherhood, with an 'intensive mothering' ideology (Locke, 2015; Pedersen, 2016). As shown in this current study, in addition to suggesting labels there were also suggestions of diet changes for the mother or giving up breastfeeding which fits in with an expectation of self-sacrificing identity (Bell, 2004). This contextual and societal pressure can add to the emotional consequences on the parent's wellbeing. This is evident in previous qualitative work has shown how with infant crying there are psychosocial implications on the parent's wellbeing, impacting their relationships and their coping (Muller et al., under review).

The reach for support in forums looking for assurance and validation of the uncertainty around excessive crying is understandable when trying to distinguish what normal crying can be when the expectations are not being met by their reality. Using forums for support has been shown in previous research; suggesting that when searching through forums, sharing fears, experiences, concerns can lead to feeling empowered (Buchanan & Coulson, 2007). Previous work exploring support groups for food allergies found that that social support was important to also empower them to communicate differently with their healthcare providers (HCPs), although they felt they could not discuss with their HCPs the use of these online forums (Coulson & Knibb, 2007). This last point was also supported in a thematic synthesis of qualitative research into how parents/carers seek information online for managing their child's long-term conditions, where parents felt that they were being steered away from help-seeking on the internet despite feeling a sense of community and feeling formed by the online world (Treadgold et al., 2020). This current study highlights that shared experiences provided in the forums are playing an important social role for those caregivers navigating through parenthood and negotiating with others, including their HCPs.

Uncertainty regarding the continuum of crying (determining whether crying is normal) becomes more complex when considering that many of the diagnostic labels have overlapping symptoms. Recent work has shown that these symptoms that are considered guideline-defined for diagnostic labels (such as excessive crying/colic, vomiting) are very common (Vincent et al., 2021). There is also confusion about allergies and/or intolerance where these labels tend to be used interchangeably in forums (Halls et al., 2018). Furthermore, there can be confusion regarding colic as seen in this current study and how colic is defined by the medical field. The medical field defines colic as a diagnostic label that describes prolonged crying in an infant without an underlying cause/condition. Although there were forum posts that referred to this medical definition of colic there was also a tendency to perceive colic as a sign that there is an underlying cause. Other instances, posts used colicky as a descriptor - an established adjective of pain, which may have caused further confusion around colic. In this current study, we were looking at how these labels are being shared and legitimised in everyday language through individual's own knowledge and experiences. These experiences have made these labels more prominent, and as shown in the discursive psychology analysis, sharing these experiences make the advice more credible. Interchangeable labels become an issue if both parties (HCPs and parents/caregivers) are referring to different symptoms, conditions, but often specific labels will link to specific treatments and perceptions. More research is needed to understand within the community, how different caregivers may perceive excessive crying and diagnostic labels.

In research with HCPs about reaching and communicating a diagnosis of other uncertain conditions such as chronic fatigue syndrome, the general practitioners (GPs) described feeling pressured in providing a label for symptoms and claimed that it was helpful for their patients to attach a label to symptoms that cannot be explained (Chew-Graham et al., 2010). It would be vital to explore what is happening in clinic settings with diagnostic labels given to excessive crying. A study examining the pathways to infants' cow's milk allergy (CMA) diagnosis in primary care from the perspective of the GPs and the parents, found that in 49% of the cases parents reported that there was a median of four visits with a HCP before receiving a CMA diagnosis with different expectations and perceptions of CMA in GPs and the parents (Lozinsky et al., 2015). As highlighted in the current study in searches about infants crying, symptom diagnostic tools are pushed to the first five results in the searches of both Google and Bing. Current scoring systems and diagnostic tools for CMA have been developed with substantial input from industry partners with a vested interest in overdiagnosis and can lead to diagnosing up to 40% of infants with CMA (Munblit et al., 2020).

Limitations

Whilst the relative anonymity of the Internet is likely to encourage a sense of openness in which individuals reveal more than they would in a face-to-face research setting, such anonymity means it is not possible to have sociodemographic data on forum participants. Given sociodemographic differences in internet access and use, those who post to forums might differ in from those who do not,

the study sample may not be representative of the wider study population (Holtz et al., 2012). Arguably, those who use online parent forums like those included in this current study are usually thought to be parents/caregivers from higher social economic status and usually mothers (Madge & O'Connor, 2005; Plantin & Daneback, 2009) The findings related to help seeking and communication with healthcare providers (through general practitioners and health visitors) is specific to the UK, however, the issues of overdiagnosis is an international issue (Allen et al., 2022) and the findings regarding concerns and understanding of excessive crying may be relevant to parents and caregivers in western cultures. However, more work is needed to explore the cultural differences and differences in healthcare systems in managing excessive infant crying. The forums have allowed for 'natural data', but this has also meant that we were unable to elicit further data by prompting for meanings and to further explore areas of interest. However, our two-analysis approach may have allowed a deeper understanding of complex interactions and exchange of medical information regarding excessive crying in infants. Despite this, about it is unclear how people who read threads but do not comment (referred to as lurkers in the literature;(Katz, 1998; Nonnecke & Preece, 2001); interpreting and using this medical and diagnostic label information to manage infant crying. Therefore, more work is needed to understand what is happening outside the online world and to find how best parents and caregivers can be supported with evidence-based information around these diagnostic labels and excessive crying.

Conclusions

Overall, this study has shown there is a tension between interpreting what is 'normal' crying and when crying is indicative of an 'underlying problem' which would suggest a search for a diagnostic label. Furthermore, in response to 'infant crying' search terms there are prominent commerciallydriven 'symptom checkers' present that may be adding to this search for diagnostic labels. Responders to posts establish themselves as credible experts and alongside normalising crying and showing empathy, often offer potential diagnostic labels to explain excessive crying and recommend and validate an ongoing drive for the original poster to peruse a label or diagnosis. The uncertainty and at times inaccuracy around these labels and terms that are used interchangeably in forums would suggest there needs further support to parents who are being exposed to these terms and trying to manage excessive crying and expectations of parenthood. More work and support are needed for those embarking in parenthood to manage common symptoms in infants.

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