

Childhood colic management under the optics of mothers and of the family health team

O manejo da cólica infantil sob a ótica materna e da equipe de saúde da família

El manejo del cólico infantil bajo la óptica materna y del Equipo de Salud Familiar

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ABSTRACT

Objective: to unveil the interrelation of childhood colic management by mothers and Family Health Strategy professional. **Methods:** a qualitative, exploratory and descriptive research carried out with 4 Family Health Strategy teams and 31 mothers who experienced childhood colic. Data collection included, respectively, focus group and individual unstructured interview. Symbolic Interactionism was adopted as the theoretical framework, and Narrative Research as methodological. **Results:** two themes emerged: "Colic approach" and "Social support and care". Professional childhood colic management is based on diagnosis and drug interventions. For mothers, the child's suffering and impotence in the face of the disease stand out. **Final considerations:** childhood colic is socially widespread because it is a physiological and self-limiting event. Mothers felt helpless in the face of childhood colic. Professionals felt the need to expand their care, with a view to achieving maternal suffering and alleviating it. **Descriptors:** Colic; Infant; Primary Health Care; Mothers; Health Personnel.

RESUMO

Objetivo: desvelar a inter-relação do manejo da cólica infantil por parte das mães e profissionais da Estratégia Saúde da Família. **Métodos:** pesquisa qualitativa, exploratória e descritiva, realizada com 4 equipes da Estratégia Saúde da Família e 31 mães que vivenciavam a cólica infantil. As coletas de dados incluíram, respectivamente, grupo focal e entrevista não estruturada individual. Adotou-se como referencial teórico o Interacionismo Simbólico e, como metodológico, a Pesquisa de Narrativa. **Resultados:** emergiram dois temas: "Abordagem da cólica" e "Apoio social e cuidado". O manejo profissional da cólica infantil sustenta-se em diagnóstico e intervenções medicamentosas. Para as mães, sobressai o sofrimento do filho e sua impotência diante deste. **Considerações finais:** a cólica infantil é socialmente difundida por ser um evento fisiológico e autolimitado. As mães sentiram-se desamparadas no enfrentamento da cólica infantil. Os profissionais sentiram a necessidade de ampliarem seu cuidado, com vistas a alcançar o sofrimento materno e amenizá-lo.

Descritores: Cólica; Lactente; Atenção Primária à Saúde; Mães; Pessoal de Saúde.

RESUMEN

Objetivo: revelar la interrelación del manejo del cólico infantil por parte de madres y profesionales de la Estrategia de Salud Familiar. **Métodos:** investigación cualitativa, exploratoria y descriptiva, realizada con 4 equipos de la Estrategia de Salud Familiar y 31 madres que experimentaron cólico infantil. Las recopilaciones de datos incluyeron, respectivamente, grupos focales y entrevistas individuales no estructuradas. El interaccionismo simbólico se adoptó como marco teórico y, como investigación metodológica, narrativa. **Resultados:** surgieron dos temas: "enfoque cólico" y "apoyo y atención social". El manejo profesional del cólico infantil se basa en el diagnóstico y las intervenciones farmacológicas. Para las madres, se destaca el sufrimiento y la impotencia del niño frente al niño. **Consideraciones finales:** el cólico infantil está muy extendido socialmente porque es un evento fisiológico y autolimitado. Las madres se sentían impotentes ante el cólico infantil. Los profesionales sintieron la necesidad de expandir su atención, con miras a lograr el sufrimiento materno y aliviarlo.

Descriptor: Cólico; Lactante; Atención Primaria de Salud; Madres; Personal Salud.

INTRODUCTION

The Family Health Strategy (FHS) takes family and teamwork as central elements of its care actions, with a commitment to humanization and integrality of care⁽¹⁾. The health professionals' work that compose it has as essential aspects the relationships and collaboration among themselves and with those who seek care⁽¹⁻²⁾.

In caring for children and their families, childhood colic is among the most common complaints⁽³⁾. It appears around the second week after birth⁽³⁻⁴⁾ and persists until the third month of life⁽⁴⁾, with a prevalence of between 3.0% and 73.0% of infants⁽⁵⁾.

According to nursing literature, childhood colic is the presence of paroxysms of irritability, agitation, nervousness and crying in children younger than three months. Crying starts at dusk, lasting three hours or more per day, occurring for more than three days and for up to more than three weeks⁽⁶⁾.

This type of complaint brings important developments on family dynamics, especially in the interaction between parents and children⁽⁴⁾; family and social life⁽⁷⁾; child care⁽⁷⁾; and with other children⁽⁷⁾. Colic brings great concerns to parents⁽⁸⁾, with negative feelings such as incompetence and impotence⁽⁷⁾, insecurity⁽⁷⁾, anxiety, and anguish⁽⁶⁾. Such feelings and experiences impact on childhood colic management by parents, both in the present and in the future, in a negative and intense manner⁽³⁾.

Although it is a frequent clinical condition, there is little scientific evidence that clearly defines the etiology, pathogenesis and specific treatment of this condition⁽⁹⁾. Professional practices are characterized by offering guidelines focused on complaints⁽⁷⁾, which often results in negative impacts on the quality of care offered to parents⁽⁷⁻⁸⁾. This knowledge gap promoted the interest in studying childhood colic management by FHS professionals and mothers.

Considering the above, the question is "How does the complaint take place and childhood colic management in the FHS from the perspective of mothers and health professionals? What are the dissonances and consonances that exist in colic management by professionals and mothers?"

OBJECTIVE

To unveil the interrelation of childhood colic management by mothers and FHS professionals.

METHODS

Ethical aspects

The Research Ethics Committee of human beings approved the study. All participants signed a consent form.

In order to maintain identity confidentiality, the professionals' speeches are identified by their category followed by an alphabetical letter (A, B, C or D) that corresponds to the FHS team that belongs, for instance, "physician A". To identify the speeches of mothers, letter "M" was used followed by a number corresponding to the order of its insertion in the research, for instance, "M6". Grammatical corrections were made with attention to not changing the meaning and content exposed.

Theoretical-methodological framework

The study adopted Symbolic Interactionism⁽¹⁰⁾ as a theoretical framework, as it involves the meanings and actions of social subjects in childhood colic management.

Type of study

This is an exploratory, descriptive and qualitative research. It should be noted that the domains of Consolidated Criteria for Reporting Qualitative Research (COREQ) referring to the research and reflexivity team, study design, analysis and results were followed in this study⁽¹¹⁾.

Methodological procedures

After the Municipal Department of Health's assignment regarding the place to be developed the study, the first author addressed nurses in charge of each FHS unit to present the objectives of the study and the methodological outlining. It was agreed that nurses would present the proposal in a team meeting to give feedback on the acceptance of participation.

The Municipal Department of Health assigned the Regional Health Administration (ARES) to develop the study, with the justification that this was the one that had the largest number of health professionals who articulate Maternal and Child Health in the municipality.

ARES had four FHS, each of which had a team composed of six community health agents (CHA), one nurse, two nursing assistants, one physician, one dentist and one dental assistant.

Professionals part of the health team linked to the FHS assigned and over 18 years old have been included in the study. Professionals unavailable to participate in the focus group on the established date have been excluded.

Considering the acceptance of participation, each team was asked to survey 10 mothers who were enrolled in the FHS unit assigned for the study, who were over 18 years old, and who had experienced or are experiencing childhood colic with the biological child born at term. Mothers who were not able to communicate and/or express themselves in an understandable way, who cared for childhood colic linked to children with congenital or genetic morbidity, and who had twins have been excluded.

It is noteworthy that of the 4 FHS, only 1 claimed that, in its area of coverage, there was only 1 mother who met the study criteria. The others assigned the number of mothers requested.

The interviewers stated their assumptions and personal interests in the research topic as well as the importance of this research for childhood colic care advancement.

Study setting

This study was carried out in a city in the countryside of São Paulo State, with a population of 221,950,000 inhabitants and a municipal human development index of 0.805⁽¹²⁾. Health in this municipality is organized into five ARES and in all there are FHS.

Collection and organization of data

To understand the mothers' perspective, individual unstructured interview was used, because it offered freedom in formulating

questions and intervention of the interviewer in the process of interaction established with the interviewee, with a view to understanding the phenomenon in focus⁽¹³⁾. Furthermore, interviews explore the experiences of participants and the meanings attributed to the object under study.

It was used as a triggering question "How do you or did you care(d) for the colic of (child name)?" Throughout her narrative, other questions were presented in order to make the elements exposed denser.

Thirty-one individual interviews were conducted with the mothers identified by FHS teams in their homes, lasting approximately 30 to 60 minutes. The main researcher through telephone contact scheduled the best day and time to take place the interview. It is noteworthy that there was no pilot interview or withdrawal. Around the 16th interview, there were indications of saturation point reaching, as it was identified repetition of information about the experience in childhood colic management, without adding other relevant ones, with possibilities of descriptions and articulations between the information offered⁽¹⁴⁾.

However, the researchers decided to continue the interviews until the number of mothers that had been raised by the professionals ceased. This decision was based on respect for the support offered by these individuals and on the commitment to mothers who had shown interest when contacted.

Regarding professionals, data collection strategy was focus group, in which information was obtained from structuring a collective conversation, in which participants expressed their perceptions, beliefs, values, attitudes, and social representations about childhood colic care. Focus groups are used to explore views on health issues, interventions, and research⁽¹⁵⁾.

It was adopted as a triggering element "How do you care for the child who experiences childhood colic?". Throughout the statements, questions and placements were asked to favor exploration, clarification and expansion of exposed aspects, aligning with the explicit use of interaction for producing data⁽¹³⁾.

Four focus groups were conducted, one with each FHS team, with an average duration of 90 minutes, in the unit on the day and time established for the team meeting. In total, 39 health professionals participated, accounting for the participation of the four focus groups.

Individual interviews and focus groups were developed from February to October 2014 by the main author followed by collaborators. They were five Nursing Graduate Program students and one undergraduate nursing student, who received relevant previous information about the study (objective, research question, and methods) and guidance on the activities that would be performed. It is worth mentioning that all collaborators were aware of the theoretical and methodological framework adopted in this research.

Individual interviews and focus groups were recorded in audio, transcribed in full and submitted to the analytical process of narrative research⁽¹⁶⁾. This choice was based on the fact that the reference favors apprehension of significant elements of interactional experiences and understanding of stories.

Analysis of data

Analysis of data was conducted by the main author separately, i.e., the mothers' interviews were analyzed and then the focus

groups were analyzed using the methodological framework adopted, thus emerging the themes of the narratives.

Based on the themes emerged, both in the interviews and in the focus groups, assessment was made in terms of similarity and articulation through a deductive and inductive process that included interpretation and integration, allowing, finally, unifying the themes.

RESULTS

Characterization of participants

The profile of the 31 mothers interviewed is characterized by the age group from 20 to 35 years old; mainly with one child (n=20, which is equivalent to 64.5%); and with complete high school (n=15, which is equivalent to 48.4%). It is worth mentioning that of the 15, four (26.7%) had incomplete higher education.

Regarding the 39 health professionals, characterization allowed identifying age ranging from 30 to 61 years old and predominance of females, with n=37 (94.8%). In terms of profession, this population included twenty-two (56.4%) CHA; five (12.8%) nursing assistants; three (7.6%) dental assistants; three (7.6%) dentists; three (7.6%) nurses; and three (7.6%) physicians. In relation to the number of children, this data ranged from zero to four, with sixteen (41%) with two children.

Childhood colic management

FHS professionals turn to the diagnosis of childhood colic and anchor their interventions especially in medicalization practices. For mothers, the child's suffering and their impotence before the disease stands out, an aspect not welcomed in professional care. The themes "Colic approach" and "Social support and care" portray the interrelationship of childhood colic management by mothers and FHS health professionals.

Colic approach

Childhood colic is interpreted and signified by mothers and professionals as a physiological phenomenon common to babies and related to gastrointestinal system immaturity and swallowing of air in feedings. Moreover, they point to its occurrence at the end of the day and identify it through the presence of inconsolable crying and manifestations suggestive of pain and discomfort, especially twisted leg movements, pondering intensity, repetition and association of signs.

Like innervation, the gastrointestinal system is not fully formed; there are some dysfunctions of stimulation, of involuntary contractions in relation to peristalsis, that cause this discomfort and that we translate as colic, right? Colic has a period to appear, which is in the late afternoon, until about nine at night. (Physician C)

The intestine is being formed, so there are gases accumulating there, and this stretches the tummy, it becomes swollen and has abdominal contractions, and it hurts. (M4)

You think of colic when mothers talk about the twisted body and leg movements with intense and inconsolable crying. (Nurse A)

Because he twisted his whole body and kept crying. So, therefore, I realized that it was a little pain from colic [...] he twisted his legs, stretched his legs too. (M15)

Professionals seek differential diagnosis of colic by comparing the situation with signs of pathological situations common to the infant and/or discomfort stemming from non-satisfaction of the child's needs.

When children are in pain and are crying too much, first we have to see if they have a dirty diaper, or if they are bothered by something, or if they have a diaper rash, or any changes, changes in the urine and all. If they are hungry, breastfeed them. If they do not breastfeed and continue to cry, after seeing all this you will see their tummy, as it may be colic. (Physician A)

When colic is diagnosed, the interventions performed by mothers and health professionals are focused on the child's comfort. Maternal approach is to alleviate the child's suffering, while for most of professionals, it is in alleviating the children's suffering and commending the mothers' complaints. Professionals seek to pass on to mothers their own experiences with childhood colic, aiming to promote support and help for management; and this act of sharing was pointed out as contributing and expanding bonding in this process.

When I see my son in this situation of suffering, with colic, I want to get rid of this pain as soon as possible, I try to seek things that alleviate. It gives me pain too. (M26)

If the mother says she has colic, we have to attend and almost always the medicine is necessary. Therefore, I agree with the physician. (CHA D)

I try to calm the mother down, clarify for her about everything she will go through, the phases she will have, and if it is very unusual, she will come back to talk. (Nursing Assistant A)

I didn't eat chocolate or soda, I just drank chamomile tea, I ate toast. I didn't eat cheese, beans, I really avoided, you know? I don't know if it was a coincidence, the colic was quiet; and I pass this information on to them. They like to listen, we get closer and talk more, you become a reference for the mother in childhood colic. (Dentist B)

However, due to the focus limited to childhood colic complaint, most professionals immediately choose to institute drug therapy, justifying that would minimize the return to the unit, a fact signaled as commonplace and that brings discomfort to the team.

They [mothers] come four, five times saying "Oh, this medicine is useless, I want another." I say that colic will continue until the three months, and I say "You will have to be patient!". I always give a remedy to prevent them from coming back [for medical consultation]. (Physician B)

The professionals verbalized that they feel a lack of directions and conclusive scientific protocols to act. Furthermore, they are afraid to indicate inappropriate non-drug conduct and become discredited. However, they do not actively engage in searching for information or face-to-face updates in scientific environment. Among those who associate other therapeutic strategies with

medications, there are some who do so with some disbelief, especially because the pediatrician already offers, in advance, at discharge from maternity, a prescription of antispasmodic.

I focus more on the issue of the leg, massage, doing an exercise to lie down to release gas, warm up the tummy with massage, I follow that line [...] it would be good to have assistance protocols, it gives more security. (Dentist B)

I feel poorly informed. Really, what to do? What is really standardized? I search the internet for some things, but I'll be honest, I have read little about this subject [colic]. (Nurse S)

The child already leaves the maternity hospital with medication prescription, already leaves with Luftal[®], Simeticona[®], without being necessary. Everything is already prescribed, and to discard this and guide other techniques, it is difficult. (Physician B)

There is also herbal and/or homeopathic prescription and, when childhood colic is not relieved with these, they choose to use allopathic medications, especially analgesics.

If considering that it is only abdominal colic or irritability, or even this not complete development in relation to gastrointestinal innervation, I usually use herbal or homeopathic medicines for children. So, sometimes I use "funchicórea" or chamomile tea for the child [...] all of this solves a lot, most help the mother a lot. If it still doesn't work out, we use a paracetamol type of pain reliever to help with discomfort. But, in general, it ends up solving, right? There is no problem. (Physician C)

Mothers revealed wide use of non-drug and drug therapy combination, mainly because they meant it as an effective and problem-solving measure.

I use Luftal[®] to eliminate gases; along with massage and warm cloth, it also helps a lot. So, it is a set of these things, because if you do only one, do only the massage, without giving the medication, it will not solve the problem. If you only give the medication and don't do massage, a warm cloth doesn't solve it either. (M12)

The non-drug therapies mentioned by mothers and professionals were similar such as leg movements, massage, breast supply, use of tea and heat in the abdomen. They also add Dr. Karp's technique as a strategy for relaxation and reduction of crying, learned from individuals who integrate their support networks.

Now, what resolved was Dr. Karp's technique, he [physician] says that it is a reflex of calming the baby and that was what saved me [...] when I found out, it was much better, he still had colic, but he calmed down a lot using these technical steps and it made me sleep. And he also slept more peacefully. (M27)

I advise to massage, warm the baby's tummy, put the baby face down on the arm and swing. (Nurse C)

Social support and care

Both mothers and professionals recognize the influence of the support network in childhood colic management. In this sense, professionals, in childcare consultations, seek to include family

members, especially parents and grandparents, envisioning that their orientations impact on child care, especially minimizing popular practices conceived by them as inappropriate such as the use of teas.

I try to deal with calling family members to go to consultation together, bringing the child. It is not only the mother, it is the father in a consultation, it is the grandmother in another [...] so that we can cover the information unifying the information in every way, everyone is trying to help that mother. Tea appears a lot, it is difficult. (Physician A)

I called my father, his grandfather [son], and I said "oh, he was very ill tonight. A lot of colic!" I went to my father, and we ended up calling our parents. (M11)

Over time, mothers go into emotional exhaustion, especially because of the responsibilities they assume to be theirs, such as the child's nurturing. Due to the son's inconsolable crying and powerlessness to cease it, they are overcome by irritation and nervousness, feelings that give rise to guilt. They were warned about the influence of their emotional states on colic and yet they lost control. For this reason, they feel privileged when they receive help from their husbands in caring for their child. Parents give massages, walk and put the baby on their lap and place it on their abdomen as a way to offer warmth and relieve colic. The mothers reported that, due to the lack of resolution in care management, parents feel distressed, insecure, and helpless.

We get worried, tired, we don't sleep at night... [the son] is crying, he gets a little angrier, you too, without patience even with him. (M22)

Terrible! Because I don't want to see my son suffering, I don't want to see him crying, I was nervous and people said "You can't! If you are nervous, he is too." Then you try to deal with it and get around it, but it is very sad. A great concern without having anyone with you. (M30)

And my husband says "let me get him and calm him down, because I'm already distressed to see you walking with him back and forth." When it doesn't work, it looks bad too, just like me. (M6)

Tiredness, right? Sometimes, you are so tired that it creates absurd stress [...] so, sometimes, you have to share your lap a little, share, because I saw that I was not in this situation alone. I like it when my husband helps, it is a time of peace. (M29)

The maternal desire is to continually resort to the physician to have the complaint of colic received, but because they mean that this action is inadequate, it is expected to expose her in the routine consultation. Moreover, health professionals were not appointed as members of the support network and have as a limit a relationship marked by gaps in meeting maternal needs to be comforted and calmed.

Going to the physician just to ask what we do when she has colic doesn't work, right!? You are afraid of disturbing [...] then I only speak at consultation. (M21)

What I really wanted was for them [FHS professionals] to talk to me more, to calm me down. Only, for them, colic is rice and beans, they don't even care. They give medicine and that's it. (M2)

Faced with the insecurity about professional recommendations and reflections on care, when they think they have experienced lack of interest and importance of their complaints, they use internet and support network to reassure themselves, seeking information and deciding how they will act. It is worth mentioning that they mean as sources of support the child's grandmother, the neighbors, the internet and God, to whom they attribute the search for comfort and strengthening.

It is a feeling that, until then, had not passed, you really despair! I wanted to do something, I didn't know what I had to do, so I looked for things on websites to get my son out of this situation, but it's hopeless, it's a feeling of incapacity. The professionals do not give the necessary attention and you are only heard with more attention by the people [professionals and support network] who have experienced this, just for them. (M11)

It's horrible, there are times when you want to cry with him, you want to cry out of despair. (M3)

So, I looked on the internet [...] many times I asked God for help to calm me down so I could take care of her; and I tried to be as calm as possible. (M19)

DISCUSSION

The analyses reveal, in general, that both mothers and health professionals come from previous knowledge to perform childhood colic management and put them at stake to achieve the relief of this problem. However, actions and strategies understood as effective end up being reanalyzed and given a new meaning with each new appearance of colic, new medical consultation, or even due to interaction with other social actors, such as family members and different health professionals, which bring new informational elements. Thus, it is affirmed that deciding for a care action is based on analysis of "I", "me" and "other".

This whole process culminates in maternal suffering, referred by the participants, in the face of difficulty treating colic effectively, with consequent cessation of the child's crying and suffering. Such findings are corroborated in a study with the newborn that points to colic as a difficulty in newborn care, reinforcing the uncertain situation in terms of scientific evidence related to management and treatment⁽¹⁷⁾.

As for health professionals, it was evidenced that they anchor their practices in understanding whether childhood colic is a physiological disorder common to the baby, with insufficient listening to other issues that concern them, especially the maternal anguish of not seeing the pain of their child be resolved.

When childhood colic complaint arose in the FHS studied, the physician was the desired professional, both by the mothers and by the other FHS members, mainly because they meant it as a reference for guidance and conduct. The physician, in many moments, prioritized medicalization, with little regard to other therapies, a behavior that was repeated among private pediatricians.

Disease care, with a biological and reductionist view, is a reflection of the Flexnerian model, the result of a report published in 1910. Despite the benefits caused at the time, this document

reverberated negatively in the professional-client relationship, so that the change of this status quo is a challenge for Primary Health Care⁽¹⁸⁻¹⁹⁾.

Medicalization leads and limits an understanding that where there is a disease there is always a remedy, in order to transfigure sufferings and complaints into diseases and needs of medical and medicalized interventions⁽²⁰⁾.

However, this reality is not unanimous worldwide. This statement is supported by a study developed in the Middle East and north Africa, which demonstrated that physicians prioritize as a strategy to promote the tranquility of parents. Other actions are related to breastfeeding and the use of formulas, as well as natural therapies⁽²¹⁾.

Both popular practices, such as the use of tea and faith, and massages are present in the cultural context of the mothers participating in this research and are meant by them as strategies capable of controlling childhood colic, which implies the integration into child care. Regarding nursing literature, it is possible to find the recognition of popular practices⁽²²⁻²³⁾ and note the contribution of massages for colic relief⁽²⁴⁻²⁵⁾. Considering that the latter has as another positive implication the reduction of the use of medications⁽²⁵⁾, it is awakened to the fact that professionals could recommend it more frequently, in order to contribute to its dissemination and adherence by mothers and family members.

Also, in this context of non-allopathic practices, homeopathy prescription by one of the participating physicians was observed in the study. According to a randomized multicenter study comparing a homeopathic compound with an allopathic compound, the former was considered safe and effective in relieving colic⁽²⁶⁾.

There was also mention of Dr. Karp's technique by some mothers. This is treated in literature as a resource in childhood colic management⁽²⁷⁾, with the suggestion that further studies be delineated to expand the evidence about its adoption. It is the execution of 5 S's, i.e., Swaddling (wrapping the baby in a blanket simulating the position and comfort in the womb); Shushing (emission of wheezing sounds, with the intention of approaching the sound heard in the womb by the fetus); Swinging (offering a swing to the baby on your lap); Sucking (giving the baby the opportunity to suck); Side/stomach position (positioning the child in lateral or ventral decubitus)⁽²⁷⁾.

Therefore, it is noteworthy that popular practices can be expanded in professional childhood colic management, with chances of favoring a singular and culturally respectful care⁽²³⁾. In this direction, to rescue the dialogue between health professionals, users and families is essential⁽²⁸⁾, since it is through it that approximations between popular knowledge and scientific knowledge can happen and effect reconstruction of health practices⁽²⁸⁻²⁹⁾ through a listening that welcomes and promotes comprehensive care⁽²⁹⁾.

The principle of integrality is put to practices in the FHS as well as disruption with the biomedical model, verticalized and centered on the biological⁽³⁰⁾. Therefore, it is relevant to review the place of bonding, active listening, expanded clinical and interdisciplinary work in health practices⁽³⁰⁾, very lacunar aspect in childhood colic management.

Health professionals need to commit to dialogues⁽³⁰⁾, especially in situations that promote suffering and vulnerabilities as revealed

to be childhood colic⁽⁸⁾. It is also noteworthy the need to pay attention to the particularities of the socioeconomic conditions of users and families, since they lead to integrality and humanization⁽³⁰⁾. To do so, professionals and users need to overcome the distancing and implement partnerships⁽³¹⁾ as well as promote the education of parents for safe childhood colic management⁽³²⁾.

Another important issue was the place of the male in child care. The role of father is undergoing changes in today's society, because he is willing and calls for collaboration in child care⁽³³⁾, a fact identified here and that should have the professional's attention, since mothers interpret them as a strong source of support. This involvement contributes to constructing a more intimate relationship; therefore, support actions to families with inclusion of the figure of the father are so necessary, with the change in the conception that child care is an exclusive act of women⁽³³⁾.

Mismatches and consequent helplessness are characteristic of childhood colic management in the context studied. Thus, including dialogue, popular knowledge, male, collaborative interprofessional work and co-responsibility in FHS health practices are unveiled needs and, at the same time, a path to comprehensive and quality care, mainly because it allows better interaction and understanding between the social actors involved, besides providing new opportunities for reinterpretations of care. Primary Health Care takes welcoming and humanization in care as one of its mottos, when bond building and qualified listening are the first steps⁽³¹⁾.

Finally, the lack of concrete and quality scientific evidence for colic management was verbalized by the professionals. The internet is a means used by mothers to search for solutions for childhood colic management. It is known that producing information on the Internet has had a high growth and dissemination. However, in some virtual spaces, information lacks reliability and security⁽³⁴⁾. Attention to these points is highlighted as part of the role of professionals, who should guide parents on the choice of reliable sources to search for information⁽³⁴⁾.

Study limitations

The limitation of this study is the occurrence in a single setting with demonstration of a single reality, in this case, the municipality of São Carlos. It is added the non-apprehension of the perception of other individuals involved in childhood colic management such as father and grandparents.

Contributions to nursing

This study contributes to promote critical reflection about the practices of FHS health teams in childhood colic management, when it points out the scope of intersubjectivity and dialogue as essential for the establishment of positive relationships between professionals and mothers/family members. Positive relationships are understood as those characterized as promoters of trust, security, and bond.

Even with a broad view, aimed at the FHS professionals, it is possible to make contributions about the performance of nurses. Considering the expertise and responsibility in articulating actions that care for the needs of mothers and children, they could have occupied a more evident and reference position in childhood colic care cases.

FINAL CONSIDERATIONS

The socially widespread meaning of childhood colic being a physiological and self-limited event, associated with the medicalization of health practices, restricted listening and the expanded clinic, with repercussions on welcoming, humanization and comprehensive care in childhood colic management. Mothers felt helpless in colic management and showed suffering due to difficulty promoting comfort to their child.

This study has the differential of simultaneously understanding the perspective of health professionals and mothers, unveiling

consonances and dissonances between them in childhood colic management. It points out to professionals the need to expand their care, with a view to achieving maternal suffering and to alleviate it. This movement may reveal therapies beyond drugs, identified as central and almost exclusive by professionals, since few were those who bet on alternative practices.

It is suggested that further studies be outlined, with greater territorial scope and with inclusion of other social actors such as parents and grandparents. Childhood colic is a frequent complaint in childcare and still lacks reflections regarding its reception in Primary Health Care health practices.

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