Revista CEFAC
Speech, Language, Hearing Sciences and Education Journal

Rev. CEFAC. 2016 Jan-Fev; 18(1):55-66

doi: 10.1590/1982-021620161810915

Original articles

Family and therapist perception of child evolution in an interdisciplinary approach on early intervention

Percepção da família e do terapeuta sobre a evolução de crianças em uma abordagem interdisciplinar de intervenção precoce

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Conflict of interest: non-existent

ABSTRACT

Purpose: to analyze and to compare parents and therapists perceptions regarding of early intervention effects in developing of their children, as well as child's development and future outlook.

Methods: this research studied nine individuals from Early Intervention Clinic. Parents and responsible were interviewed. They were recorded and literately transcribed. The information was analyzed qualitatively and confronted considering the following child development aspects: linguistic, motor, social and psychic.

Results: seven out of nine individuals analyzed showed similar parental and therapeutic perception concerning the development characteristics analyzed. In two cases, there was disagreement between family members and therapists regarding children development, when family members expressed different expectations from the therapists about the future of their child. Regarding communication advances, all parents and therapist realized improvements. **Conclusions:** the perception of therapists and parents demonstrated positive effects of interdisciplinary early intervention as manifested in the concordance between therapists and parents views in seven out of nine individuals analyzed. This study also reinforced the importance of conducting a qualified monitoring of family difficulties regarding to limitation of their children and guide them appropriately depending on the disease or disorder presented.

Keywords: Child Development; Early Intervention (Education); Child Language

RESUMO

Objetivo: analisar e comparar a percepção dos pais e dos terapeutas referente aos efeitos da intervenção precoce no desenvolvimento de seus filhos, bem como acerca da evolução da criança e perspectivas futuras.

Métodos: participaram deste estudo nove sujeitos, incluídos na clínica de Intervenção Precoce. Para a coleta dos dados realizaram-se entrevistas com os pais e/ou responsáveis pelas crianças e com os terapeutas de referência, as quais foram gravadas em áudio e transcritas literalmente. As informações foram analisadas qualitativamente e confrontadas, considerando os aspectos do desenvolvimento linguístico, motor, social e psíquico das crianças.

Resultados: dos nove sujeitos analisados, sete apresentaram percepção parental e terapêutica semelhante para as questões do desenvolvimento abordadas e em dois casos houve divergência entre a visão dos familiares e dos terapeutas acerca do desenvolvimento das crianças, em que os familiares demonstram expectativas muito distintas das dos terapeutas quanto ao futuro dos filhos. Em relação à comunicação, todos os pais percebem avanços como as terapeutas.

Conclusão: a percepção das terapeutas e pais demonstrou efeitos positivos da intervenção precoce interdisciplinar, manifestada na concordância de pontos de vista em relação aos sete dos nove sujeitos analisados. O estudo reforçou, ainda, a importância de se realizar a escuta qualificada das dificuldades da família quanto à limitação de seus filhos e orientá-las adequadamente a depender da patologia e/ou distúrbio apresentado.

Descritores: Desenvolvimento Infantil; Intervenção Precoce (Educação); Linguagem Infantil

Received on: January 22, 2015
Accepted on: October 16, 2015

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INTRODUCTION

For many years, the hypotheses of language acquisition, motor and cognitive development, and psychic constitution of babies were the main focus on the theoretical discussion involved with early development and had as a central unit of analysis the behaviors of babies. Currently, there is clarity about the importance of baby's relationship with those who exercise the parental function, considering that development is a process of constitution in which the biological and the psychic are dependent in a complex relationship between baby and their environment[1,2].

Therefore, one can imagine that a desired baby and a mother with mental health are constituted in a dyad very early, offering field for their development. However, when the baby is born with any evident biological limit such as syndromes or neurological damage, or present evident language disorders without an evident lesion, as the Specific Language Impairment (SLI), characterized by several studies[3,4], the imagery that the family has on child while good speaker may rupture and endanger also the parental bond with baby. Some studies show that this rupture in the parental bond with baby may have effects on the mother-child dialogue that turn out hamper the child insertion into routines in which dialogue allows exposure to language [5].

It is known that babies with syndromes or evident neurological lesions are diagnosed early, but individuals with language specific disorders may have access to speech therapy only at the end of the second year of life when they are not talking [3]. Therefore, the parent-baby relationship may be compromised and psychosocial difficulties may be added to the biological limits of the baby during their development. Furthermore, some research on development risk factors[6-9] show that psychosocial and socio-demographic may predispose to the onset of developmental disorders [6,7,9], among which, the language is frequent factor, since babies with psychic and /or developing risk have lower initial speech production than babies without this risk[9], besides important qualitative language difficulties in the first two years of life [3,10]. Therefore, it is fundamental detect any risk or abnormal development and be offered family support as well as early intervention, considering both the brain plasticity as minimize the effects of the condition that the baby presented at parent-infant relationship[10-13].

In this context, early intervention is an important provision of health care, as it can both prevent the pathology installation, as to minimize secondary effects as the psychopathology establishment in cases of syndromes or organic damage such as Down Syndrome or Encephalopathy Not Progressive Motor, by type of support that is provided to parents to exercise their functions with this son who is different from the imagined[14]. However, is necessary be especially careful regarding to the modality of attendance these babies and their families, once that it works with the psychic constitution during the first years of life[13]. Such attendance should not be disciplinary and multiple, it may endanger the performance of parenting functions when the family is without a professional reference.

It is known that simultaneous introduction of different professionals may generate a dissociative effect on the parental function exercise, damaging the baby development. For that reason, the arrangements for Interdisciplinary and Single Therapist were inserted in the clinical practice for care infants and children[13]. The Interdiscipline is configured as creation of a common space in which knowledge is not limited to professional identity of the therapist who serves, it is necessary that the therapist has a broader knowledge of predicted in their discipline to children's development, in another words, a speech pathologist need to have in addition to the knowledge of the language, swallow and hearing commonly respondents in early intervention cases, a minimum knowledge of cognitive and psycho-affective development, in general studied by psychologists, and psychomotor aspects, these deeper by physiotherapists and occupational therapists. This knowledge shared on an interdisciplinary view allow to happen in many cases, a single therapist approach that corresponds to the action of an expert on early intervention, with specific training in child development and not with partial knowledge of a discipline on it. Also, should prioritize the presence of parents, which is signified by the therapist, so that they can perform their parental functions so crucial for babies [10,13]. On the program in which it operates this research, the family inclusion strategies are created in the therapeutic process, such as parents-baby set sessions and the possibility of psychological support to parents. In the set session articulate scenes that range during the session, namely: parent-therapist; baby-parent; baby-therapist and baby-parent-therapist [13]. In the moments when the scene is parent-therapist, there are many aspects of parents' perceptions of the development of their children, or even doubts about the therapeutic process [13]. In case of children older than three years, depending on their clinical status, the intervention with the child

in individual session and continued interviews with parents can be the most appropriate intervention[15,16]. However, this space is not always enough to access the parents' perception; covered more thoroughly, for this reason the operating group of parents and continued interview are involved strategies. The evolutionary perception that the therapist has to each baby, in addition to being comparative to own baby, is related to their sample, in another words, the therapist tends to compare to the performance of similar cases treated, even if it adopts a singular perspective intervention [10,13], which may require new intervention devices to work with parents and supervision of therapists.

Thus, the goals of this study are to analyze and compare the parents and therapists perceptions about the early intervention effects in developing of their children, as well as, their perceptions regarding the children evolution and future perspectives.

METHODS

This study was approved by the Research Ethics Committee of the Federal University of Santa Maria (CEP / UFSM) under the protocol number 0284.0.243.000-09 and used the mandatory ethical standards for research involving human (Resolution 196 / 96 of the National Health Council - CNS). All subjects in the study were informed about the goals and procedures and, after reading the Informed Consent and Informed (IC), have signed even though according to this research and the dissemination of its results while maintaining anonymity of the participants. The research was developed at Speech Therapy Service (SAF), from the home institution. This study is part of the research project entitled “Parental Roles and Risk Factors for Language Acquisition: speech therapy interventions.” The study was consisted of nine children aged 2 years and 1 month and 4 years and 7 months, three girls and six boys, with language disorders associated or not with developmental disorders, and who were in therapy for a minimum of six months in the early intervention program or in the language therapy at internship clinical. The therapy may or not be unique to the program. Some cases presented therapy in single therapist modality and others cases presented concomitant therapies at other institutions, particularly the cases of non-progressive chronic encephalopathy (NPCE), commonly identified as cerebral palsy, with physiotherapy intervention. In the case of single therapist, there was a support of the interdisciplinary team in order to sustain the necessary knowledge in each case. The single therapists in language disorder cases were speech language pathologist, physiotherapists for cases of NPCE and occupational therapists for Down Syndrome (DS) cases. The frequency of sessions within the program was twice a week, as well as, the sessions provided outside the institution, in physiotherapy, with this the possibility of a higher frequency in some cases. The group meetings to anchor the interconsultation occurred every two weeks. Also, there was weekly supervision of the case by Professional speech language pathologist and occupational therapy.

To collect the data, semi-structured (with attached script) interviews were conducted, with those responsible for children, as well as with reference therapists in order to identify the perception of the case and their evolution, and compare with the initial parental perceptions. Also, diagnosis issues and future perspectives envisioned by parents or their substitutes were discussed. Therefore, the aspects that guide the questions were if the parents has clarity about the biological son limits and / or psychic, the acceptance level of difficulty and the relationship between the imagined and the real son, as well as how the therapy mode there was or there was not given support to dealing with challenges that were emerging in the relationship with child.

The interviews were conducted and recorded on audio for later analysis. Posteriorly, the recordings were literally transcribed. The data were analyzed qualitatively through analysis content[17] in order to confront the parents and / or guardians and therapists perceptions, considering the evolutionary aspects of language development, motor, social and psychic of the child. For this purpose, the interviews were read and reread countless times, trying to identify the themes that emerged from the parental discourse.

One of the interviews focus was about the progress in the development and care provided to children by family members. Therefore, the interviews were conducted after a minimum of six months of treatment and focusing on feelings and parental perceptions of the child evolution, not necessarily in their therapeutic methodology perceptions. The interviews conducted in this study were confronted with initial interviews answers conducted by the therapist's case, when early intervention began. Such confrontation was possible because there were initial interviews investigated aspects in the script of this research.

RESULTS

Figure 1 presents general aspects of identification, clinical and therapeutic history of the nine subjects in the study.

All subjects present language impairment, S8 and S9 presented maternal deprivation. Regarding to S8, the mother died when he was three years old, generating such deprivation. Also, prior this trauma, the family report suggests difficulties for the mother to waive emotional care to the child. About S9, the mother cannot perform her function, which leads to important psychic risk. Another fact to be noted in Figure 1 is that despite the indication for initial therapy program with single therapist, the family resorted occasionally to other therapies by medical indication. This is a city reality which the program has to deal with, because many times ethical confront emerge by the therapeutic approach which indicates the family needs choice as in the S4 case.

Figure 2 are analyzed the history of pregnancy and delivery, as well as the clinical status and family feelings by receiving the diagnosis.

Subject	Age	Gender	Clinical Status	Therapeutic History
S1	2:1	F	Encephalopathy Not Progressive Motor tetraplegia type and dysphagia	The demand was for speech-language, but in the program indicated initially physiotherapy and assessment of dysphagia for subsequent insertion of the weekly speech therapy. Do not have therapies outside the program.
S2	2:10	F	Down Syndrome	In compliance with single therapist – speech therapist- for eight months. Does occupational therapy for 12 months and physical therapy for 14 months in aother institutions.
S3	2:8	M	Coffin-Síris Syndrome	In speech therapy in the program for 12 months. Receive respiratory physiotherapy for 17 months in another institution.
S4	2:8	F	Hydrocephaly, Cleft Palate, hearing impairment and autism spectrum	In speech therapy in the program for 18 months. Does physical therapy 12 months ago in another service in town. Did attempt to behaviorist approach by medical indication, but not adapted.
S5	4:7	M	Verbal Dispraxia	In speech therapy in the program for 12 months.
S6	3:2	M	Blindness and autism spectrum.	In compliance with the occupational therapy program three years ago. A year ago it holds combined sessions of speech therapy to occupational therapy. He did physical therapy in other institution for three months.
S7	3:9	M	Verbal Dispraxia I	The speech therapy began in Community Speech Therapy internship 12 months ago. The mother's complaint was that her son did not speak and that the vocalizations produced were not easy to understand. Moreover, he had a hard time interacting with other children.
S8	4:3	M	Verbal Dispraxia and maternal deprivation	Conducted service with a speech therapist Specialties Clinic, which referred him to therapy in the EI program, for having knowledge of it. Does psychological therapy for 12 months in another institution.
S9	3:0	M	Maternal deprivation	Began speech therapy in a group setting and not to present evolution was transferred to individual care in the EI program, weekly for 12 months.

Figure 1. Identification, clinical and therapeutic history

Subject	Pregnancy history, childbirth and baby evolution	Feelings by receiving a diagnosis
S1	Pregnancy was quiet and uneventful, plus delivery was troubled because I was already passing of time to be born, taking place then cesarean section. Born 42 weeks. With about a month the mother noticed difference in the development of the girl when compared to other children. He presented of seizures around five months when conducted Cranial ultrasound and consisted to brain injury.	At first he could not elaborate the news because it was involved with doctors and referrals. When she began physical therapy and had contact with the EI professional, she acknowledged the daughter difficulties and reported initial shock.
S2	The mother believes a healthy pregnancy, but that was not quiet. In the 14th week of gestation I knew the baby had a disability, which was only discovered after birth. Cesarean section was performed without clinical complications. Denies neonatal jaundice and other complications.	Knowing that her daughter had a disability was worse than find out later that it was Down syndrome. The mother reports that when she saw daughter for the first time, was happy to know that it was SD, because it is a known syndrome and who would know how to handle the difficulty.
S3	The mother has high blood pressure from the 12th week of pregnancy, requiring rest and medical attention. One day before the child's birth, was hospitalized presenting contractions. Cesarean section was performed. The baby showed no sucking reflex, being suckled with the cup method. At 3 months was admitted with bronchiolitis for 28 days, was referred to another hospital genetic reference region. Up to 1 year and 3 months had a diagnosis of cystic fibrosis, passing the clinical genetic diagnosis for Coffin-Siris syndrome.	From the first moment she does not know how to react because it does not know the syndrome, so did not know what to expect from the child's development. After a few days felt great anguish because, as it was not informed by medical staff details on the syndromic son. Anxiety grew as did internet searches about the syndrome and found material where the description was rather negative and limiting. She reported initial shock, but found support in speech therapy, overcoming gradually the anxiety facing the diagnosis of the child.
S4	Pregnancy risk. Presented gestational diabetes and high blood pressure, required hospitalization for one month before child birth.	The mother says that during pregnancy was not diagnosed any abnormal development of the child, making it difficult to accept the diagnosis of hydrocephaly after birth and preferring not remember this lived phase.
S5	Healthy pregnancy, and the term birth and cesarean delivery. In kindergarten, about three years old, her mother noticed that the other children spoke more than his son and he had trouble interacting with colleagues.	The mother says she was sad and distressed because they will realize much more the difficulty of the child and compare it with children of the same age.
S6	High-risk premature birth and 29 weeks gestation. He remained in hospital for 45 days in the ICU NEO and held two blood transfusions, besides presenting meningitis during that period. At five months was diagnosed visual impairment.	His mother affirms that it was very painful know of visual impairment and that parents had extreme difficulty accepting the diagnosis. The maternal grandmother, however, provided support at this time.
S7	No peculiarities pregnancy, healthy and full term birth, but requiring 36 hours of induction to natural delivery. The baby took a while to cry, but did not need any follow-up after birth. Associated with communication difficulties to a burn event that the child had around 18 months, followed by hospitalization.	The mother says she feels anguished for wanting the child to develop expressive language as soon as possible.
S8	The pregnancy was troubled and agitated. The mother was nervous and had systemic hypertension, treated with medication. Born 39 weeks and delivered vaginally, one day prior to elective caesarean section. The paternal grandmother always believed that by not speak and present autism spectrum traits, the grandson needed help but could not interfere with function of denial and parental resistance. After the death of daughter in law, with acceptance of the child, sought specialized service and follow up with a neurologist.	The paternal grandmother said that for always believing in difficulty grandchild and in need of treatment, being diagnosed reacted naturally, although it is confronting significant changes with the passing away of the daughter in law. Held no knowledge of the change, since professionals be suspected autism. The psycho-diagnosis and speech therapy diagnosis showed other pathologies.
S9	The pregnancy was uneventful without clinical complications, and the mother had high blood pressure, without using medication. The delivery was normal and no special requirements, was born 38 weeks and immediately cried. The mother did not specify the change in the child, showing little knowledge about it.	The mother says that due to the fact that her eldest son, also have speech development delayed, usually reacted without surprise, and claim that it is normal for children submit such amendment and difficulty.

Figure 2. History pregnancy, childbirth and family feelings by receiving a diagnosis

In previous reports is interesting to note that, except for S9 case, all mothers felt distressed by the diagnosis and, in some cases as S1, even denied it. Only S8 grandmother was relieved with language impairment diagnosed and psychic risk, because doctors had autism suspected, unlike the EI team. Also, is curious to note that S5 and S7 whose children have been diagnosed with less gravity (restricted to language expression) are presented very anxious for the suppression of the children difficulty. The exacerbated

anxiety presented in S3 is related with syndrome rarity, and cannot assimilate as would be the son`s development from such genetic confirmation. The diagnostic effect in the S5 case was worse than S7, because the first one does not realize the son's difficulty in all its extension as S7. It is noticed that the reaction of these two mothers differs from the S2's mother, whose knowledge of the Down Syndrom, presented by her daughter, brought relief because it is a known pathology.

Subjects	Communication evolution	Changes in child / family environment after therapy	The child now and in the future	There is need of psychological support
S1	The mother realizes that child is able to express feelings through the eyes, she came to understand the speech of the mother and the everyday situations and produces some vocalizations.	Before her daughter spent most of the day lying in her stroller, without participating in the family routine. Today, she rejects lie and is always involved in the family's daily activities. There was a change of the child's desire and the mother's attitude to daughter.	Feels very happy to see her daughter in the evolving aspects of motor and language development. For the future, want to see the child running and playing with other children, but that is mainly independent stand, where he stayed most of the day.	Has conducted psychological support before, but points out that it was not the daughter, but the loss a loved family member one. He believes it is a good support to endure hardship.
S2	When the neurologist asked if she had 50 words realized she had a big own vocabulary	There was change of routine with greater involvement time for treatments, but do not claim change in the relationship, because I joked and took care of it before early intervention. After intervention with speech therapy invests more in song and story.	Family recognizes who is now better development than children with higher SD and assigns the IP. Believes she can do many things, not necessarily academic, but do not know exactly what.	The mother says that swings in their emotional stability and is sometimes good and sometimes not so. Takes anxiolytic and thinks that perhaps it could be good support.
S3	Realize significant improvement in understanding language and communicative intentions. Although oral expression is impaired, reports that the child is able to communicate with gestures, vocalizations and other expressions.	Reports clear behavioral perception of the child, and the family routine, believes that father's playing changed because the reviews developed in the IP session were extended to the family routine. They began to report daily activities and play more with her son.	Recognizes the child various skills, however, expect further development of expressive language. For the future, presents science possible limitations, among them the regular school. The greatest wish is to see him speak.	Believes that the worst phase, when the diagnosis was given, has passed. However, think might eventually need this support over the years and the development of the child..
S4	Daily realize the occurrence of changes in the child for the better because it draws mother and cries when she wants something.	The mother walked away completely from work for believing that his life is to take care of her daughter. Feels surprese by the girl's developments.	Currently, see well, despite the limitations, but always shows evolution. For the future is difficult to predict, since the doctors say you cannot go to school like other children	The mother thinks that does not need such monitoring because the worst is over and reacts to all the bad news we receive in relation to the child.
S5	Realize improvement in oral expression in her son and said that families have come to understand it better after therapy.	At home it is just mother and son, does not notice much change.	Recognizes that the child is well, but needs to improve in some aspects. For the future, imagine very talkative and would like to see him sing.	Believes that it is not necessary.
S6	She believes that every day the grandson learn something new and try to show the family what you learn in session.	There was a time that was very difficult to understand what the grandson wanted, which made him cry a lot. Today is calmer and better understand the situations of day-to-day, in addition to better express their desires, reflecting the coexistence of all at home.	See as a normal boy who just does not see. Believes so will have a development as normal children and not have difficulties.	Consider monitoring both for the family and for the child considers necessary.
S7	Realize improvement in the child expressiveness primarily because the boy effort to demonstrate that others understand.	Today is a quieter boy and a better understanding of family orders, making living together in family easier and more enjoyable.	Realizes that the child needs to evolve further and believes that this will happen over time. To future, wants the child be a good speaker.	Believes that it is not necessary in her case, but for other mothers may be essential.

Subjects	Communication evolution	Changes in child / family environment after therapy	The child now and in the future	There is need of psychological support
S8	There is progress in speech, as can ever express in words what you want, and especially in relation to the desire to relate to people, and accept to remain in session with the therapist.	The main change is evident in the behavior and attitude of the father which previously did not recognize the real need for the child to receive treatment. Currently, it reveals more considerate and understands how it should be done the proper stimulation of language, from the narration of events and reading children's stories.	Both the grandmother as the family recognize that the boy has already borne considerable developments in aspects of speech and behavior. For the future, believe that will reach full development and will relate well with people.	He believes that the psychological support has been fundamental to the development grandson.
S9	Mother says that prior to therapy, the child did not speak more than two words and currently already form sentences and, as the behavior is the child calmer.	Not report the occurrence of changes in attitude and conduct of the family, stating that the boys have always treated the same way, regardless of the guidelines.	Apparently recognizes the evolution of the boy, who has shown satisfactory performance in school. For the future, expecte to be even better.	Mother believes there is no need, because the child is well.

Figure 3. Family perception of the development

Subject	Communication and language evolution	Global development evolution	Familiar involvement
S1	In communication, presented great verbal evolution (vocals) and nonverbal (gaze and gestures), she began to perceive the world around them and call the party's attention to themselves.	Great evolution psychomotor and head control, providing progress in the representation of the world. With the cognitive development is now possible to insert an alternative form of communication.	The family is present and participatory. The mother raises questions and reports her daughter's achievements. During dysphagia on guidelines resisted the withdrawal of water, at which point we realized the rejection / daughter disability denial. It has difficulty in understanding the evolution of the child and accept that will have serious limitations in development.
S2	The patient presents good development of comprehensive language and expressive language, demonstrating increasing the phonetic inventory and increased vocabulary.	It presents considerably positive developments in aspects of the play, passing the sensorimotor stage for symbolism.	It is notable family involvement, particularly the involvement of the mother. She is able to move to the daily life of the family that is experienced in session, thus promoting the child development.
S3	Came to understand the communicative situations, showing interest for the proposed activities, respects the communicative turn, has articulated and differentiated vocalizations to certain situations. Demonstrating good verbal and nonverbal development.	There was a positive trend and contrary to what reported in literature about syndrome, he presented psychomotor development, behavioral, cognitive, and communication important for the proposed design.	The mother is dedicated and participative in the therapeutic process by putting in place the necessary guidelines for the overall child development.
S4	This is a case with significant limitations, either the neurological level, sensory (hearing impairment) and also some significant contact with each other, requiring dedication of the therapist, but also caution in interpreting the gestures and scenes. It can be considered an evolutionary gain in communicating the entry of speech in EI, along with occupational therapy, since in addition to the look and body touch, if leveraged-other communication skills, listening.	The child did not move clarity. For anyone who meets you can see that is connected to the other longer (but still very little time). But the family is changing some attitudes with the girl on a daily basis, which is causing satisfaction for everyone.	It is a family should be very respected and admired. Since they managed to establish a bond with the child even with so few resources of it. The family suffered the doctors prohibited, needing some time to understand what would be a diagnosis of autism, as we arrived to the IP clinic with this diagnosis. The biggest evolution is the family relationship. When therapists suggest something (music, posture, invitation, food) family replies that it did at home when the girl responded positively.

Subject	Communication and language evolution	Global development evolution	Familiar involvement
S5	In the language is able to stand, talk and experience the different social contexts with good communication. She started the narrative period, being in late remission phase of articulation changes, related to verbal dyspraxia.	Before therapy was difficult to separate from the mother and to move from absolute dependence to relative. He slept with their mother and had difficulty entering alone in therapy. Today is more independent, sleep alone and agree to remain in therapy only with the therapist.	The mother was always very dedicated and willing to meet the guidelines, despite the suffering by separating the excessive attachment. He noticed the child's needs and followed virtually all of our guidelines, but maintains a very large attachment.
S6	It is inserted into the discourse of everyday life and relationships even if they do not use instruments such as speech, for example. However, it has good non-verbal development, over three years of EI, managing to manifest announcing their feelings and desires through facial expressions, gestures and vocalizations.	Arrived as a baby to EI when it was possible to identify classic symptoms of blind children whose parents do not have guidance. It was a very tearful boy and suffered with the environment around him, unsure express their feelings. Psychically run a great risk of producing a psychosis. However, he left a shutdown with auto-aggression to requests for games and family demands.	There was difficulty in joining the IP initially, requiring a joint meeting with family members about the significant risk related to the mental health of the child. Since then, her grandmother brings more often the calls. The family believes the desire, willingness and availability of therapists. But they do not believe much in the child and therefore does not come often. They know they do not give up. They believe in what we say, but in time to realize they do not, claiming boy disability or family problems.
S7	At the beginning just vocalized, rather compromising the relationship with the speaker. Throughout the intervention, began to respect the communicative turns, respecting orders, in addition to name, use verbs and build simple sentences, checking for large developments.	It was a very withdrawn child with socialization difficulties, but can currently develop group activities and get along with other children.	Initially the mother had trouble understanding the need for family involvement in the therapeutic process to better evolution of the child. With common guidelines, he understood the proposal and went on to have greater involvement in the therapeutic process both in session and at home.
S8	It is noted that has better express his wishes with words and phrases endowed with meaning. In addition, there is some independence grandmother and behavioral changes in social situations such as parties and outings. It is a cheerful child who currently shows emotional feelings, laughing and playing with others.	It presents significant developments in the linguistic aspect, and especially affective as it comes in part mastering your fears and frustrations, showing affection, and evolution of social behavior.	Since the beginning it proved to be a well organized and structured family, despite the S8's mother's death. It is notable family involvement in the therapeutic process and the progress achieved post-therapy. Grandma puts into practice all the guidelines properly, raises questions and curiosities, of all changes made by the grandson. His biggest difficulty was in getting to the limits grandson both in relation to steer clear of toys as in leaving the grandmother's lap during the first therapies.
S9	Before the intervention has very few vocalizations and currently issuing of the first words, still isolated, building brief reports. As for the play was once exploratory and disorganized, there is a certain symbolism, although rudimentary, and stay longer with the same toy.	The construction and establishment of a link are hampered by poor attendance to treatment. Nevertheless, considerable progress is found in the aspects of language and speech production, the symbolism and general behavior of S9.	It is a complex family, where the maternal grandmother demonstrates commitment and apparently dominates family issues, while the mother, perhaps because it is young, it is revealed rebel. Although, not stimulate the child properly, is showing change of heart, and trust in the therapist. In addition to S9 (third child), has another older son in speech therapy, and a newborn girl. It is perceived lack of family planning and life. Therefore, therapy was nominated for her mother, who does not realize the needs of children.

Figure 4. Therapists Perception on development

When confronting the families responses (Figure 3) with the therapists (Figure 4) about the children evolution in aspects of language development, motor, social and psychological, it is clear that in regard to communication and general aspects of behavior, all mothers recognize the children evolutions, especially in terms of comprehension and oral expression, and refer desire and possibilities for the child participation in the family daily activities. This perception corresponds with therapists' perception, except in S1, when the dysphagia discussion presented difficulties in acceptance daughter`s deficiency and said that not realize evolution in her daughter, because, at the time, their expectation was that she walked and speak. Such aspect becomes evident in the daughter future perception, exposed in Figure 3, in which the goal for the child is too difficult to perform, once running is an unrealistic expectation for a tetraplegia child. In this sense, it is also interesting to note that the S5 expectation is that his son sings and S7 that be a good speaker, just focusing on aspects whose base is currently deficient: speech. Also the S6 case draws attention, which the family believes that this is only the blindness and in the other aspects will be a child with normal development. Still on the future expectations, S2 realizes her daughter from the comparison with other children with Down Syndrome, older than S2 and have a worse development than her. Realizes that she has potential and accepts that will not necessarily academic. The same is seen in S3 and S4, which relate know the academic impossibility of their children, but believe they can always progress. Already the S8's grandmother seems to realize that the boy's difficulty lies in the subjective and inter-subjective areas, which creates a greater expectation to child engage well in different social environments.

About the effects of early intervention in the family environment and child, some mothers identify the therapist entrance, be a speech therapist or other reference professional, as a milestone in the child development and important as support for the family, both in general aspects of development, and specifically regarding communication (S1, S2, S3, S6, S7, S8). Interestingly, S4, S5 and S9 not cite familiar effect in particular, especially S5 and S9, which are cases where mothers do not seem to realize their difficulties in interacting with sons. While S5 has difficulty to let her son grows and become independent, S9 presents contrary difficulty, in caring the child and realize their necessity.

The S4's mother presented questions about the effects of EI with ludic focus, such as the program, according on the neurologist indication by behavioral therapy, which could not be in the session with her daughter. Gave up this because the child cried a lot during that intervention and she realized that the program approach include her in the process, unlike behavioral approach. Although the EI was not directly cited, she affirms perceive constant evolution in her daughter. The same is noticeable in S5 and S9.

DISCUSSION

In the present study was observed concordance between parental and therapist perceptions about the children evolution aspects in the language, motor, social and psychic development in all cases, but not in completely mode in S1, where there is maternal denial about the daughter disability, which also emerges in M6's discourse on S6 where the psychic difficulty is not realized by the family. According to some studies, the main reactions expressed by parents against the child's disability diagnostic pass with shock at the news, followed by denial and feelings of guilt, sadness, anger and anxiety about the baby until it reaches the equilibrium stage and acceptance [18.19]. It was observed that in S5 and S7 anxiety is the most evident symptom. Mothers of S5 and S9 do not realize their difficulties in interacting with their children, for opposite behaviors. While the excessive attachment S5, S9 for lack thereof. In the S5 case, there was a common situation in the language clinic disorders, the absence of the paternal function, common element in reports cases in the literature [20,21].

Some authors affirm that pregnancy is configured as an important step on the woman's identity structuring process and the representations that this builds on their child. Throughout this process, the suspicion or confirmation of the physical and mental integrity of the future child can become an obstacle to the establishment of the dynamic mother-baby [22,23], once the family experiences feeling the loss of their desired and idealized son, leading to an existential and emotional conflict that requires them to review all the dreams and expectations for the child. This initial difficulty, however small, increases over time and can be cured or permanently installed depending on the family conduct adopted before this reality and the significance that this event will have for each [24,25].

Therefore, it becomes paramount importance, the way in which parents explain the difficulty / limitation

of their children, in another words, the way they understand the significance of the problem once that according to overcome the deficiency, create expectations, both positive and negative, ranging from the full development of the child to complete incredulity regarding the child's situation. From this perspective, is interesting the S7 case, in which the mother associates the son's communication difficulties, verbal dyspraxia, with one episode of burn. It is known that this kind of explanation attributed by the mother, who has no basis in scientific knowledge, presents her hypothesis based on concepts of popular culture, since they need a concrete explanation that satisfies specific association [26]. It is interesting that this type of explanation related to trauma, throws into question something external, almost magical that focuses on the child, which seems to play a role in eliminating any genetic biological cause or psych - environmental therefore exempt family of any responsibility or blame for the child's disorder. In regard to children with syndromes and evident physical disabilities / sensory, such as S1, S3, S4 and S6, several studies claim the difficulty of dealing with the presence of a biological limit [27,28], even leading to false beliefs about the son evolution [28], which is evident in S1 and S6, which correspond to two of the most biologically compromised children of the sample. These results brings question about the ethical difficulties that early demand clinic, once that dealing with expectations that will not happen is presented as a common challenge in the EI clinic, with which the therapist must deal very cautiously, which is in the way between not reinforce false expectations and at the same time, support investment in the potential shown by the child in day-to-day in their interactions. In addition, the family grieving process is continued and devices such as the interview continued seem to be an important space to talk about the difficulties arising out the limits in the child development[15,16.]

Another aspect that is highlighted in the results is that although the research group in which it is inserted, the data collection seeks an interdisciplinary approach and a single therapist strategy, emerge demands for multiple professionals, arising from the difficulty of medicine professionals to understand the importance of psychological factors in family to care the baby. The pressure suffered by the S4's mother, by the neurologist medical, to make a behavioral approach with her daughter without the mother's presence in session and with multiple therapists, demonstrates a lack of understanding of the importance of symbolic register to the legality of child acquisitions. . In this sense, it is worth noting the Cunha [28] and Cauduro[29] work about the importance of parental care in the neuroscience context. While the first author explains the basic principles of brain growth in development in connection with the care, the second affirms the importance of care from a rapprochement between Winnicott and neuroscience. Both studies allow supposing that the intervention that considers the infant-caregiver interaction is much more effective in terms of brain registration, once that focuses on the fundamental limbic system memory, and maturing in the first year of life. This system, together with the subcortical and cerebellar structures, will form the basis for the cortical maturation in the second year of life in children with normal development, in another words, a consolidated affective relationship is necessary for purely instrumental interventions can make sense in children's lives and their families. For this research`s children, although the chronological age is greater than the second year of life in all cases, including those with significant neurological limitations (S1, S3, S4, and S6) it is evident that early intervention also focuses on the relationship that underlies the cortical acquisitions in progress, or even about the possible limits to both. It should be noted, among limits, access a fluent verbal expression, which may be impossible in some cases (S1, S3, S4), which may depend on alternative forms of communication.

CONCLUSION

Considering the proposed initial analysis regarding the comparison of parental and therapists perceptions on the effects of early intervention in the development of their children and care to them, the study showed correlation between parental and therapeutic insights about the evolution aspects of development language and motor in all cases. In social terms and psychic of children, in two cases there was no agreement because the family shows poor perception of the present and difficult expectations to perform in the future of children.

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