

CONSTITUTION OF THE EXPERIENCE OF MOTHERHOOD AND INFANT DEVELOPMENT RISK

Constituição da experiência da maternidade e risco ao desenvolvimento infantil

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ABSTRACT

Purposes: to analyze the possible relation between difficulty on maternal experience constitution and the presence of developmental risk indexes, as well the interference of psychosocial and obstetric variables in this aspects. **Methods:** the quantitative descriptive type, comparative casual about behavioral manifestations of the mother-baby interactive process. The sample was made up of 182 moms and their babies, these born in term or pre-term, in a University Hospital in the central region of Rio Grande do Sul, whose babies spent/passed by neonatal hearing screening in the period from March to June 2010. It was held an interview, applied protocol IRDIs and filmed the dyad interaction. **Results:** showed that difficulties on maternal experience constitution were statistical correlated with the presence of developmental risks. The psychosocial and obstetric variables didn't influence this correlation. **Conclusions:** systematize highlight that the difficulties in the constitution of the experience of motherhood have serious risk of factors for the emergence of risk indicators for child development, because behavioral alterations in the people who exercise the maternal function reflected on the initial proto conversation of the mother-child dyad, what may created the risk for the child development in general, and for child language acquisition in a specific way.

KEYWORDS: Communication; Child Psychology; Anxiety; Mother-Child Relations

■ INTRODUCTION

Caring for a child takes energy, affection and attention. The mother needs to be psychologically available to convey affection and upbringing, which implies an emotional parenting involvement for the child to develop in a more self-assured way¹. If the mother is having any emotional symptoms, it can lead to consequences for the development of the child, as demonstrated by a cohort study in the Norwegian public health services. Conducted with 900 families, this study stated that children subjected to an environment of stress and anguish are more vulnerable to developing emotional problems in the future².

This possibly occurs due to the reflection of the maternal emotional state on the mother's responsiveness to the child's demands. The maternal responsiveness is characterized by maternal behaviors contingent, appropriate and immediately related to the behavior of the child, such as synchrony, reciprocity in the responses, the repetition of the sequences of games, the focus of mutual attention and sharing of affective states. She suffers from multiple influences and must be understood in a wide reference system involving biological and contextual variables of the history of the dyad, as well as broader cultural aspects³. A study of 21 mother-infant dyads revealed this multiplicity by comparing the responsiveness from seven single mothers and fourteen married ones, which demonstrated greater responsiveness from married mothers with regard to crying babies and vocalization. These results support the theory that indicates that single mothers may experience more stress when they need to meet the demands of the

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babies by themselves, especially in their first year of life⁴. Therefore, not only the maternal position is important in the relationship between mother and baby, but also the spousal support, which generally occupies the paternal position.

Children who experience a dysfunctional mother-child relationship can manifest diminished affective responses, difficulties in socializing with strangers, sleep disturbances, exacerbated separation anxiety, gastrointestinal disorders, lack of appetite or constant episodes of vomiting⁵, as well as difficulties in the acquisition and development the language⁶.

Researches say that the baby imagined during pregnancy has an important impact on the future mother-infant interaction, because the mother invests her libido in order to constitute a subjective space to receive the reality baby. It is necessary, therefore, to also examine the baby's condition at birth, its symbolic appetite, this one conceptualized as an innate drive to seek another human being, and the possibility of this having an effect on maternal responses^{7,8}. It is known that the baby undergoes significant changes in the first few months, such as the emergence of social smile, a form of intentional communication, based on the first intersubjective interactions with adults that have effects on social cognition and language acquisition⁷. These characteristics of the babies combine in a unique and complex way with the possibilities of the adult to care for and interact, in different styles, anchored in various cultural bases^{9,10}.

These theoretical observations allow us to understand the enormous importance of setting and meeting basic relationships, the possibility of a baby having for itself an *engaged mother* and symbolically having appetite. This will be reflected in a protoconversation in the first years of life. The protoconversation is characterized by the dialogue in which the adult speaker holds the baby while enunciating, not yet speaking, by offering senses to the baby's bodily manifestations (vocalizations, crying, smiling, babbling, bodily gestures, gaze). The "momish"⁶ is an evidence of this initial protoconversation^{10,11}. When this protoconversation does not occur satisfactorily, there is the possibility of the baby presenting psychological or development risks¹¹. The psychological risk is defined as the presence of signs of psychological distress evidenced in noisy series (inconsolableness, sleep disorders such as not sleeping well, eating disorders, etc.) or in silent series (sleeping all the time, not showing any initiative to interact with others, etc.), which directly affect the psychic structure. As for the risk to the development, it relates to the effects of the baby 's psychological risks or biological changes in other structural aspects such as cognition and in

instrumental aspects of the development, such as the psychomotor aspect and language as a communicative function^{11,12}.

A Brazilian multicenter study, with psychoanalytic theoretical bases, showed that 18 indicators, proposed for children up to 18 months, and investigated in a cohort study of 1-36 month-old children, allowed to predict risks to child development, and some were more specific to predict psychic risk¹². This research investigated sociodemographic, obstetric and psychosocial variables, as well as specific aspects of child development. The outcome of this research was given by the psychoanalytic and psychiatric assessment of children aged three. The research makes clear that the analysis of the risk indices to child development (IRDIs) occurs in the observation of the relationship between those who exercise parental functions and the baby. The interactional focus, adopted in the indices mentioned, allows for the hypothesis of this research that the analysis of the IRDIs could reflect problems in the baby's symbolic appetite and the presence of difficulties in setting up the experience of motherhood. These difficulties may relate to changed maternal emotional states¹³⁻¹⁵, or the difficulty of imagining the maternal role, among other elements that can interfere with this establishment^{7,9,16,17}.

Considering these aspects highlighted in previous research, this study aims to analyze the association between the difficulty in setting up the experience of motherhood and the presence of risk indices to child development, as well as interference or not of socioeconomic, demographic, obstetric and psychosocial variables, in the studied association.

■ METHODS

This study was approved by the institutional ethics committee under number CAAE 0284.0.243.000-09, of Universidade Federal de Santa Maria – RS.

This research is of a descriptive quantitative type, with a comparative casual character on the behavioral manifestations of the mother-infant interactive process¹⁸. The sample consisted of 182 mothers and their babies, these born at term or preterm, at a university hospital in the central area of the Brazilian southern state of Rio Grande do Sul, whose babies passed by the neonatal hearing screening in the period March-June 2010. The calculation of this sample was made using as a basis the average annual attendance of 900 babies in neonatal hearing screening and the prevalence of maternal emotional states such as anxiety and/or depression, estimated at 15% in various studies of the Brazilian reality, which could explain, at least in part, the difficulties in setting up the experience of

motherhood. Studies of the prevalence of difficulties in setting up the experience of motherhood in the Brazilian and international reality were not found.

Babies born with malformations or syndromes and hearing loss were excluded from the study due to the commitment that these factors lead to the development of children and also babies whose mothers had a very compromised psychic structure, such as psychosis, etc.

According to the Regulatory Guidelines and Standards for Human Research (Resolution 196/96 of the National Health Council), mothers were contacted at the neonatal hearing screening service and invited to participate in the research. They were informed about the objectives and procedures of the research and, after reading the Statement of Free and Informed Consent, they signed it as volunteers.

Data collection was performed by the psychologist/researcher in a room set aside for this purpose, in the hospital itself, for approximately 30 minutes, through a semi-structured interview about the experience of motherhood, developed and standardized by Schwengber and Piccinini¹⁸. This interview aims to investigate the obstetric history of mothers and get the socioeconomic, demographic, obstetric and psychosocial data. During the interview, the psychologist/researcher identified the need to exclude or not the dyad from the observation of the mother's psychic commitment and/or the baby's evident biological limit.

Socioeconomic variables were family income, education and profession. The demographic variables were age, marital status and number of children. Obstetric variables were the number of pregnancies, number of parturitions, history of miscarriage, preterm delivery, mode of delivery, number of prenatal consultations, planning of the pregnancy, low birth weight, complications in newborns and type of breast-feeding. Psychosocial variables were social support, history of mental illness in the family and difficulty in the formation of the maternal experience.

The data obtained in this interview was coded and a database was built in a spreadsheet (Excel). Among them, a coding for the presence or absence of difficulty in the establishment of maternal experience (DCEM) was created. This data was assessed from two open questions present in the interview protocol, which were: if there was a history of mental illness in the family (family of the mother, of the husband or someone close), and if the mother was going through some situational crisis, i.e., if there were any family or personal problems, at the time, that generated feelings and difficulties in relation to maternity. The answers to these questions were recorded during the interview, and

coded as presence or absence of difficulty, without measuring its severity or lack thereof. To encode the presence of difficulty in the establishment of maternal experience, it was observed in the interview: lack of handling the baby, feeling of inability to care for them, excessive fatigue, hopelessness, apathy, tension and irritability, as well as family conflicts (the mother-in-law wants to separate, the husband was arrested, difficulty in relationships with parents), and even marital conflict (constant bickering with the husband, recent separation, the husband is depressed). On the other hand, the coding for the lack of difficulty was identified in the interview, in which mothers showed good interaction with the baby, had good social support, had no history of mental illness in the family nor evident situational crisis.

As babies assessed were at ages 0-4 months, the five risk indices of the first phase of the initial IRDIs were observed in the interaction between mother and baby. In the absence of an index in the interaction with the mother, it was tested with the researcher, especially index 3, which deals with the child reaction to "momish". The five indices analyzed were:

1 – **When the child cries or screams, the mother knows what she wants.** This index was observed from situations in which the mother assumed the baby wanted something and she could assign a possible interpretation to this demand, e.g., eating, sleeping, changing positions, etc.

2 – **The mother talks to the child in a style particularly directed to it (momish).** Here the interaction between mother and child was analyzed in terms of harmony, not only if the mother spoke in momish, but if her speech was attuned to the baby's productions.

3 – **The child reacts to the momish.** In this item it was observed if the child engaged in protoconversation, and especially if such participation was actively sought. As some mothers, depending on the depressive and/or anxious emotional states, were unable to talk to their children in such an attuned way, the researcher tried to do that with the babies and analyze such a response when it occurred.

4 – **The mother offers something to children and awaits its reaction.** Here the mother's capacity for waiting for the child's response was observed, i.e., of giving it a chance during the protoconversation.

5 – **There is exchange of glances between the child and the mother.** This item was observed only with the mother during the times of protoconversation and/or silent exchanges between mother and baby.

The methodology of this study followed the IRDIs marks of the multicenter survey of risk factors

for the child development¹¹, which consists of the annotation of the presence of the index as absence of risk to development, or in its absence, as an indicator of the presence of risk. The presence of psychological risk was considered only when the five indices of the phase were jointly absent, as provides the mentioned multicenter survey.

It is worth noticing that the indices were observed during the interview with the mother and soon thereafter. Then, a brief interaction of the mother with the baby was filmed for 10 minutes. This film was made at a distance so as to interfere as little as possible in the dyadic relation. The instruction given to mothers is that they talked and/or played with their babies as they did at home. The purpose of this was to record the interaction so that there was a second assessment of the five indexes by another experienced reviewer. As some babies were sleeping during and after the interview, within a week reassessment of the indices in their home was sought. Therefore, all risk indices were checked until a (present or absent) value for each could be obtained.

The quantitative data analysis was performed using descriptive and inferential statistics. The non-parametric test of independence of chi-square with a significance level of 5% was used. These analyses were performed using the *Statistica 9.0* computer package.

■ RESULTS

Table 1 shows the frequencies of absence and presence of the Difficulty In The Establishment Of Maternal Experience (DCEM).

Table 1 – Frequency of absence and presence of difficulty in the formation of the maternal experience

DCEM	f (%)
No	116(63,7)
Yes	66(36,3)
Total	182(100,0)

Caption: DCEM - Difficulty in the Formation of the Maternal Experience

It is observed in Table 1 that 36.3% of mothers had some difficulty in maternal role.

The levels of risk for the child development are shown in Table 2.

Table 2 – Percentage representation of the risk levels to child development

Risk Indices to Child Development (IRDIs)	f (%)
Without risk	137(75,4)
1 to 2 absent	29(15,9)
3 to 4 absent	15(8,2)
5 absent	1(0,5)
Total	182(100,0)

Caption: IRDIs – Risk Indices to Child Development

It can be seen in Table 2 that the majority of the sample (75.4%) showed no risk indices, i.e., the dyads have good interaction and are healthy. It is observed that 24.6% of the dyads in this study had at least one risk indicator.

Table 3 depicts the frequency of the IRDIs in relation to the socioeconomic and demographic risk factors.

It is observed that there is no significant difference in the proportions of IRDIs in the socioeconomic and demographic variables ranges tested.

The frequencies of IRDIs regarding obstetric and psychosocial risk factors are presented in Table 4.

It is observed that, in most of the variables, there is no significant difference in the proportions of IRDIs in the obstetric and psychosocial variables ranges tested. Only on the type of breast-feeding it is observed that mothers who use more than one way of feeding both had a higher proportion of risk indices (40.5%), which was statistically different compared to mothers who only breast-fed naturally or artificially ($p = 0.027$).

Table 5 depicts the frequency of presence or absence of risk indices to child development (IRDIs) in relation to the difficulty in the establishment of maternal experience (DCEM).

Table 3 – Distribution of the risk indices to child development and their socioeconomic and demographics risk factors for the sample (n = 182) of the study

Risk factors	Number of mothers (%)	Risk indices (IRDIs) (%)		
		Absent	Present	p
Socioeconomic				
Family income (minimum wage)				
Less than 1	52(28,6)	35(67,3)	17(32,7)	0,120
More than 1	125(68,7)	98(78,4)	27(21,6)	
Schooling				
Basic education/illiterate	78 (42,9)	56(71,8)	22(28,2)	0,662
High school education	90 (49,5)	70(77,8)	20(22,2)	
College education	13 (7,1)	10(76,9)	3(23,1)	
Profession				
Homemaker	98 (53,8)	70(71,4)	28(28,6)	0,194
Other	84 (46,2)	67(79,8)	17(20,2)	
Demographics				
Age (years)				
Under 20	34 (18,7)	26(76,5)	8(23,5)	0,565
20 to 34	117 (64,3)	90(76,9)	27(23,1)	
35 or more	31 (17,0)	21(67,7)	10(32,3)	
Marital status				
Married/consensual marriage	156 (85,7)	120(76,9)	36(23,1)	0,207
Single	26 (14,3)	17(65,4)	9(34,6)	
Number of children				
1 or 2	1421 (77,5)	108(76,6)	33(23,4)	0,444
3 or more	41 (22,5)	29(70,7)	12(29,3)	
Total	182 (100.0)	137 (75.3)	45 (24.7)	

m. w. = minimum wage. Missing data: family income (5); schooling (1). Non-parametric statistical test of independence of chi-square.
*Significant $p \leq 0.05$.

Caption: IRDIs – Risk Indices to child development

Table 4 – Distribution of the risk indices to child development and their obstetric and psychosocial risk factors for the sample (n = 182) of the study

Risk factors	Number of mothers (%)	Risk indices (IRDIs) (%)		
		Absent	Present	p
Obstetric				
No. of pregnancies				
1	77 (42,3)	57(74,0)	20(26,0)	0,183
2 to 4	88 (48,4)	70(79,5)	18(20,5)	
5 or more	17 (9,3)	10(58,8)	7(41,2)	
History of miscarriage				
Yes	32 (17,6)	27(84,4)	5(15,6)	0,189
No	150 (82,4)	110(73,3)	40(26,7)	
Preterm births				
Yes	50 (27,5)	38(76,0)	12(24,0)	0,889
No	132 (72,5)	99(75,0)	33(25,0)	
Type of parturition				
Vaginal	68 (37,4)	50(73,5)	18(26,5)	0,673
Caesarean	114 (62,6)	87(76,3)	27(23,7)	
Pregnancy				
Planned	81 (44,5)	62(76,5)	19(23,5)	0,343
Non-planned	95 (52,2)	72(75,8)	23(24,2)	
Unwanted	6 (3,3)	3(50,0)	3(50,0)	
Complications with newborns				
Yes	59 (32,4)	46(78,0)	13(22,0)	0,684
No	121 (66,5)	91(75,2)	30(24,8)	
Type of bread-feeding				
Exclusively maternal	127 (69,8)	99(78,0)	28(22,0)	0,027*
Artificial	18 (9,9)	16(88,9)	2(11,1)	
Mixed	37 (20,3)	22(59,5)	15(40,5)	
Psychosocial				
Social support from husband				
None	34 (18,7)	25(73,5)	9(26,5)	0,376
Husband	44 (24,2)	30(68,2)	14(31,8)	
Others	104 (57,1)	82(78,8)	22(21,2)	
History of mental illness in the family				
No	146 (80,2)	111(76,0)	35(24,0)	0,636
Yes	36 (19,8)	26(72,2)	10(27,8)	
Total	182 (100,0)	137 (75,3)	45 (24,7)	

NB = newborn; DCEM = difficulty in the establishment of maternal experience. Missing data: complications with newborns (2). Non-parametric statistical test of independence of chi-square. * Significant $p \leq 0.05$.

Caption: IRDIs – Risk Indices to Child Development

Table 5 – Frequency distribution of the risk indices to child development based on the presence or absence of difficulty in the establishment of maternal experience

DCEM	No. of dyads (%)	IRDIs (%)		p
		Without risk	1 or more absent	
Absent	116(63,6)	98(84,5)	18(15,5)	0,000*
Present	66(36,3)	39(59,1)	27(40,9)	
Total	182(100,0)	137(75,3)	45(24,7)	

Non-parametric statistical test of independence of chi-square. * Significant $p \leq 0.05$.

Caption: IRDIs – Risk Indices to Child Development; DCEM – difficulty in the establishment of maternal experience

Regarding the DCEM risk factor, it was observed that the IRDIs are significantly higher ($p = 0.000$) between the mothers with presence of difficulty in performing the maternal role than those that did not have this difficulty, i.e., there is a higher proportion of babies with the presence of risk factors in mothers with difficulty performing the maternal role.

■ DISCUSSION

The results of this study, despite the low frequency of DCEM in the sample studied, showed that the difficulty in the establishment of maternal experience correlates significantly to the presence of IRDIs, i.e., these mothers' babies had a higher risk than the babies of the mothers who did not have such difficulty.

These results suggest that several factors contribute to the psychological and development risks, including some constitutional of the babies¹⁹, which shows that the difficulty in setting up the experience of motherhood can affect the communicative exchanges between mother and baby, but does not constitute the sole factor to be considered in the explanation of the presence of risk to child development.

In another study, it was shown that children of mothers who have postnatal depression, compared with those of non-depressed mothers, show decreased frequency of positive facial expressions and more negative expressions and are more likely to develop depression at an early age⁵. In relation to male depression (father), research shows that it originates in feelings of exclusion in view of the mother-infant dyad. As an effect of this exclusion, the man would see himself only as a provider, who must work and meet the requirements of the postpartum woman²⁰, which would limit the good family life. Both studies show that parents' emotional states can affect the family dynamics and hinder the formation of the couple in their parental duties. However, such states are not significantly reflected in the establishment of the experience of motherhood if there are family protection factors, such as spousal support. As for factors such as non pregnancy planning, they seem to have much more harmful effects on the emergence of maternal emotional states changed and on the establishment of the experience of motherhood^{20,21}. In this research, this effect was not observed when obstetric and psychosocial variables were analyzed in relation to the difference between mothers with and without DCEM.

Several authors have emphasized that the relationship between mother and baby exists, since before the pregnancy, in the woman's fantasies related to the possibility of having a child. This

causes that, during pregnancy, the mother anticipate the birth of the child, from the marks left by her own history, and personify the fetus through the attribution of characteristics and personality. Once the baby is born, this image will be more or less confirmed, which leads the mother to interpret and guess its needs, because the birth of a baby never fully corresponds to what the mother was expecting before the birth⁷. Therefore, the mother needs to mourn the fetus and the pregnancy to focus her attention on the relationship with the baby, who should have the reference in the child's father and its name. Possibly, many factors, still not detailed in this analysis, have influenced mothers of this sample with DCEM to present difficulties in making such a transition. For now, it can be said, however, that these factors have a statistically significant relationship with the change in the initial protoconversation between mother and baby, viewable by the presence of risk to development, measured by the non-parametric statistical test of independence of the chi-squared.

Further analysis of the data will be needed, since it is known that multiple factors are interfering in each area of the mother's care in relation to her baby. This is clear from studies on breastfeeding²², on eating disorders¹, and on the initial interactions²³.

It is worth noting, finally, the element of the qualitative analysis of the indices most frequently altered, such as the identification by the mother of what the baby wants (IRDI 1), the use of a particular language directed by the mother to the baby (IRDI 2) and the exchange of glances between mother and baby (IRDI 5), which indicate problems in the axis of supposition of subject, establishing demand and alternation between presence and absence. It is known that the dialogue is made of alternation between the interlocutors and, in the case of the interaction between an adult and a baby who does not yet speak, by the assumption of a subject, the speaker, it is observed in such changes the risk for the acquisition of the baby's language, when considered clinic proposals that take the interaction as central to the acquisition and development of language^{24,25}. Perhaps the difficulty in the transition between pregnancy and dealing with the newborn baby are factors involved in establishing these axes. The changed IRDIs suggest mothers that are excessively present or absent and that have difficulties in dialogic investment with the baby, by the absence of a particular style of language directed to the child. This fact is of particular relevance for the development of language and communication, if the psycholinguistic and psychoanalytic studies on the importance of momish are considered^{6,10,25}.

■ CONCLUSION

The difficulty in the establishment of maternal experience is a serious risk factor for the onset of risk indicators to child development, i.e., mothers with these difficulties are more likely not to establish some basic axes of the relationship with the baby such as the assumption of a subject, establishment of demand and switching between presence and absence.

Some of the IRDIs assessed may be more directly related to the acquisition of language, such as the use of speech and momish and of the speech attuned to the baby's actions, the possibility of the mother proposing something and waiting for the baby's response, which allows the affirmation of the importance of early identification of difficulties of the establishment of the experience of motherhood to the field of speech-language pathology.

RESUMO

Objetivos: analisar a possível relação entre dificuldade na constituição da experiência da maternidade e a presença de índices de risco ao desenvolvimento infantil, bem como a interferência ou não de variáveis psicossociais e obstétricas em ambos aspectos. **Métodos:** tipo quantitativo descritivo, com caráter casual comparativo sobre as manifestações comportamentais do processo interativo mãe-bebê. A amostra foi constituída de 182 mães e seus bebês, estes nascidos a termo ou pré-termo, em um hospital universitário da região central do Rio Grande do Sul. Foi realizada uma entrevista semi-estruturada sobre a experiência da maternidade com as mães e aplicado um protocolo de índices de desenvolvimento infantil com a díade. A análise estatística deu-se sobre o cruzamento dos resultados de ambas avaliações. **Resultados:** a presença de dificuldades na constituição a experiência da maternidade relacionou-se estatisticamente com a presença de risco ao desenvolvimento infantil. As variáveis psicossociais e obstétricas não apresentaram interferência significativa nos resultados. **Conclusões:** sistematizam os argumentos apresentados e destacam que as dificuldades na constituição da experiência da maternidade são fatores de risco grave para o aparecimento de indicadores de risco para o desenvolvimento infantil, pois alterações no comportamento de quem exerce a função materna se refletem já na protoconversaçãoinicial da díade mãe-bebê, o que pode gerar risco ao desenvolvimento infantil de um modo geral, e à aquisição da linguagem em particular.

DESCRITORES: Comunicação; Psicologia da Criança; Ansiedade; Relações Mãe-Filho

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