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Original Article

Early interactions between mothers and hospitalized premature babies: the focus on the essential needs of the child

Regina Helena Vitale Torkomian Joaquim[a], Monika Wernet[b], Adriana Moraes Leite[c], Luciana Mara Monti Fonseca[c], Débora Falleiros de Mello[c]

[a]Departamento de Terapia Ocupacional, Universidade Federal de São Carlos – UFSCar, São Carlos, SP, Brasil.
[b]Departamento de Enfermagem, Universidade Federal de São Carlos – UFSCar, São Carlos, SP, Brasil.
[c]Escola de Enfermagem, Faculdade de Medicina, Universidade de São Paulo – USP, Ribeirão Preto, SP, Brasil.

Abstract: Introduction: The literature indicates to be of vital importance the experiences and care that every child has the right for a healthy development, considering their needs for continuous relationships, physical protection, respect for individual differences, stimulus and confidence building, as the establishment of boundaries and stable communities that support cultural continuity. Objective: To identify aspects of early interactions between mothers and premature babies during hospitalization, highlighting the essential needs. Method: An exploratory study using qualitative data analysis, based on the conceptual framework of the essential needs of the child. Interviews with 14 mothers of premature babies, with thematic content analysis were performed. Results: Analysis of maternal reports showed limited interactions between mothers and their premature babies due to the physical separation, lack of opportunity of contact, and incipient professional reception, mentioning anxiety, guilt, insecurity, and difficulties to assume the care of the babies. Results suggest that the needs of the child become vulnerable. Conclusion: The early contact allows mother-child dyad by means of gaze, touch, cuddle, among others. The study reaffirms the importance of maternal interaction in the care of premature babies, in order to promote healthy child development. It is for health professionals to organize supportive care environments that prioritize the protection needs of the child and of the family.

Keywords: *Infant, Premature, Mother-child Relations, Hospitalization, Integrality in Health, Occupation Therapy.*

Interações entre mães e bebês prematuros: enfoque nas necessidades essenciais

Resumo: Introdução: A literatura indica de vital importância as experiências e os cuidados aos quais toda criança tem direito a um desenvolvimento saudável, considerando suas necessidades de relacionamentos contínuos; de proteção física; de respeito às diferenças individuais; de estímulos apropriados à idade; de estabelecimento de limites e de comunidades estáveis, amparadoras de continuidade cultural. Objetivo: Identificar aspectos das interações entre mães e bebês prematuros hospitalizados, destacando as necessidades essenciais. Método: Estudo exploratório com análise qualitativa temática dos dados, fundamentado no quadro conceitual das necessidades essenciais da criança, com base em entrevistas com 14 mães de prematuros hospitalizados. Resultados: Relatos maternos apontam interações limitadas em razão de separação física, falta de oportunidades plenas de contatos com o filho e acolhimento profissional incipiente, mencionando ansiedade, culpa, inseguranças e dificuldades para assumir o cuidado. Resultados sugerem, como desdobramento, que as necessidades essenciais da criança ficam em vulnerabilidade. Conclusão: Contato precoce com o filho pode trazer a apropriação gradativa de vínculos, em

Corresponding author: Regina Helena Vitale Torkomian Joaquim, Departamento de Terapia Ocupacional, Universidade Federal de São Carlos, Rod. Washington Luís Km 235, SP-310, CEP 13565-905, São Carlos, SP, Brasil, e-mail: joaquimrhvt@gmail.com; regin@ufscar.br
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busca de interações socioafetivas saudáveis. O estudo reafirma a importância da interação materna nos cuidados ao bebê prematuro para promover desenvolvimento humano. Cabe aos profissionais de saúde a organização de ambientes de cuidado sustentador, para garantir as necessidades essenciais da criança e o cuidado integral à saúde.

Palavras-chave: *Recém-nascido Prematuro, Interação Mãe-bebê, Hospitalização, Integralidade, Terapia Ocupacional.*

1 Introduction

The mother-child interactions in the early stages of life contribute to human development (ESTEVES; ANTON; PICCININI, 2011), especially in the emotional environment (ESTEVES; ANTON; PICCININI, 2011; SHAH et al., 2013) essential for the child (BRAZELTON; GREENSPAN, 2002). According to Flacking et al. (2012), reciprocity and sensitivity in the interaction require good relationship and are articulated to the behaviors of the individuals between them. They are reciprocal processes of engagement that become progressively more complex, as the individuals advance in each other´s knowledge and improve their ability to adjust and regulate their behaviors.

The prematurity is increasing worldwide and it is a public health problem, considering that the estimate for 2030 is that the mortality in the neonatal period will be high, with the complications of premature birth and those related to the intrapartum period as the main causes of death in children (LIU et al., 2015).

Studies have shown that the quality of mother-child interactions influence perinatal and neonatal outcomes, especially those related to the child's emotional, social and cognitive growth and development and to their essential needs (BRAZELTON; GREENSPAN, 2002; MELO; SOUZA; PAULA, 2013; MELLO et al., 2014). Thus, there are concerns in health care with recognition of the repercussions of early relationships in human development (SCHAEFER; DONELLI, 2017).

The needs are recognized in their contributions to health promotion and child development. It involves six needs: (a) continuous supportive relationships (care and affection), especially for the caregiver's presence and the way in which they interact with the child; (b) physical protection, safety and regulation, related to the maintenance of the physical and physiological integrity of the child, involving food, hygiene, sleep, shelter, movement, monitoring of growth and development, support for healthy habits, protection against infections and accidents, and the use of the legislation and other measures to protect physical, social and environmental damages; (c) experiences of respect for individual differences, expressed by the recognition of the specifics of the child in the care offered, excluding standardizations; (d) developmentally appropriate experiences involving encouragement and promotion of the child's self-confidence and feeling of being accepted, cared and loved; (e) the establishment of boundaries, organization and expectations with the development of the capacity for empathy, through affection, security and bond; (f) stable and supportive communities and cultural continuity, articulated with the concept of being the community and culture foundations for the development of the child and his/her family, considering the aspects of health care, education and health in their social network (BRAZELTON; GREENSPAN, 2002).

For Kreutz and Bosa (2013), the premature baby birth often puts the mother and the family facing certain limitations of care in the hospital, and feelings of anxiety, fear of death and frustration that parents need to learn to recognize and to relate, reinforcing the importance of social support and co-responsibility with health professionals, especially for the efforts to promote the mother-baby bond (CARTAXO et al., 2014; JOAQUIM; SILVESTRINI; MARINI, 2014; VIERA et al., 2010). According to Bengozi et al. (2010), during the hospitalization of premature infants, this relationship may suffer institutional influences, from their routines and procedures, usually little linked to maternal interaction and care desires.

Aspects of the interactions between the mother and the premature baby and the promotion of health in the hospital scope are little spread, particularly with focus on the essential needs. In this sense, there is the promotion of mother and child interaction among other recommendations for healthcare, mainly due to the repercussions in the process of attachment and bond (BRAZELTON; GREENSPAN, 2002), child development (BRITTO; ULKUER, 2012; BORCK; SANTOS, 2010) and the establishment of parental role (BORSA; NUNES, 2011; FALBO et al., 2012), considering that the interactions between the mother and the premature baby are fundamental and affect the care of the child, the promotion of its development and its needs (ESTEVES; ANTON; PICCININI, 2011; SHAH et al., 2013; FLACKING et al., 2012; SCHAEFER; DONELLI, 2017). Thus, this study aimed to identify aspects of the interactions between the mothers and the preterm infants, highlighting essential needs during hospitalization, and contribute

to the discussion about the role of the occupational therapist in this context.

2 Method

This is a qualitative, exploratory study based on the conceptual reference of the essential needs of children (BRAZELTON; GREENSPAN, 2002), developed during the postdoctoral internship of one of the authors.

The data collection was carried out with mothers who were together with their preterm infants in the neonatal intermediate care unit of a city in the interior of São Paulo. The choice of this unit was due to the understanding that the initial stressors related to childbirth and preterm birth would already be relatively stable and to be the outstanding aspects of the interaction with their child in the maternal memory. The inclusion criteria adopted were: being a mother of a premature baby hospitalized and being over 18 or legally emancipated. The exclusion criteria were: to have a child with some diagnosed congenital or neurological malformation. The data collection was from November 2013 to January 2014, established as funding for potential participants, a process developed with the support of professionals from the unit. Thus, the sample was of convenience, and the density of the obtained material was sufficient to show the phenomenon in focus, so from the tenth interview, there were no significant information additions, with repetition of many of the already data obtained.

The open interview was the selected data collection strategy, using the triggering statement "Tell me about interactions with your child during his/her hospitalization." Other statements and questions were used to dense and detailed reports about the interactions experienced and their contextualization. All interviews were recorded in audio and transcribed in full. The text from this transcript has undergone the processes recommended by content analysis of the inductive theme type (BUETOW, 2010). Buetow (2010) established the exploration of the material according to its repeated readings, in a first moment aiming at the identification of significant situations to the phenomenon in exploration. Subsequently, new readings are developed to select excerpts and establishment of thematic units. The aspects found were analyzed based on the essential needs reference of the child (BRAZELTON; GREENSPAN, 2002), highlighting the complexity and interweaving of the multiple dimensions in the interactions between the mother and the child.

The research was approved by the Research Ethics Committee, opinion number 346.177/2013, and followed the recommendations for research with human beings of Resolution 466/2012, using a free informed consent form (TCLE) of all participants. The preservation of the identity of the participants was respected and the identification in the speech excerpts was made from the letter M (mother), followed by the Arabic number translator of the interview order developed in the study.

3 Results

Fourteen mothers participated in the study, ranging from 14 to 42 years old, with six being in the 10-20 age group, four in the 21-31 age group and four in the 32-42 age group. Nine of them had a cesarean delivery and five of them had a normal delivery. All of them reported having a prenatal care with a number of consultations equal or greater than six. None of them had previous experience of prematurity and seven of them were primiparous. Three of them had twins. As for the infants, the gestational age ranged from 24 to 36 weeks, birth weight was between 640 g and 2,565 g, the Apgar score was between 2 and 10 in the 1st minute and between 3 and 10 in the 5th minute of life. The hospitalization time of the children ranged from 2 to 98 days.

The aspects of the interactions between the mothers and the premature babies are presented from three thematic units: premature birth: anxiety, guilt, and separation; contact with the baby; maternal care: a learning process during hospitalization.

3.1 Premature birth: anxiety, guilt, and separation

The period before the birth for the mothers is a stage of anxiety and expectation regarding the clinical situation of the baby and of themselves. All of them are immersed in a routine completely different from usual and not imagined. The passage of time is emotionally time-consuming and associated with her and the baby clinical evolution. They are especially concerned with the child's health.

> *I thought about her health, what matters is her health* (M10).

> *The time is slower. It is a time that the body rests, but it tires the mind* (M5).

In this situation, the health professionals can be supportive or not and this evaluation is related to their assertiveness in the indication of their

hospitalization. There are cases where mothers are going from their homes to the maternity and are hospitalized only at the imminence of a complication, such as the rupture of the amniotic sac, occurrence of bleeding, signs of infection, increased blood pressure, among others.

Some mothers are gradually approached from the situation, especially by explanations. Others experience professional helplessness and are only welcomed (sometimes incipiently) with their own attitudes, both of search and of emotional unrest. All of them express knowing the procedures, equipment, and routine of the service diminishing the emotional repercussions of childbirth/premature birth, something unknown and frightening.

> *He* [doctor] *prepared me for the medication and for the fact that he said the baby might come preterm. Since the gestation, he has already warned me that he* [baby] *could come at any time, cesarean or normal delivery. So, I've been preparing myself psychologically and the whole family* (M12).

There are feelings of guilt (especially in adolescent mothers) and the maternal feeling of collaborating for the child's early birth and her suffering. They suffer with their child, sympathize with it, and engage in their struggle for survival and recovery. Also, they compare their situation with those of other mothers who already have their son next to them when they refer to understanding and suffering. They desire closeness of the child and complain of the helplessness in the health care directed to them. Such helplessness bring worries and sufferings, with consequences for interactions with the child.

> *I used to come and I cry more, I used to look at her and I could not cry. It was complicated. She was still suffering, fighting for her. And we feel a little remorse. I was just crying, lately, she was getting better and as she was evolving I was getting happier and improving along with her* [...]. *Nobody expected me to get pregnant* (M8).

> *Yesterday* [the day the baby was born and the mother cannot keep it in the room] *it was horrible. You see the other mothers of cesarean and normal delivery and the baby is there, is already with them. Theirs came and mine did not come ... I thought: it is better for him* [son] *to stay there* [NICU] *to recover and then he comes here. But, the feeling is horrible, to see the mothers there with their other children nursing and yours is not yet* (M7).

3.2 Contact with the baby

The interaction of the mother with the baby in the initial moments of his life is almost inexistent in the need for therapeutic and diagnostic procedures for its survival. Visual contact is mostly the first and only type of interaction, but with great representativeness. For some of the mothers, this is enough in the sense of verifying that your baby is alive and being watched. Others want physical contact with the child.

> *I wanted to watch the baby birth, to see the little face, what he was like. I told him that he might even let me sleep, but at the moment I wanted to see. Just knowing that you're there, you see, at least it's already a little comforting. I had seen it, but I could not take him at the time he was born. They took him quickly inside. He was already a little tired, so I went to see him quickly. Only then the* [professional nursing] *girl let me get him a little before he took the shower I take him. He was awake. It was the best thing, the best feeling* (M12).

> *It was a big emotion. They took it out and they quickly showed the two of them, it was a very big emotion because I only believe it when I was there watching them, then I realized more or less, now I am seeing the difficulty that is caring* (M13).

When finding, looking, and touching the child takes time, there is a sensation of fear, anguish, and expectations regarding his or her survival, consummation of contact, and pursuit of desired protection. Those who have physical contact with the child, through authorization of entries in the hospital care unit, complain about lack of freedom and little time for interactions with the child.

Many mothers do not know the details of what is happening to their baby, they only know the information of "normal" or "usual" situations. They accompany the children within their possibilities and institutional permissions.

In this study, all the interviewees explicitly suffered from the refusal to be in the unit with the child and have free access to it. Suffering is magnified by the imagination of what the child is going through, which is a result of what they see and hear in unit. They point out that technical words are learned over time. They remain in thought with the son and his situation and, thus, they are approaching him.

> *They say that the immune system is very weak, the saturation is falling. So, I kept looking at her and thinking, I think that is why the remorse came,*

> *I kept crying, looking and thinking, seeing her suffering* (M8).

> *She* [the nursing professional] *spoke to me and I could not sleep, because it's horrible. I took a fifteen-minute nap, but I got up and went to the nursery. I would go back to the bedroom and talk to my mother and go for a walk. I walked, looked at the glass and it was there, I stayed the whole night like this. Then, in the morning, they* [the nursing professional] *said that he* [son] *could not go back* [to the room]*, which he was still going to take exams. Even so, I stayed all the time going there to see him* (M7).

When the baby needs hospitalization in a neonatal intensive care unit (NICU) and the mother has contact with the child in the incubator, there is a fear of touching it. The ways of interaction such as touching and looking, seem primordial to mothers, although the baby's appearance and equipment cause fear and strangeness. They talk with the baby as a way of interacting and elaborating the situation.

> *On the first day, I was afraid to put my hand on her, the skin was very sensitive that she was extremely premature, very fragile even, that I was afraid to put my hand. On the second day, I started to have more, I was losing my fear, I started to talk more with her. That was, it was always the same routine because I could not get her, by the hand. In the incubator, you cannot do much* (M8).

> *She was full of needle-filled injection in the incubator and I had not seen any babies in the incubator. It was strange until the moment she took her needles out now, so she's crying, it was weird, it was ugly. It was for her sake, but it's strange to see* (M11).

There are contradictory emotions and a unique way for each mother to deal with the first contacts. For some of them, it seems like abandonment to the baby, with the understanding that after birth their survival depends only on him. They sympathize with the child, an aspect that causes immense pain.

> *It was painful. Although before I was in pain, she was together, but I thought of myself. By the time, I saw her there* [incubator]*, I was sad because I was not feeling any pain. Now, she was fighting for herself, suffering. I was very bad* (M8).

For other mothers, the fact that the baby has survived, regardless of what "costs" it, is sufficient for maternal well-being. The reports indicate a sense of relief for the baby's survival and, at the same time, apprehension about what happened in the first moments of the mother-child dyad. In the interaction, they look at the number and type of devices and the technological devices used by the child and associate them with their well-being/severity.

> *It was the feeling, it was the best thing in the world, being able to see him. That he was fine, thank God, that he was not wearing a respirator, that he was not with anything, only being fed by the same probe* (M12).

The reports also suggest the mother's need to continue the connection with her previously visceral baby, with new forms of contact between the two, through looking, touching, picking up her lap, among other things, in short, doing maternal things.

3.3 Maternal care: a learning process during hospitalization

Giving care to a baby is something that a lot of mothers are getting ready throughout the gestation. In the case of premature birth, this time of "getting ready" is perceived as shortened. Moreover, when hospitalization is necessary, the new mothers are faced with an adaptation to this new context. This situation can potentiate maternal difficulties and bring consequences to the development of care. They miss someone close to support them at those times. Some of them wished to have their mother close and others wished to relate divine strength as an empowerment to do it.

> *I do not know how to take care of a child, no. Today, it was the first time I changed diapers. It is complicated. I wanted my mother to come here to teach me, she cannot come, she cannot* (M8).

> *Everything was different, it is a very different adaptation, only God to help. It's something completely different, there was no son. It is difficult to prepare and to be living it* (M13).

Taking care of a baby is a learning process consolidating in the interaction between the involved ones, mother, baby, family and surrounding people.

Some reports pointed out that in the situation of hospitalization little is allowed to mothers, except obedience to professional commands. However, there is no systematic orientation and sometimes dualities in what is recommended to them. Mothers learn about their baby, the routine of the service and the technical care, living day to day, but emotionally fragile.

> *One* [health professional] *comes and talks: you only give the breast, the other speaks: only bottle and then the breast. We do not know what it right, it's complicated* (M14).

Maternal care is restricted primarily to observation, since in the unit studied, at the time of data collection they experienced the negative performance of care. For example, the bath, initially, is not performed by the mothers. According to them, the justifications are for the fragility of the baby and the devices of care used by him. They also point out other justifications used by the professionals to deny them the care of the child or his placement in his lap, related to the infection, the thermal instability of the child and the repercussions in his recovery.

> *He* [premature baby] *has to stay in the incubator and I cannot even get him, or anything, it's bad. It's good to be in the room, you change it. Staying there* [in the nursery] *I cannot even touch him* (M7).

> *We cannot get him because of the temperature* (M8).

The participants refer to feel as mothers when the baby is close, in physical contact with them, as well as when they perform care such as changing, bathing, and breastfeeding. This proximity allows, over time, knowledge of the baby's responses to their behavior and vice versa, aspects establishing and extending the bond between them.

> *She goes down to the nursery and I know that the one closest to her is me, the worst phase has passed, now she is calmer. I'm closer to her, I used to stay only thirty minutes, and the most I could do was just to take her by the hand, now I pick her up, I give her milk, I change her diaper, I take a shower. So it's a lot closer than before. She already knows who I am, this is her mother. She starts to cry I take her, she already stops. I shake my hand. If I move away, she starts again, I have already realized: when it is in the lap also until the saturation improves, it becomes much more comfortable. Not me as the mother, she does not know, but she having more contact with me, more attached, she is feeling me more* (M9).

The hospitalization puts the baby to some procedures that distract and modify the initial forms of interaction, for example, the baby with a tube, in the phototherapy, in the incubator without or with oxygen, with a helmet.

> *He was taking serum, so he could not get him out of the incubator. Now, he's taking that light, he was jaundiced, he could not get it, because he had to stay in the incubator. It's a little worse because you could not get on your lap and stuff like that. But, I was like that, next to him we were already well* (M13).

> *I'll pick him up, I give him care, will not you?! The little girl is the same thing, but it's all in the probe, she cannot take it all the time. I take the right milk and I give it to him, he is accepting it. I am now learning to change the diaper, to wipe the little belly bottom. All this is getting routine* (M14).

The reports indicate that mothers learn the care of their preterm infants based on what they observe, what they are oriented to and about their baby, which allows them to feel gradually secure and capable.

4 Discussion

This study highlights the importance of promoting and protecting the maternal interaction with the hospitalized premature child. The approximation of the preterm infant and the gradual appropriation of their care during hospitalization are relevant to the safety and extension of the bond, as well as to the constitution of the maternal occupational identity of the woman (CHRISTIANSEN, 1999; MARTINS, 2017). The reports obtained are consistent with the idea that mothers are reference figures in childhood, with the participation and responsibility for care, and interaction is the basis for the children to build their identity and safety, aspects evidenced in other investigations (CARTAXO et al., 2014; BORCK; SANTOS, 2010; BRADLEY; PUTNICK, 2012).

In hospitalized newborns, the study by Borsa and Nunes (2011) points out that women are lack of support during hospitalization, generating difficulties in the process of development and performance of the maternal role, a fact that needs attention and changes in the first years of life that are the most critical and most vulnerable period for the development of any child, since it is essential for intellectual, emotional and moral growth (BRAZELTON; GREENSPAN, 2002).

The experience in NICU is understood by mothers as a shocking event in their lives, with feelings of sadness, worry, and tiring routine, but necessary for the survival of the child. Even among those who reported more tranquility and happiness with the recovery of the baby, the initial period was described as very difficult and painful (CARTAXO et al., 2014). According to Almeida et al. (2016), the occupational therapist favors daily spaces for the experience of creative, affective acts and for the construction/expression of meanings, perceptions, and reflections regarding what is lived and what is not done in the hospital.

According to Brazelton and Greenspan (2002), according to the essential needs of the child, the experiences and types of care the child is entitled are of vital importance. The first of the needs is the need for a sustained relationship. The mothers of this study experienced physical separation and discontinuity of contact with the child, placing the child and themselves in vulnerability in terms of this need.

The need for physical protection, safety, and rules, which refers to providing protective environments that can ensure healthy development at birth, childhood and adolescence (BRAZELTON; GREENSPAN, 2002), revealed the lack of professionals and gaps. The study by Dantas et al. (2015) emphasizes the importance of the identification by the health professionals working in NICU of the mothers of hospitalized preterm infants who perceived as having little social support.

The maternal reports indicate that the maternity and NICU environment requires transformations to become a safer and more favorable scenario for human interactions. In this way, it can guarantee more protection and support to the mothers, particularly in the process of birth, childbirth and period of hospitalization of preterm infants. Thus, the idea of a supportive hospital environment is defended, which privileges the protection and safety needs of each child and family. In this sense, it seems to be important the presence of professionals who act in the integrality of the care offered to the mother and her baby, expanding the hospital practices for the identification beyond the biological needs of both mother and baby. In particular, with regard to occupational therapy interventions, in which it is possible to know, understand and help people, in this case, the mothers of preterm infants, to reflect on the daily life in the hospital, on the occupations that take place in this daily life and how this situation fits into their life history (ALMEIDA et al., 2016).

The mothers pointed out needing and wanting the support of the mother or a member of the NICU team to increase their knowledge, capacity, and abilities for the care of the child. Allowing the mother to experience her role and to have autonomy in the care and interaction with her baby, in a supported manner is to effect the uniqueness of attention. In this sense, the results point to the importance of guaranteeing another need, that directed to the respect of individual differences (BRAZELTON; GREENSPAN, 2002), not only in relation to the baby but also to the mother-child dyad.

Caring for the premature baby means more than an execution of learned tasks, represents an exercise in (re) knowledge of the child, acceptance and affective attachment (ARAÚJO; RODRIGUES, 2010). For the mother, counting on the presence of an occupational therapist to assist her in establishing the occupational identity of the mother may be the possibility of fulfilling the essential needs for healthy development. Motherhood is a time-dependent process that allows women to develop the meaning of family life. Thus, the hospitalization process, as in the case of preterm infants, can be influenced by the attribution of negative meanings, uncertainties, social prejudices and the lack of contact with infants in the hospitalization environment (ARZANI et al., 2015).

For Piccinini et al. (2012), the positive or negative evaluation of the work of health professionals refers to the reception related to information, guidance and listening to mothers, among other aspects. Having information about what is occurring, what will occur, the outcome of examinations or even being informed and oriented about aspects that seem to be obvious to health professionals can also be a factor that interferes with maternal safety and their confidence in the team. Professionals need to rethink about the support offered and the constitution of safe and supportive environments contributing to the conformation of the motherhood. The study by Arzani et al. (2015) points out that one of the ways to ensure it is to provide more opportunities for contact and interaction between mothers and their babies, in the moments of caring for their children, a fact revealed as incipient in this study.

A qualified prenatal care is a practice that contributes to the access to information and to a positive evaluation not only of the team but also of the process by which the mother experienced it (PICCININI et al., 2012). As far as the mothers of this study are concerned, this has not always been indicated. In general, as Sassá et al. (2014), health services are distanced from the global context of their users and provide support for the biological development of infants, specifically in the case of the follow-up of preterm infants, with a fragmented view of family care.

The results suggest that professionals may be more concerned with fulfilling the routine of the service and providing specific care for the baby's survival, with essential care for motherhood and interaction.

From the perspective of the interviewed mothers, professionals are seen with prescriptive attitudes, with little space for the initial interactions between mother and baby and for the construction of a shared care. Despite all the discussions that address humanization in neonatal care, according to Carmona et al. (2012), systematized strategies to support women and

their families are still incipient, and initiatives are usually punctual and according to the work of some professionals sensitive to the issue.

This research suggests analyzing and organizing a minimum time for initial contact between the mother and the preterm infant, safeguarding children's health at critical moments, but also attentive to maternal needs to ensure the construction of their maternal occupational identity, benefits, and expansion of care. Sufficient contact for the beginning of the establishment of the mother-child bond is complex and there are several relational patterns, some with greater risk than others, and it is important to reduce maternal stress and early separation in hospitalization (KORJA; LATVA; LEHTONEN, 2012; SHAH; CLEMENTS; POEHLMANN, 2011; WOODWARD et al., 2014).

According to the essential needs in childhood (BRAZELTON; GREENSPAN, 2002), it is important to be aware of the opportunities of care offered to the child to grow and develop. Participants refer to feeling mothers in fact when the baby is close, in moments of physical contact, at the time they perform care such as changing diapers, bathing and breastfeeding, doing things that will help them to constitute their mother's occupational identity. This closeness allows, over time, the knowledge of the baby's responses to the mother's behavior and vice versa. Thus, building spaces of warm and close care contributes to the construction and establishment of essential links to human health. The initial proximal processes to establish the bond with the baby result from the combination of three main moments: physical contact, conversation, and breastfeeding valorization, as forms of reciprocal interaction (CARTAXO et al., 2014).

It is the responsibility of health professionals to organize supportive care environments, which privilege the protection and safety needs of each child and family. Specifically, the occupational therapist needs the understanding of this daily life, so different from the one expected by women to carry out their first tasks with the baby, that the maternal occupational identity begins to build and consolidate.

5 Final considerations

This study enabled to understand the elements of the interactions between mothers and premature babies hospitalized. He identified the physical separation of the child and the lack of opportunities full of contacts with him as limited interactions due to the incipient professional reception. These aspects suggest that the essential needs of the child are vulnerable, reflecting anxiety, guilt, insecurities, and difficulties to take care of the child and the construction of the maternal occupational identity. Faced with this, there may be repercussions for the early development of the child born premature, given the fact that the bond and attachment is a process implied with the essential needs. Investments in this area are protectors and promoters of the health of this child and the mother.

Meet and intimate contact with the child can bring about gradual appropriation of bonds, in search of healthy socio-affective interactions, which are of extreme relevance to human development. Thus, it is imperative to give mothers opportunities to relate early and fully to their children, especially in the context of premature birth. Such practice will expand the interactions between mothers and children by expanding their maternal practices and qualifying the psycho-affective and physical care in the child's care. Also, it consolidates premises for fair, humane and integral care.

It is important to emphasize the principles of protection of children's rights, to meet their basic needs and practices guided by them, effectively contributing to health promotion and disease prevention, and the importance of co-responsibility between mothers, families, and professionals. The approach of the thematic and conceptual reference in other contexts can bring contributions to new research and practices aimed at defending and ensuring the essential needs of children and to broaden the discussion of the process of construction of maternal occupational identity, considering the limits of this study, developed in a single health unit of a city.

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Author's Contributions

Regina Helena Vitale Torkomian Joaquim and Débora Falleiros de Mello: conception and design of the study. Regina Helena Vitale Torkomian Joaquim, Débora Falleiros de Mello, and Monika Wernet: analysis and interpretation of the data and critical review of the text. Regina Helena Vitale Torkomian Joaquim, Débora Falleiros de Mello, Monika Wernet, Adriana Moraes Leite and Luciana Mara Monti Fonseca: analysis of the final version of the text. All authors approved the final version of the text.