PSYCHOLOGIST INTERVENTIONS IN THE NEONATAL ICU: INTERACTION BETWEEN MOTHER AND BABY IN CONDITIONS OF PREMATURITY

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Elane Martins Silveira[1] and Maria Lucimeyre Rabelo França[2]

ABSTRACT

Prematurity, the condition of the baby born before 37 weeks of gestation, is considered a risk factor for problems in the psychic development of the baby, who is usually indicated for hospitalization in the Neonatal Intensive Care Unit (NICU). In this environment, psychology is concerned with the psychic constitution of this baby. In order to analyze the psychologist's interventions with mothers and babies in the NICU, a qualitative study was carried out, through an action research, with nine mothers with premature babies hospitalized in the NICU of the Assis Chateaubriand Maternity School (MEAC). The research was approved by the Research Ethics Committee of MEAC, under opinion No. 6,028,807. The interaction between mothers and their babies was perceived and stimulated, who enchanted and were enchanted as active agents of interaction. Thus, the psychologist in the NICU has an important role, since he can provide well-being, learning and protection to the psychic health of babies and their mothers.

Keywords: Hypervitaminosis. Vitamin D. COVID-19. Vulnerability.

[1]Preceptor Psychologist in the Multiprofessional Residency Program in Health, with emphasis on Transplants, at the Walter Cantídio University Hospital, at the Federal University of Ceará
Psychologist (Faculty of Intensive Technology - FATECI)
Specialist in the Multiprofessional Residency format in Hospital Psychology and Women's and Children's Health (Federal University of Ceará)
Specialist in Neuropsychodiagnosis (UNICHRISTUS)
Specialist in Neuropsychology (FAVENI)
Specialist in Psychoanalytic Clinic (Estácio do Ceará)
Multiprofessional Residency in Hospital Psychology with emphasis on Women's and Children's Health at the Federal University of Ceará (UFC)
E-mail: elane.msilveira@gmail.com
ORCID: https://orcid.org/0000-0001-5106-7027
LATTES: https://lattes.cnpq.br/6212742220461005
[2]Preceptor Psychologist in the Multiprofessional Health Residency Program, with emphasis on Women's and Children's Health at the Assis Chateaubriand Maternity-School, at the Federal University of Ceará
Bachelor of Science in Psychology (UFC)
Specialization in Hospital Psychology (UNYLEYA)
Specialization in Preceptorship in Health (UFRN)
Master of Education (UFC)
Doctorate in Education (UFC)
Email: lucimeyrerf@yahoo.com.br
ORCID: https://orcid.org/0009-0006-8546-1042
LATTES: http://lattes.cnpq.br/1907085475072944

INTRODUCTION

Psychic processes are regulated by the pleasure principle, that is, the organism receives an unpleasant tension and regulates itself to reduce it, through an avoidance of unpleasure or a generation of pleasure (Freud, 2016). In the baby, initially unable to promote this specific action, this process happens through an experienced other, who communicates the helpless subject with the external world, generating neuronal stimuli (Freud, 1985/1996).

The premature baby may not be prepared for this communication, since he may need to concentrate all his energy to survive, in order to avoid the displeasure of the many stimuli that exist in a Neonatal Intensive Care Unit (NICU), a space reserved for him to receive intensive help and continue to develop or treat some problem at birth. He can turn to himself in this initial process of his development (Moreira et al., 2003), not responding in the same way as the baby born at term to the stimuli offered.

In addition to the entire NICU apparatus, the baby depends on the parents' psychic conditions to become a subject (Moraes, 2021), and does not even exist if no one is there to be a mother (Winnicott, 1975). This demand, which is difficult to meet by the team, places parents as protagonists of care.

By subject, we mean the way in which the human being goes from being a biological subject to a subject of language, becoming a subject of desire (Chemama, 1995). The way this happens can define the baby's psychic constitution, which is based on the assumption that the Other makes of the baby (J. Jerusalinsky, 2002). The Other in psychoanalysis is exactly what symbolically determines the subject, the question of its existence and its history, which depends intimately on what unfolds in this Other (Quinet, 2012).

If the parent-baby psychic interaction begins painfully, it can lead to present and future pathologies (Moraes, 2021). It is from this justification that the present work was developed, since, during the experience of one of the authors as a resident in the NICU, many parents were distressed and did not know what to do after the birth of a premature baby, often needing the interventions of the psychologist to assimilate the affective needs of their baby.

Psychology, in this environment, integrates mother-baby care, acting in the prevention of psychological suffering, with psychological support for families who may go through a crisis situation due to the hospitalization of their babies in these units (Assis Chateaubriand Maternity-School, 2022a).

In view of this reality, an interventional research was carried out, whose general objective was to analyze the interventions of the psychologist with the mothers and babies

in the meeting in the NICU. To achieve this objective, the specific objectives were to intervene in the interaction of the mother-baby binomial, considering the importance of voice and touch, through emotional support to the patient; and to describe the perception of the participating mothers about their experience in the intervention of the psychologist in the NICU.

Taking into account that the psychologist can help parents to be conquered by their baby (Arrais & Mourão, 2013), the question that guided this work was: how does the psychologist's intervention have repercussions on the parents' encounter with their babies in the NICU?

METHODOLOGY

A qualitative study was carried out, through action research, a type of empirically based social research, which involves researchers and participants in a cooperative and participatory way (Thiollent, 1986), based on the accompaniment of mothers in the meeting with their babies in the NICU, with guidance on the importance of interaction with the baby, through resources such as touch and voice, and with interviews with mothers about their perceptions of the lived experience.

To enrich the theoretical foundation of the work, relevant works of psychoanalytic basis were included, emphasizing authors such as Sigmund Freud and Donald Woods Winnicott.

The research took place at the Assis Chateaubriand Maternity Teaching Hospital (MEAC), in Ceará, and followed the Guidelines and Standards for Research in Human Beings (Brasil, 2012), being submitted to the MEAC Research Ethics Committee and approved by opinion No. 6,028,807.

The participants were respected in their dignity and autonomy, having their vulnerability recognized and their freedom to contribute and continue in the research or to withdraw from it at any time, through the Informed Consent Form.

The target population was mothers of babies hospitalized in the NICU of MEAC, as well as the babies themselves, in conditions of prematurity. The inclusion criterion was the gestational age at birth of the baby, between twenty-six and thirty-six weeks and six days, since the period is justified by the fact that it is from twenty-six weeks of gestation that the fetus begins to respond to the mother's own voice stimuli (Parlato-Oliveira, 2017), and before this period it would be more difficult for the baby to respond, since he is focused on other priorities.

Infants with gestational age at birth less than twenty-six weeks, and greater than thirty-six weeks and six days were adopted as exclusion criteria; mothers who did not accept to participate and those who were unable to complete all stages of the research for some reason, such as discharge or transfer of the baby or the mother's withdrawal from participating until the end. At first, the parents were also invited to be part of the research, however they preferred not to participate, although some were very active in caring for the hospitalized baby.

Nine women with a baby hospitalized in the NICU, aged between 25 and 41 years, participated in the research, all of whom had premature cesarean delivery, due to some complication during pregnancy. Each mother was given fancy names in order to preserve their confidentiality. The choice of names, whose meanings are related to the sea, was made in the context of the enchanting power that mothers exert on their babies, through the manhês, as the "mermaids" who enchant (Laznik, 2021).

The babies were born between 27 and 34 weeks, weighing between 990 and 2585 grams. Some of them were hospitalized to gain weight, develop the ability to breathe, perform surgeries, among other needs. It did not delve into the characteristics of its organic conditions, since this is not the focus of this research.

The instruments used during the survey were the Psychosocial Care Form, the Initial Interview, the Intervention Script and the Final Interview.

The Psychosocial Care Form (Assis Chateaubriand Maternity-School, 2020), is composed of questions in order to collect sociodemographic data, clinical and emotional aspects of pregnancy, childbirth and postpartum.

The Initial Interview and the Final Interview were constructed based on the need to capture the participants' perception of the resources available to the binomial before and after performing the intervention. The Intervention Script was based on studies on the prevention of risks to the baby's psychic constitution, considering the mother-baby interaction, and consisted of interventions to be carried out, according to the needs of each participant binomial, during the intervention in the NICU.

Information collection was carried out in three stages. The 1st Stage, Invitation to participate in the research and Initial Interview, comprised the search of mothers who had newborn babies hospitalized in the NICU of MEAC, collecting data on the baby's history, explaining them and inviting them to participate in the research, along with the baby's father figure, if present. Soon after, the Initial Interview was applied, collecting the mothers' perceptions before the intervention.

In the 2nd Stage, Intervention, participatory observation and interventions were carried out, based on the meeting of each mother with her baby in the NICU environment. In this phase, the mother-baby relationship was observed, followed by interventions such as offering emotional support to the mother, providing guidance on the role of parents in the baby's psychic development and helping to construct the meaning of the interaction experience for her. The interventions took place according to the needs of each binomial, following the pre-established script. This moment was recorded in a field diary, for better analysis, according to the content observed.

Laznik (1999) suggests that, from the professional gaze surprised and enchanted by the "Freudian king" that exists in the baby, mothers can identify with this "gaze". When they could see nothing but a body, they could be offered this "look" and given identification with it.

The 3rd Stage, Final Interview, aimed to capture the participants' perceptions about their interaction with the baby and about the baby's responses to this interaction. The interviews were recorded and later transcribed in order to undergo data analysis.

This was followed by Content Analysis, a method that classifies its phases as pre-analysis, exploration of the material, treatment of the results, inference and interpretation (Bardin, 2016).

The mothers' discourses obtained through the instruments used in the research were transcribed and tabulated, and composed material for the analysis of the research data.

In the pre-analysis, a floating reading of the collected material was performed. Then, the material was explored, through rereading, identifying the themes that were repeated in the speeches and observations.

Based on these, the treatment and interpretation of the results were carried out, observing some points, divided here into three major categories, chosen according to the most repeated statements, following the meaning of the experience of prematurity and hospitalization in a Neonatal ICU.

RESULTS AND DISCUSSIONS

The content analysis made it possible to identify three major categories: the relationship of mothers with the environment and professionals of the NICU; the mothers' perception of their relationship with the baby; and the mothers' perception of the psychologist's intervention.

MOTHERS' RELATIONSHIP WITH THE ENVIRONMENT AND NICU PROFESSIONALS

The NICU environment, unknown to most parents, can be frightening, both because of the stereotype of the ICU related to the proximity of death (Lima & Smeha, 2019), and because of the technological apparatus that surrounds and mischaracterizes the idealized baby, which would be the result of the rebirth of parental narcissism, updated under the tendency to attribute all perfections to the child (Freud, 1914/1996). Since idealization is crossed by this context, the narcissism of the parents themselves is reached, making it difficult for them to hide all their faults.

This estrangement to the environment was perceived in the statements of some mothers, as can be seen when Naia says: "*At first, it's scary, right? You receive the news: 'Naia, your child is going to the ICU', you already know that it is a more specialized follow-up, and everything, you know? But to say that I know what it's like inside, I don't know."*

While it was scary that their babies needed to stay in the NICU, there was understanding and confidence that it represented a place of intensive care, as the name implies.

Despite the confidence of the majority, mothers want to take care of their babies, as Marina says: *"of course the best place is to be with the mother, to be breastfeeding directly from the breast (...), but I also know that there, despite the small difficulties, there is what is necessary for him, right?".* The NICU, an environment that says nothing about who the baby is, feels, or thinks, presents itself as an interdictor of parent-infant contact (Frantz & Donelli, 2022).

These mothers were shown that, although the care of the health team is indispensable there, they can still do a lot for their children, especially when it comes to the affective bond, which is "almost vital" to them (Szejer & Stewart, 1997, p. 313), and that the team has no intention of replacing it, but of joining forces for the lives of the babies.

MOTHERS' PERCEPTION OF THEIR RELATIONSHIP WITH THE BABY

Mother-baby interaction is part of a relationship under construction, which begins even before conception, from the woman's first relationships and identifications, from childhood to the desire to have a child and the pregnancy itself (Freitas & Marques, 2022).

The risks of prematurity for the processes of child development and psychic constitution can be presented through signs, such as the lack of response to the manhês, the absence of exchange of glances and the lack of summoning the baby to the adult (Roth-Hoogstraten et al., 2018). In the mother-infant relationship, different interaction resources were observed, such as voice, touch and gaze, encountered spontaneously or stimulated during the intervention, in order to prevent such risks.

The voice

Manhês, a voice directed to the child through rhythmic, melodic and vocal characteristics, is presented as a form of interaction with babies, who, even as newborns, perceive minimal differences between musical sounds and melodic forms, especially when emitted by the mother's voice (Trevarthen et al., 2019).

The voice was mentioned by the mothers as a resource used since pregnancy, as observed in the answers to the question about what the baby might like them to do: "*I think singing, because I sang when she was inside me, and I don't know if she listens, but I sang! I even sang there today, and that's when I saw her kind of wanting to hear it"* (Nalu). The patient liked to sing to her baby, and she noticed how much she reacted to the melody, looking at her attentively, sometimes moving her little foot, sometimes raising her little hand.

Laznik (2021) compares the mother's voice, charming and irresistible, to the voice of a mermaid, as mythology tells, considering that this power is already in action even before the baby is born, being prior to the look, which the mothers confirm, when they say that babies respond to the manhês still in the womb.

Before the intervention, Gal said that *"it's crazy to talk to a baby in the belly".* Now, wouldn't this be the madness of which Winnicott speaks, and which, in this case, had the course of its development drastically redirected by prematurity? To this "madness", Winnicott (2000) attributes the term *primary maternal concern,* a state of identification of the mother with the baby, that is, her ability to have an exacerbated sensitivity to his needs, which would be pathological if there were no baby. After the intervention, in which the researcher spoke for the baby and for her, lending her resources, Gal was able to feel more comfortable to strengthen her bond with her baby, including through other resources.

Mália, before going to see her baby in the NICU, believed that he would like her to talk to him, and says: "*Talking helps a lot, he will feel welcomed, right? He needs to listen to the voice of his mother and father, right? They say that the recovery gets better."* Mália uses the manhês spontaneously, saying that she is there next to her baby. The baby looks at her and moves his little foot, when she says that he looks like his father. She says she realizes that her presence and also her father's presence have helped the baby develop faster. When pronounced in melody, the voice is loaded with affection "that appeases and promotes security for the baby" (Parlato-Oliveira, 2017, p. 19).

The touch

Benefits such as reducing the time of mother-child separation, facilitating the mother-baby bond, reducing stress and pain, and improving the quality of the baby's neuropsychomotor development are made possible through skin-to-skin contact between the binomial, which begins through touch and continues through the Kangaroo position (Assis Chateaubriand Maternity-School, 2022b).

Winnicott (1983, 2000) talks about phenomena closely linked to touch. *Handling* is the baby's own bodily handling, through touching, bathing, changing diapers; and *holding* is the care that includes the physical holding, and much more than that, the psychic support of the baby in the mother's subjectivity. These techniques provide the baby, little by little, with the awareness of being inside his own body, which is part of his constitution as a subject.

The mothers in this study were in the process of building this relationship, a process of identifying the forms of interaction of the baby, as Gal tells us: "*I did not feel interaction with the voice, but physically I did".*

Gal was unable to use the manhês during the intervention, and not even during pregnancy, however, after the first consultation, she was able to understand that she was in the process of building a relationship with the baby: "*I didn't talk much, I felt strange, to play this role. It was something that we (...) still had time to build. It was towards the end of the pregnancy, there were still almost three months, which were interrupted"* (Gal).

In this construction, Gal considered touch as a possible interaction, already in the initial interview: *"The only thing we can do at the moment is touch"* (Gal). The singularities of the relationships established between each mother and baby must be taken into account, since motherhood is built with the questions and fantasies of a mother in relation to a baby, and there is no previous model that fits all women (Corrêa, 2022). In this way, initially from touch, the relationship between Gal and her baby was solidified.

The look

The premature baby may have a real body different from what the mother imagined: sometimes thin, small, full of devices that cause strangeness, therefore not corresponding to the idealized baby of pregnancy (Pergher et al., 2014). How to look then, this strange baby to what he imagined, without anguish?

Iara, during the intervention, comments that the baby *"is strange".* In fact, she was surprised by the amount of equipment that supported her, such as the tube, the plastic to keep the heat. It was noticed, at this point, that she wanted to know about it, and the researcher gave some guidance and facilitated communication with the rest of the team.

At the end, Iara says: *"she's beautiful, isn't she?"*element. It was noticed that estrangement was part of the process of adaptation to the environment. The mother was becoming familiar with the specifics of the premature baby and also with the equipment she needed. A baby born in a "non-place" would have a higher level of psychophysical helplessness and would thus be exposed to greater psychic risk (Menéndez & Marceillac, 2004). Situating the premature baby can be difficult for the mother who has had little time to develop *primary maternal concern.*

Laznik (2021) points out a complex articulation between the organic reality and the parents' gaze as what comes to constitute for the baby the experience of his body. This gaze, which is not to be confused with vision, is above all a particular form of libidinal investment, which allows parents an anticipatory illusion in which they perceive the organic real circumvented by what it can become.

The baby as an active agent of interaction

Iara was preparing to leave the room, when she let go of the little girl's hand, which soon became agitated. Iara spoke about the experience: *"I said I was coming, then she started to get a little attentive, agitated, then she quieted down a little. From what I saw, I think she wanted me to stay, because she was pulling her little hand."* One of the interventions used at this time was the orientation to explain that she would return, in order to create the perspective of "absence" between mother and baby. The mother said: *"we'll come again, daughter!"* (Iara), and had a calm baby as an answer.

Absence, which only exists from a presence that was previously concretized (Laznik, 2021), made it possible for the being who looks (mother) and the being who is looked at (baby), the delimitation of the baby's self and body, which tend to be defined as effects of this mother's instituting gaze. The mother said at the end: *"she won't let me go!"*, and could see a baby who quiets down when she feels safe, and reports: *"I felt very good, because I didn't expect the baby to understand!"* (Iara).

In this way, babies are seen as active agents in the interaction with their mothers, and enchant and seduce them, with the way they give them what they are looking for, or beyond, something they did not even imagine possible, having "an increasingly decisive role in their becoming", since even if the other is a source of inspiration and says about the baby, it does not determine the latter's interpretations of what is said (Parlato-Oliveira, 2017, p. 11).

THE MOTHERS' PERCEPTION OF THE PSYCHOLOGIST'S INTERVENTION IN THE NICU

The nine mothers considered that the intervention had repercussions in some way for them and their babies. In their reports, statements emerged that pointed to the intervention as a protective factor for the psychic health of the mother, the baby and as a learning factor, as can be seen in the following subcategories.

Intervention as a protective factor for the mother's mental health

Kai, when stating the importance of monitoring psychology during the meeting with the baby in the NICU: *"I improved a lot! (...) My way of thinking has improved a lot. I had no one to talk to, right?"*, refers to the need to feel welcomed in their feelings and words, thus perceiving their anguish dissolved through these words, in line with what Simonetti (2018) points out about the course of anguish, through words in clinical work.

Gal reports on her perception of the intervention:

> From what we were talking about, and also with the proposal to go there with me, I think something changed in my thoughts. Until then, I think the penny hadn't dropped! (...) It was all different from what we had thought! So I think that in this sense it was very important, right? To help create that connection with the child.

Gal's perception denotes that she was able to reflect on and appropriate the process of being the mother of a premature baby, both through elaboration, which demands time from the patient (Freud, 1914/2010), and through guidance.

Analytical listening and interventions were able to allow each mother, through language, to have the *holding* for her own helplessness, which is actualized in her, through the helplessness and fragility of the baby who has just been born (Komniski & Chatelard, 2018).

As they speak, their thoughts change and doubts give way to a more concrete relationship. Hence the importance of psychological listening, since through the sayings, this relationship is built, and the experience of being a mother of a premature baby.

Intervention as a factor of protection and stimulation of the baby's mental health

In the Final Interview, all mothers stated that the psychologist's interventions contributed to the baby's development.

Mália believes in the importance of the intervention, considering that it can interfere with the baby's development: *"It was awesome! So, for him to have much more*

improvement, right? And also, I think he's feeling protected. We see his way like this: today is totally different from yesterday."

Mathelin (1999), when talking about the work of the psychoanalyst in the NICU, proposes the work of resuscitating the child's desire, articulated with the parents' desire, since, metaphorically to medical resuscitation, essential to life, the word can bring back the will to live.

Winnicott (2000) talks about the baby's experience of the threat of annihilation, a very primitive anxiety, constituted by reactions to the intrusion of the environment. Such a reaction depends on providing him with an environment with minimal intrusions. For the premature baby, this intrusion happens much more frequently and in much larger doses, since procedures and technical manipulations are constantly carried out, and the mother cannot always be present.

In this way, the psychologist with a psychoanalytic approach "borrows himself" as a mediator and translator of the suffering of the parents and the baby, seeking to excuse the parents and legitimize the potential and strength of the baby (A. Jerusalinsky et al., 2015).

Intervention as a learning factor

Each professional who works in the NICU has his or her role, and the importance of the performance of one does not cancel out the importance of the performance of another. Otherwise, the medical report would be enough for the mothers to assimilate what they are told. However, doubts can go beyond a rational and technical discourse, persisting as unknown, the spring that inaugurates and agitates the discourse (Espíndola & Carvalho, 2020).

Iara says that she considers it very important to follow up with Psychology during the visit, making her feel safe to interact with her baby. The psychological listening and the guidance made possible in the intervention made her feel understood in her feelings and doubts:

> Without the intervention, first I wouldn't understand anything, and I think the baby would be kind of like that. Because sometimes, I tried to explain it to her, but I didn't understand anything (...). I only went to pick her up after the psychologist understood me and explained it to me, because my fear is of hurting her a lot.

When verbalizing about the professional-mother-baby tripod, mediated by psychology, the mother reports that she learns, and can then pass it on to her daughter, in order to situate her in the process of psychic construction about what happened to her.

The intervention sought, as suggested by J. Jerusalinsky (2002), to authorize mothers to exercise their conscious and unconscious knowledge with their baby, and also, when necessary, to lend signifiers and sustain the meaning of the baby's gestures as part of its development, that is, to provide the symbolization of this baby for them.

CONCLUSION

Welcoming and offering psychoanalytic listening to the mother, so that she can talk about her impressions and anxieties; perform psychological follow-up in the NICU space; lending her voice and looking at the baby, when necessary, talking to him using the manhês, indicating his reactions at that moment, asking who he looked like, so that he felt at ease, and even "authorized" to interact with him, were some of the interventions used.

Such interventions made it possible to strengthen the bond, favored the interaction between mother and premature baby and the coping with feelings such as guilt and fear of interacting with their baby, which could provide the presence of mothers who were more comfortable to play their role in a "good enough" way, which has a great influence on who the baby can become.

The mothers' perception emphasized the importance of the psychologist's performance in this scenario of so many insecurities and uncertainties, promoting reflections and the possibility of taking ownership of the process of being a mother of a premature baby with safety, psychological support and learning. Each one brought, in their experiences and speeches, demonstrations of what the theorists mentioned in their studies, such as the suffering in the face of the unexpected rupture of the mother-baby relationship, produced by a premature birth and the hospitalization of the baby in a NICU; the need for a *holding* performed by the team for the mother, so that she can hold for her baby; the power of mutual passion that arises from the mother-baby interaction.

The research resulted, then, in contributions to the participants and the scientific community, as it enabled the mother-baby interaction, in order to facilitate the construction of the bond and, consequently, minimize the risks arising from prematurity and the length of hospitalization in the NICU. This mother-baby interaction promoted relief, reducing anxiety, and better understanding of the mothers about the care their children were having in the NICU. The research emphasizes the importance of the psychologist's performance in the NICU and points to the need for new studies in the area, in order to detect and prevent risks and problems in the psychic constitution of babies as soon as possible, since this care does not end with hospital discharge.

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REFERENCES

1. Arrais, A. R., & Mourão, M. A. (2013). Proposta de atuação do psicólogo hospitalar em maternidade e UTI neonatal baseada em uma experiência de estágio. Revista Psicologia e Saúde, 5(2), 152–164. http://pepsic.bvsalud.org/pdf/rpsaude/v5n2/v5n2a11.pdf

2. Bardin, L. (2016). Análise de conteúdo (1st ed.). Edições 70.

3. Brasil. (2012). Resolução nº 466, de 12 de dezembro de 2012. Diário Oficial da União. https://bvsms.saude.gov.br/bvs/saudelegis/cns/2013/res0466_12_12_2012.html

4. Chemama, R. (Org.). (1995). Dicionário de psicanálise: Larousse. Artes Médicas.

5. Corrêa, H. C. S. (2022). Feminino e maternidade: Mais ainda, a partir da prematuridade. Revista Psicologia USP, 33, 1–8. https://doi.org/10.1590/0103-6564e20210025

6. Espíndola, V. B., & Carvalho, I. S. (2020). O ato de nomear o bebê internado em uma unidade de terapia intensiva neonatal: Uma aposta no advento do sujeito? Ágora: Estudos em Teoria

7. Psicanalítica, 23(2), 81–89. https://doi.org/10.1590/1809-44142020002007

8. Frantz, M. F., & Donelli, T. M. S. (2022). Vivências parentais no contexto da prematuridade: Da UTIN ao primeiro ano de vida do bebê. Ágora: Estudos em Teoria Psicanalítica, 25(2), 20–30. https://doi.org/10.1590/1809-44142022002003

9. Freitas, E. M. S., & Marques, A. M. S. (2022). A relação entre a fase pré-natal e a constituição do bebê como sujeito psicanalítico. Brazilian Journal of Science, 1(8), 94–104.

10. Freud, S. (1996). Projeto para uma psicologia científica. In Publicações pré-psicanalíticas e esboços inéditos (Vol. 1, pp. 212–297). Imago. (Trabalho original publicado em 1895)

11. Freud, S. (1996). Sobre o narcisismo: Uma introdução. In A história do movimento psicanalítico, artigos sobre metapsicologia e outros trabalhos (Vol. 14, pp. 81–110). Imago. (Trabalho original publicado em 1914)

12. Freud, S. (2010). Recordar, repetir e elaborar: Novas recomendações sobre a técnica da psicanálise II. In Observações psicanalíticas sobre um caso de paranóia relatado em autobiografia ("O caso Schreber"), artigos sobre técnica e outros textos. Companhia das Letras. (Trabalho original publicado em 1914)

13. Freud, S. (2016). Além do princípio do prazer (R. Zwick, Trad.). L&PM. (Trabalho original publicado em 1920)

14. Jerusalinsky, A., Bernardino, L. M. F., Lacerda, E., Wajntal, M., Catão, I., Mota, S., Pesaro,

15. M. E., & outros. (2015). Bebês em risco de autismo e os recursos do psicanalista para ajudá-los. In A. Jerusalinsky (Org.), Dossiê autismo (pp. 408–417). Langage.

16. Jerusalinsky, J. (2002). Enquanto o futuro não vem: A psicanálise na clínica interdisciplinar com bebês. Ágalma.

17. Komniski, P. C. N. V., & Chatelard, D. S. (2018). Nascimento: Cesura, catástrofe e psicanálise. Estilos da Clínica, 23(3), 523–541. https://doi.org/10.11606/issn.1981-1624.v23i3p523-541

18. Laznik, M.-C. (1999). Os efeitos da palavra sobre o olhar dos pais, fundador do corpo da criança. In D. B. Wanderley (Org.), Agora eu era o rei: Os entraves da prematuridade (pp. 129–140). Ágalma.

19. Laznik, M.-C. (2021). A voz da sereia: O autismo e os impasses na constituição do sujeito. Ágalma.

20. Lima, L. G., & Smeha, L. N. (2019). A experiência da maternidade diante da internação do bebê em UTI: Uma montanha russa de sentimentos. Psicologia em Estudo, 24, Article e42603. https://doi.org/10.4025/psicolestud.v24i0.42603

21. Mathelin, C. (1999). Da pulsão de morte ao desejo de vida, ou as vicissitudes de uma terapia intensiva. In D. B. Wanderley (Org.), Agora eu era o rei: Os entraves da prematuridade (pp. 61–79). Ágalma.

22. Maternidade-Escola Assis Chateaubriand. (2020). Ficha de atendimento psicossocial. UFC.

23. Maternidade-Escola Assis Chateaubriand. (2022a). Manual técnico - Serviço de Psicologia da Maternidade-Escola Assis Chateaubriand. UFC.

24. Maternidade-Escola Assis Chateaubriand. (2022b). Procedimento operacional padrão - Contato pele a pele e posição canguru nas unidades neonatais. UFC.

25. Menéndez, O., & Marceillac, M. (2004). ¿Por qué mantener juntos o separar a los bebés de sus mamás en las terapias intensivas neonatales? Revista Chilena de Psicoanálisis, 21(10), 210–220. https://pesquisa.bvsalud.org/portal/resource/pt/psa-92740

26. Moraes, M. H. C. (2021). Psicologia e psicopatologia perinatal: Sobre o (re)nascimento psíquico (1st ed.). Appris.

27. Moreira, M. E. L., Braga, N. A., & Morsch, D. S. (2003). Quando a vida começa diferente: O bebê e sua família na UTI neonatal. Fiocruz.

28. Parlato-Oliveira, E. (2017). O bebê e a voz. In E. Parlato-Oliveira & D. Cohen (Orgs.), O bebê e o outro: Seu entorno e suas interações (1st ed., pp. 17–27). Langage.

29. Pergher, D. N. Q., Cardoso, C. L., & Jacob, A. V. (2014). Nascimento e internação do bebê prematuro na vivência da mãe. Estilos da Clínica, 19(1), 40–56. https://doi.org/10.11606/issn.1981-1624.v19i1p40-56

30. Quinet, A. (2012). Os outros em Lacan. Zahar.

31. Roth-Hoogstraten, A. M. R. J., Souza, A. P. R., & Moraes, A. B. (2018). A complementaridade entre sinais PREAUT e IRDI na análise de risco psíquico aos nove meses e sua relação com idade gestacional. CoDAS, 30(5), Article e20170268. https://doi.org/10.1590/2317-1782/20182017268

32. Simonetti, A. (2018). Manual da psicologia hospitalar: O mapa da doença. Artesã.

33. Szejer, M., & Stewart, R. (1997). Nove meses na vida da mulher: Uma aproximação psicanalítica da gravidez e do nascimento. Casa do Psicólogo.

34. Thiollent, M. (1986). Metodologia da pesquisa-ação (2nd ed.). Cortez.
35. Trevarthen, C., Aitken, K. J., & Gratier, M. (2019). O bebê nosso professor. Langage.

36. Winnicott, D. W. (1975). O brincar e a realidade. Imago.

37. Winnicott, D. W. (1983). O ambiente e os processos de maturação: Estudos sobre a teoria do desenvolvimento emocional. Artmed.

38. Winnicott, D. W. (2000). Da pediatria à psicanálise: Obras escolhidas. Imago.