The maternal perception about language symptom in three cases of risk to development and the search for early intervention

A percepção materna do sintoma de linguagem em três casos de risco ao desenvolvimento e a busca por intervenção precoce

La percepción materna acerca del síntoma de lenguaje en tres casos de riesgo para el desarrollo y la búsqueda de la estimulación temprana

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Abstract

Objective: Analyzing the maternal perception on language symptom in three cases of risk to development and its relation to the search for early intervention. **Methods:** Three subjects were followed up in longitudinal research after the application of the Clinical Risk Indicators in Child Development (IRDIs) protocol, from the first to the eighteenth month of life. After the conclusion of the IRDIs research, three babies were evaluated again between 21 (M) and 24 months (R,T).This evaluation consisted of interview that tried to find general health data of the subjects, with focus on issues related to communication and language. We attempted to capture the perceptions of each parent about the presence or absence of language disorder in their child. The analysis was based on the production of meaning from the dialogue established between the researcher and mothers. **Results and Discussion:** The longitudinal follow-up of

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these families and their children enabled the awareness-raising with regard to listening to the suffering of the subjects, and the establishment of therapeutic demand, in early intervention (in one case), as well as for speech and language therapy (in two cases). **Conclusion:** The therapeutic demand for early intervention or speech therapy occurred in a singular way, case by case. The research suggests the need for insertion of a longitudinal follow-up of the psychic constitution and of the development of language, beyond motor and nutritional aspects, the most traditional focus in child health policies.

Keywords: language; child development; risk; child health.

Resumo

Objetivo: *analisar a percepção materna do sintoma de linguagem em três casos de risco ao desenvolvimento e sua relação à busca por intervenção precoce.* ***Método:*** *Três sujeitos foram acompanhados em pesquisa longitudinal a partir da aplicação do protocolo Índices de Risco ao Desenvolvimento (IRDIs), do primeiro até os dezoito meses. Após o termino da pesquisa do IRDIs, os três bebês foram avaliados novamente, um bebê aos 21 meses, e os outros dois aos 24 meses. Essa reavaliação constituiu-se de entrevista que buscou dados gerais da saúde dos sujeitos, com foco principal em questões de comunicação e linguagem. Buscou-se captar a observação de cada mãe acerca da presença, ou não, de distúrbio de linguagem em seu filho. Trabalhou-se com a análise da produção do sentido, a partir do diálogo estabelecido entre a pesquisadora e as mães.* ***Resultados e Discussão:*** *O acompanhamento longitudinal das mães e de seus filhos facilitou a sensibilização das mães em relação à escuta do sofrimento dos filhos. Facilitou também o estabelecimento da demanda terapêutica em intervenção precoce em um dos casos e a abordagem terapêutica fonoaudiológica nos outros dois casos.* ***Conclusão:*** *A demanda por intervenção precoce ou terapia fonoaudiológica ocorreu de modo singular em cada caso. A pesquisa sugere a necessidade de um acompanhamento longitudinal da constituição psíquica e do desenvolvimento da linguagem, para além de marcos motores e nutricionais, foco mais tradicional na política da saúde da criança.*

Palavras-chave: *linguagem; desenvolvimento infantil; risco; saúde da criança.*

Resumen

Objetivo: *Analizar la percepción materna acerca del síntoma de lenguaje en tres casos de riesgo para el desarrollo y su relación con la búsqueda por estimulación temprana.* ***Método:*** *Tres sujetos fueron acompañados en investigación longitudinal por medio de la aplicación del protocolo Indicadores de Riesgo al Desarrollo (IRDIs), del primero hasta los dieciocho meses. Una vez concluida la investigación del IRDls, los tres bebes fueron evaluados nuevamente un bebe a los 21 meses y los otros dos a los 24 meses. Esta reevaluación consistió de una entrevista que buscó datos generales de la salud de los sujetos, centrándose en cuestiones de comunicación y de lenguaje. Se trato de captar la observación de cada madre acerca de la presencia o no de trastorno del lenguaje en su hijo. Se trabajo con el análisis de la producción de sentido, a partir del diálogo establecido entre la investigadora y las madres.* ***Resultados e Discusión:*** *El seguimiento longitudinal de las madres y sus hijos facilitó la sensibilización de ellas escuchar los sufrimientos de sus hijos. También facilitó el establecimiento de la demanda terapéutica en la intervención temprana en uno de los casos, y el abordaje terapéutico fonoaudiológico en los dos casos.* ***Conclusión:*** *La demanda por intervención temprana o por terapia fonoaudiológica ocurrió de manera particular en cada caso. Esta investigación sugiere la necesidad de un seguimiento longitudinal de la constitución psíquica y del desarrollo del lenguaje, más allá de los hitos motores y nutricionales que constituye el enfoque más tradicional de la política de la salud infantil.*

Palabras clave: *lenguaje; desarrollo infantil; riesgo; salud del niño.*

Introduction

When babies are born with a clear biological limitation, for example, in case of presence of syndromes, an early medical appointment of these babies is performed in order to offer them the appropriate care according to the health needs. However, in cases of risk to development, which includes the mental risk, the insertion of detection instruments for the early referral is still unexpressive in the system of health. In this sense, recent research carried out in France[1] and in Brazil[2,3] prove the possibility of early detection and referral in cases of risk to development and/or to mental skills as stated by the psychoanalytic theories of Freud[8] and Lacan[9].

From the possibility of early detection through the Clinical Risk Indicators in Child Development (IRDIs)[2], a longitudinal research of babies in a University Hospital of a medium-sized city was carried out. Through this research, some works were initiated, the ones which may prove the importance of those indices for the detection in cases of risk to development and/or mental, as well as to acquisition of language, from statistical verification[4,5,6] and case studies[7].

However, the follow-up of babies in projects such as the ones which make use of IRDIs was not proceeded by immediate access to early intervention to babies who presented a risk to development, in a multicentric study[2] and also in studies carried out by the staff of a University Hospital of a medium-sized city[4,5,6]. We give emphasis to the fact that since the beginning of the research of this group, mothers who were not well emotionally, as well as the mothers of babies who presented a risk to development, were instructed to a medical care according to the main demand of the case. However, the search for it was not immediate, in most cases.

In this paper, we focused on the reflection about the moment in which the family, specifically the mother, realized that the son needed early intervention or that she accepted it by the researcher indication and sought speech therapy care or, in other words, how the establishment of therapeutic demand occurred. From nineteen cases of risk to development, followed up until the conclusion of IRDIs research in a medium-sized city in Rio Grande do Sul, five presented language difficulties, of which three of these cases are analyzed in this paper.

Then, the analysis of the maternal perception of language symptom on children at risk to development, and also the effects of it on the search for early intervention, were the aims of this paper.

Method

This research is characterized as a case study of qualitative and retrospective approach. The research named "Parental functions and risk for acquisition of language: speech therapy interventions," approved by the Ethics Committee of the University where it was carried out under the number 0284.0.243.000-09, had 182 babies born at term or pre-term, without organic changes, at the University Hospital of medium-sized city of Rio Grande do Sul as its initial sample.

Babies who presented congenital malformations, genetic syndromes, congenital infection detected in the neonatal period, before the beginning of the study, were excluded from the study because these factors themselves would represent factors of risk to child development.

After carrying out the newborn hearing screening (with positive results, i.e. without hearing loss indicative), the babies started to be followed up after the end of the first month of life, during 18 months, through the Clinical Risk Indicators in Child Development (IRDIs) (verify Table 1). Therefore, they were assisted from the first month of age, through the application of IRDIs in the age groups 0-4, 4-8, 8-12 and 12 to 18 months, and also with continuing interviews with their parents.

0 TO 4 INCOMPLETE MONTHS	AXES
1. When the child cries or screams, the mother knows what the child wants.	SA/DE
2. The mother talks to the child in a style particularly addressed to the child (motherese).	SA
3. The child responds to motherese.	DE
4. The mother proposes something to the child and waits for the response.	AP
5. Mother and child exchange eye-contact.	SA/AP
4 TO 8 INCOMPLETE MONTHS	
6. The child uses different signals to express different needs.	DE
7. The child responses (sound, vocals) when the mother or someone else addresses him/her.	DE
8. The child actively seeks contact with the mother's eyes.	DE/AP
8 TO 12 INCOMPLETE MONTHS	
9. The mother understands that some demands from the child may be a way to call her attention.	DE/SA
10. During body care, the child searches actively to play love games with the mother.	DE
11. Mother and child share a private language.	SA/AP
12. The child feels ill at ease with unknown people.	PF
13. The child shows cute behavior.	DE
14. The child accepts semi-solid, solid and varied foods.	DE
12 TO 18 MONTHS	
15. The mother alternates moments of dedication to the child with other interests.	DE/PF
16. The child endures well the mother's brief absences and reacts to longer absences.	DE/PF
17. The mother no longer feels compelled to meet all demands from the child.	PF
18. Parents establish small behavior rules for the child.	PF

Table 1 - Clinical Risk Indicators in Child Development (IRDIs)[2]

The parents or guardians of the babies received detailed explanations about the aims and procedures of the study and they were observed in their interactions with the babies for analysis of the first stage of the Clinical Risk Indicators in Child Development. At that moment, the mothers were interviewed about the experience of motherhood[10] and evaluated by the scale of Beck[11], which is a fast way to evaluate the frames of mind. It consists of the Beck Anxiety Inventory (BAI) and Beck Depression Inventory (BDI)[11]. The data associated to the application of the scale of Beck[11] were not analyzed in this research because they were already discussed in another study of the group[5].

As the University Hospital also attends the cities of the region, more than 50% of the sample was constituted of babies resident in nearby cities. Then, it was natural that losses occurred during the longitudinal follow-up. In addition to this reason, there were others, such as the withdrawal of the family, moving to another city and logistical difficulties of the research group, as the fact that babies used to live in several districts of this medium-sized city and some of them had changed the address or phone number, turning it impossible to find them in time for the entire collection.

From the initial sample composed by 182 children, a group of 56 children continued to be evaluated until the end of the project which was concluded by the end of 2011, when we collected the last indices of risk to development. From these 56 children, 22 were assisted until their twenty--fourth months for presenting risk to development. To carry out this research, we used a sample of three children, three boys (R., T and M), located in this group of 22 children, who at twenty-four months presented risk to child development and also to language acquisition.

After the IRDIs research, three babies were evaluated again between 21 (M) and 24 months (R, T). This evaluation consisted of an interview at the clinic school of the Hearing, Speech and Language Sciences Major, lasting about an hour. This interview tried to find general health data of children and its main focus was the communication and the language, trying to capture the observation of each mother about the language disorder of her child. The analysis of the language functioning of the three boys covered the formulation of a language functioning hypothesis[12], the exploration of the mechanisms and enunciative strategies[13] and also the relationships between form and meaning set out in dialogue with the family members[14].

The history of each of the three children in the cohort study of 1 to 18 months, mother speech at 21 and 24 months of age of the child, as well as the description of the process of the demand establishment for early intervention are shown here, in the format of case studies. The analysis of the production of meaning was used, from the dialogue established between the researcher and mothers, trying to demonstrate how the researcher prepared the question and how they answered. This is a content analysis of what was said by the mother, but trying to keep the dialogue and therapist issues as a scenery. Therefore, it is not only a content analysis[15], once it tries to simultaneously expose the expression/interpretation of the interlocutors in the dialogue situation.

As a result, this paper configures itself as a narrative of the researcher about the cases. At some moments, it presents excerpts of the speech of the mothers in conversation with the researcher to reveal the observation of mothers in the establishment of demand for the therapy, and, at other times, some scenes of the interview between researcher and mother are presented, which are transcribed in a spelling mode, with the indication of the researcher (P) and the mothers of the children (MT, MR, MM).

Results[1]

The results are shown in three broad categories; each one tries to synthesize the process of establishment of demand in each case. The brief history of each of them (sex, age, sociodemographic characteristics and clinical data) is exposed below, in each case.

The non-maternal strangeness to the absence of the speech of the son: paths of the MT-T dyad

T. is the fourth son of a Family that is constituted by the mother (27 years), the father (29 years), older siblings, two girls of 10 and 4 years old and a boy of 8 years, and the youngest brother of six months. The mother does not have the support of the family with the child care. In the evaluations, she was visibly tired and depressed. All family members live in the same house, and the older children attend school in the neighborhood. The mother of T is a housewife and she has incomplete elementary school level; the father works as a mason and has incomplete high school level. The family income is approximately R$ 510.00.

T. was born of an unplanned pregnancy, preterm, and he did not present complications at birth. In the first phase of IRDIs, around the fourth month, the absence of IRDI 2 was detected ("The mother talks to the child in a style particularly addressed to the child (motherese).)." We evidenced that when the evaluator talked to the baby by using the motherese, T. responded with smile and vocalizations. By identifying this risk, at the moment, the research team invited the mother of T to join a group of mothers who had significant signs of depression. The mother presented a moderate level of depression, and had indications for intervention, but she thought it was not important to make part of the therapy group.

In the second phase, when T. was 6 months, no special features related to IRDIs were observed. However, the mother reported that he was hospitalized twice because the child had crisis of bronchitis since the third month of age. In the third phase, at 10 months of T., the mother said he was with profound anemia and he was under treatment. At that time, we observed that T. was not very active during the meeting.

When evaluated the last phase of IRDIs protocol, at 18 months of T., the absence of IRDI 16 was observed ("The child endures well the mother's brief absences and reacts to longer absences."), and 18: ("Parents establish small behavior rules for the child."). T. would not stay with anyone beside his own mother, once he used to cry a lot because of her absence. In addition, no rule was inserted in the education of the child. In the presence of

[1]Translator's note: In order to make the excerpts of the dialogues understood, an adaptation to English was written (expressions in parentheses) - the original text in Portuguese is presented in italics.

strangers, T. would get even closer to the mother, who reported that he was breastfed on free demand.

Regarding the language, it was observed that T. produced a few words, presenting little possibility of moving from the shown reference to the verbal one[13]. Thus, the emergence of enunciation mechanisms of co-reference was practically absent, which is not expected for his age group, setting up as a language disorder.

In the interview at 24 months, the mother seemed unaware or not to process some characteristics that guide the development of T., as the evolutionary milestones, for example, stating that T. walked at 9 months, when asked about the beginning of deambulation: "nove méis mais ou menos", (around nine months), and also about the fact that T. does not have crawled. According to the follow up which was carried out, it is known that T. crawled at nine months and after 12 months he started to march.

In relation to the communication and to the language, we noticed that T. was agitated and not talking too much to the mother or to his brother. The mother did not mention anything that could be interpreted as an indication of some peculiarity or some kind of difficulty in terms of language acquisition of the child. Her speech was much reduced and, in most cases, she would merely confirm, deny or even say that she did not remember how T. expresses himself. Some excerpts from interviews with the mother of T are shown below. In the dialogue 1, the researcher tries to know more about the period of babbling and the first words, as well as the understanding of T.

Dialogue 1:

Excerpt 1

*Re: E assim...,quando ele começou a fazer aquele balbucio assim, aquela fala enroladinha? Respondia quando tu falava com ele? (*So... when did he start to produce that babbling, you know, that unrecognizable speech? Did he answer when you talked to him?)

MT: Um ano e um mês. (One year and one month).

Re: As primeiras palavrinhas? Um ano? (The first words? One year?)

MT: Uhum. Era enrolado, mas saía. (Uh-hum. It was unrecognizable, but it occurred.)

Re: Sim! (Yes!)

MT: Era enrolado, mas saía alguma coisa. (It was unrecognizable, but it occurred something.)

Re: E, quando ele era mais bebê assim, aquela conversinha sabe? Aqueles enrolados de bebê, sabe? (And, when he was younger, that chat you know? Those unrecognizable speech of baby, you know?)

MT: Aí, não lembro. (I do not remember that.)

Excerpt 2

Re: E como vocês se comunicam com ele?É mais por gestos ou ele já tá falando mais? (And how do you communicate with him? Is it more with the use of gestures or is he talking more?)

MT: Ah, ele fala mais assim...se eu falo alguma coisa ele vai lá e sabe o que que é... (Oh, he talks more this way ... if I say something he will go there and know what it is about ...)

Re: Uhum... Mas o que predomina assim...ele se comunica mais por gestos ou mais por palavras? (Uh-huh ... But what predominates so ... he communicates more through gestures or more through words?)

MT: Por palavras e por gestos. (Through words and gestures.)

Excerpt 3

Re: E assim tu consegue entender o que ele tá querendo? (And so you can understand what he wants?

MT: Uhum. (Uh-hum.)

Re: Ele, também, te entende? (He understands you,too?)

MT: Uhum. (Uh-hum.)

Re: E as coisas que ele quer, quando ele pede alguma coisa é pela fala? (And the things he wants, when he asks for something… is it through speech?

MT: Pela fala e também aponta. (Through speech and he also points at.)

Re: Ele ta falando agora mais palavras que tu consegue entender? (Is he now talking more words that you can understand?)

MT: Uhum. (Uh-hum.)

We observed that the mother of T believes she has good communicative interaction with her child because she does not have difficulty to understand or to be understood by T. She does not think it is weird the fact that there is almost no production of words by T, which becomes evident at the excerpts 2 and 3. This situation suggests that the strangeness of the researcher in the evaluation of 24 months brought T into therapy.

It is noteworthy that we talked to the mother that T. was struggling to move forward in language acquisition, as expected for his age group.

Once alerted to this fact, the mother came to therapy, but it is interesting to mention that she did not present to be afflicted in relation to the low oral expression of her son.

Early observation that something did not go well in the development of the child: paths of the MR-R dyad

R., male, was born on the 6th month of pregnancy of an unplanned pregnancy. He is the fifth son of a family that consists of his mother (40 years), his father (42 years), and his four older siblings (three girls - ages 4, 12 and 19 years, and one boy - 14 years). All live in the same house, which is located in the countryside near the city. Regarding the formal education of the parents, both did not conclude elementary school. The children attend the school nearest to their home. The mother is a housewife, the father is a driver, and the family income is of approximately R$ 700.00.

Due to prematurity, he was admitted to the Neonatal Intensive Care Unit of the University Hospital for about 3 months. The baby has pediatric assistance at Premature Sector of the same hospital since his hospital discharge. His mother was also admitted in that hospital for 42 days in an induced coma due to bleeding caused by placental abruption, being 28 of them in the ICU. After recovery of both, the mother said she did not remember about the pregnancy or about her stay at the hospital, and she also reported that she even thought that R. was the son of her oldest daughter.

In a first contact with the IRDls project team, three weeks had passed since R. left the hospital, he was 1 month old (corrected) and he was sleeping. At that time, we observed that the oldest daughter met the maternal role. In addition, the mother referred to the baby as having syndromic features (the mother reported that he looked like babies with Down syndrome). In subsequent meetings, we realized that this first impression was due to prematurity of R. The mother did not show any level of depression and anxiety in the initial evaluation of the dyad.

In the second test of IRDls, a week after the first evaluation in which R. was sleeping, we asked the mother to talk to the baby as she was used at home. During filming, the baby remained in the lap of his mother, who tried to calm him by cradling, once R. cried a lot. The mother explained the crying of the baby by saying that he was not used to leave the house, and she also reported he was with a stomachache. The mother used the motherese to talk to her baby, however, her tone of voice showed a level of disappointment and displeasure by the situation they were in. The baby remained crying most of the time; he was avoiding keeping eye contact with the mother, which demonstrated a lack of harmony between the mother and the baby. We also verified that the mother could not identify the demands of R., which characterized the absence of IRDI 1 ("When the child cries or screams, the mother knows what the child wants.") At 6 months of age (corrected), R. attended with his mother and his older sister, the one who took care of him most of the time at the second evaluation of IRDls. The baby was smiling and interacting with his mother and his sister. However, the mother proved to be nervous and worried, asking several times if the researcher thought he was fine. At that time, we identified the suspicion of mother regarding the presence of some biological limit in R.

At the follow-up of the third phase of IRDls, at 11 months of age (corrected), the difficulties in the relationship between the mother and the baby, which seemed softened in the previous phase, became present again. R. demonstrated to be more agitated. At this stage, we observed the absence of the risk indicator 10 ("During body care, the child searches actively to play love games with the mother."). According to the report of the mother, the baby was aggressive to the touch, he did not like body contact, and he did not look for her to play.

At 17 months of age (corrected), while the last stage of IRDls was tested, the boy presented a persistent restlessness, which was already observed in the previous evaluation, and the mother reported that he did not focus on games, he used to destroy his toys and that he was very aggressive with people and objects, which was also observed by the researcher. At this stage, we observed the absent IRDls: 15 ("The mother alternates moments of dedication to the child with other interests.") and 18 ("Parents establish small behavior rules for the child."). R. needed to be under constant care of the mother and family members, as his agitation put him in danger, once he did not understand/respond to the demands from the parents. The mother showed fatigue when talking about the child, and she stated that he was different from all the other children, asking for help of the team.

As a result, R. was sent to the Early Intervention Program of the institution, an interdisciplinary program dedicated to child development and guided by theories that support the intervention by an only therapist[16] and what is the language, that is, what belongs to the language[12,13,14]. In the evaluation

carried out at this program, we observed that R. had not built a body image to support him in relation to objects, to space and especially in relation to other persons. Furthermore, he presented little linguistic development. From the early intervention medical care, R. was reconstructing his place in the family. The body in movement, mentioned as the catalyst of developmental disorders, is now understood as the potential space for the construction of a new relationship with the subjective world[17]. The possibility of the functioning of language associated to the demands of R. allowed full access to the symbolism and his improvement in the process of linguistic constitution[13].

It is noteworthy that at the follow-up throughout the stages of collection of IRDls, from the analysis of the interaction regarding the mother--baby dyad, we observed that there was no filling of the shift by the other (mother) of tuned mode, which was materialized in absence of protoconversation[1]. After the early intervention period, in a new analysis of the interaction of the dyad, we observed that R. in addition to the first present enunciation mechanism, showed evidences of the second enunciative mechanism of verbal co-reference to contrast the speech of the mother by stating 'taaa' and 'catá', his productions to "sit", and some incursions to the third enunciative mechanism[13] by the instantiation of the name, when he looks to the mirror and says "Ata" (All right) to his name.

Then, when R. was evaluated for this study, early intervention was being held. At that time, R. was 24 months, he attended with his mother and his sister, and they made reports about how he was developing. They understood that there was a delay in his general development, which was also related to language. The following dialogues indicate what the mother and the sister observed in relation to the communication/language of R.

In dialogue 2, the researcher investigates the beginning of the vocabulary of expression for R, as well as his understanding.

Dialogue 2:

Excerpt 1

Re: Primeiras palavras assim, quando ele começou? (So, the first words, when did he start to produce them?)

MR: Ele começou agora, faz pouco tempo, sabe ele só pronuncia assim, que nem assim... pouco e mãmã...até nisso ele tá meio atrasadinho. (He started now, not long ago, you know, he only pronounces this way, like this way, pouco and mãmã..... even at that he is kind of slow.)

Excerpt 2

SR: Agora que a gente ta entendendo mais ou menos o que ele quer. (Now we kind of understand what he wants.)

MR: Mamá, agora que ele tá pedindo mamá... (Mamá, now that he is asking for mamá ...)

Re: Ah, agora que ele começou? (Ah, did he start now?)

MR: Ahan. (Aham)

Re: E quando, antes quando ele queria alguma coisa, ele não usava a fala? (And when, before..., when he wanted something, he did not use speech?)

MR: Não. (No.)

Re: Vocês tinham que perceber o que ele queria? (Did you have to notice what he wanted?)

SR: É, agora ele aponta e pede... (Yeah, now he points and asks...)

Re: Ah, agora ele aponta e pede... (Ah, now he points and asks...)

SR: Quando ele começa a fala a gente entende o que ele quer dizer, mas quando não dá, ele aponta. Que a gente entende que ele quer dizer mãe e pai foi agora... (When he starts to speak we understand what he means, but when we do not, he points out. We just realized now that he meant mother and father ...)

MR: Agora eu já sei, mais ou menos, o que ele quer... (Now I know, more or less, what he wants...)

In both excerpts, we observed that the mother and the sister noticed the emergence of enunciation mechanism of verbal co-reference, in which we could notice the strategies of R to make himself understood, now not only shown by reference, but also by spoken language.

The case of R. evidences, therefore, an improvement in language and the minimization of the effects of prematurity in the process of acquisition as an effect of early intervention. A general progress at the development of R. was also observed, with the elimination of obvious risk to the beginning of the intervention. Even noticing the language disorder of R., his mother and his sister justify it as an effect of prematurity and they have as main focus, from early intervention, on what he could do, like when they say "now he points and asks". They identify the progress of R. and after the date of collection they think R. is in continuing improvement, requesting the occupational therapist, as well as the speech therapist (who started his medical care), if he could have his medical discharge, once they live in another city and they believe they

could stimulate him without the therapy, due to his inclusion in preschool.

Another aspect to be considered is that the researcher needed to ask few questions, considering the two parts, because it was enough to suggest a theme and both of them, mother and sister, seemed to have what to say. We have to mention that before the early intervention, the mother did not know what to say about her own son.

The identification of language disorder: paths of the MM-M dyad

M. was born at 8 and half months of pregnancy of a planned pregnancy. The boy is the second child of a family which consists of his mother (40 years), his father (33 years), and his sister (14 years). They all live in the same house, and the sister goes to school. Regarding their education, the father concluded Elementary School and the mother has not concluded High School. She is a housewife and the father works as a plasterer. The family income is of approximately R$ 2,000.00.

The baby did not present any problem at birth. In the evaluation of the first stage of IRDls, M. was a month old; the mother was very shy during filming, but she seemed to be fine and, according to her report, the baby was already looking for the voice of the parents when they spoke to him.

In the initial interview, the mother reported that she had depression in the previous year due to concerns at work, but she decided to leave work in order to get pregnant and got better. She took medication for a few months (prescribed by a physician), stopping the treatment on her own.

In the second stage of IRDls, at 5 months of M, he and his mother were good, with no special features. In the third stage, we detected the absence of IRDI 12 ("The child feels ill at ease with unknown people.").

In the last stage of IRDls, the baby was 18 months and he was very close to his mother. Besides her, the baby would stay just with the father. The mother said he was afraid to walk since he had fallen when he was 1 year and 1 month old.

During the evaluation, he only stayed at the lap of his mother, he did not want to come down or play with the researchers. At that age, M. still presented a demand to the breast in the evening. We noticed the absence of IRDI 15 ("The mother alternates moments of dedication to the child with other interests.") and 16 ("The child endures well the mother's brief absences and reacts to longer absences.").

At 21 months, the baby and his mother were invited to a meeting for the evaluation and the mother, when contacted by phone, quickly agreed, saying that M. was "lazy" to speak. In her report, the mother said the boy pointed and produced some sounds for communication, but that he was not progressing according to his age. When he was one year he started to speak a few words, but according to his mother, he got scared with the noise of the truck of the neighbor and started to talk less. The following excerpts from an interview with the mother were carried out due to the 21 months of M.

In dialogue 3, MM reports that she had noted a regression of language acquisition in M., and makes a comparison of language acquisition in M, compared to his older sister.

Dialogue 3:

Excerpt 1:

MM: Isso, ele falava assim a nanãna.. daí ele tava assim com um ano, um ano assim ele já dizia pro grêmio ele dizia o "emio". Falava umas coisas assim...só que daí ele meio regrediu assim, sabe? Ele meio voltou assim...pra coisas que ele meio que já falava mais declarado. (Yeah, he was saying nanãna... he was like that when he was a year old, a year old and he could say "emio", referring to Grêmio. He spoke a few things as well... But then he kind of regressed, you know? To things that he kind of already spoke more declared.)

Re: É, eles tem muita coisa ao mesmo tempo pra aprender aí acaba esquecendo outras... (Yeah, they have a lot to learn at the same time so they forget other things...

MM: Aí a gente tem uma cachorra, aí o meu marido, ele disse vai deita! e ele olhava ela e dizia "ata ata" e depois ele não falou mais isso aí. Ele começou assim ó: quando ele começou meio falar assim... éé... falou e...meio parou um pouco ai depois só hiahiehihehiiahi (nasal)- (So we have a dog, then my husband, he said "Lie down"! And he looked at her and said "ata ata" and then he did not say that anymore. He started saying: he started talking like that... éé ... and talked... sort of paused and after he said only hiahiehihehiiahi (nasal))

Re: Tudo que ele queria ele apontava? (Did he point at everything we wanted?)

MM: Sim, e agora ele tah uhuhuhuhuhmmm (nasal). Se ele quer água ele vem assim e ó: huhuuhhuhumhh. Se ele quer comer alguma coisa, faz uhuhuhummm. E ai eu digo água, água eu falo né? Mas ele sempre com o pai dele depois...assim uhuhuhhmmm. (Yes, and now he is

uhuhuhuhuhuhmmm (nasal). If he wants to have some water he says ó: huhuuhhuhumhh. If he wants to eat something, he says uhuhuhummm. And then I say, water, right? But he always acts this way with his father… this way uhuhuhhmmm.)

Re: E tu usa palavras então com ele? (And so do you use words with him?)

MM: Sim, aí ele diz a nanãna e, às vezes, eu digo amamama e ele ananãna, papapa ele diz... Ai um dia ele acordou, há um mês atrás, há dois mês atrás, avavaoavava ele dizia sem eu falar assim né. E que a minha mãe mora ali do lado ta sempre aqui, aí ele começou avavva... (Yes, then he says nanãna and sometimes I say amamama and he says ananãna, papapa he says... Oh, and one day he woke up, a month ago, two months ago, he said avavaoavava without I say that way. My mother lives beside us, she is always here, then he started avavva...)

Excerpt 2:

Re: Sim, tava procurando... E tu acha que é satisfatória a comunicação de vocês? Vocês se entendem? (Yes, I was looking for... And do you think that is satisfactory the communication between you? Do you understand?)

MM: Eu entendo ele, mas só que eu digo assim ó: a outra, a menina que, hã, irmã dele, com 8 meses ela dizia "bobó". A G. tinha uma amiguinha dela, ela dizia a "bebéia". Ela chegava e dizia "bebéia bebéia". A R. pra falar R., nós tinha uma vizinha, ela ia lá e falava "Diandi". (I understand him, but I say that: the other, the girl who, uh, his sister, with eight months she said "bobó". G. had a friend of hers; she called her "bebéia". She would come and say "bebéia bebéia". R. in order to talk, we had a neighbor, she went there and spoke "Diandi".)

Re: Aham, falava mais que ele, com menor idade... (Aham, she used to talk more than him, even though she was younger when she produced those words)

MM: Com 1 ano e dois mês ela falava Diandi e ele não... (She was 1 year and two months and could say Diandi, but he cannot.)

P: Ele não faz isso? (He cannot say that?)

MM: Não, não faz. (No, he cannot.)

Re: Que idade tem a irmã? (How old is the sister?)

MM: Ela tá com 14. (She is 14.)

Re: E ela entende ele? (And does she understand him?)

MM: Entende, só que eu digo assim, pra mim ele tá um ano atrasado na idade dela...então até a minha mãe diz assim: não deixa tomar susto quando eles começam falar! Então, tinha um vizinho que tem um caminhão, né?! Então, às vezes ele chegava e soltava assim o freio tssshhhh e aí ele gritava, gritava...assim desesperado, chorava assim. Então daquilo ali ele levou uns sustos, e foi daquilo ali! (She understands, but I say, for me he is a year late in comparison to her age ... so even my mother says: do not let him to get scared when they start talking! So there is a neighbor who has a truck, right?! So sometimes he arrived and released the brake tssshhhh and then he yelled, screamed ... so desperate, crying a lot. So because of that he got scared, and that was the reason!)*!*

From the excerpts exposed in dialogue 3, we observed that mother of M realizes that her child has a language problem, and so she uses the language development of her older daughter as a parameter. In addition, she exposes some speech details about the language functioning of M., when she gives some examples of articulatory variation of some signs (banana), or forgetting others. The explanatory hypothesis of the mother for the language problem of the boy is that he got scared and since then he regressed in language.

We also observed in the excerpts of dialogue 3 that the mother has the need to talk about the subject, being the evidence of the language symptom of the child the reason why they started the therapy. His statements are long and full of details about the language of her child, without the need to ask a lot.

Discussion

The three subjects reported in this paper presented language disorder, each one in his own peculiar way, as the language is particular to each subject, with its regularities and irregularities[18]. They are three cases in which the risk to development was detected, from IRDIs, and in one case, an early intervention (from 17 months) was carried out, which resulted in a greater progress in child development and in the language acquisition by this subject.

In order to reflect about the process of identification of the language symptoms in these children by their families, we chose the work Surreaux[12] which suggests that the language symptom is a unique combination, by the subject who enunciates. Thus, the notion of symptom, in clinical language, is marked by questions that the failure evokes[12].

In the case of T., R. and M., the identification of the failure marked by the absence or restriction

on speech, happened differently. In the case of T., we verified that his mother did not notice that there was a language disorder, even after the explanation of the researcher about the unexpressed language progress of her son, she did not seem to be concerned with the issue.

From the history of IRDIs, it is possible to observe the disconnection regarding the child appears in the first interactions between MT and T, with the absence of the IRDI 2 ("The mother talks to the child in a style particularly addressed to the child (motherese)."). It is important to mention that the indicator corresponds to the axis theoretical of the subject assumption (SA), which refers to maternal anticipation, once the baby is not constituted as a subject. The constitution of the baby just depends on this anticipation and the meanings that the mother gives to the appeal of the child, and therefore, she faces it. The baby, consecutively, will try to correspond to what was offered. This is how subjectivity can effectively be built[2], and how the child has full access to the symbolism, for which the language functioning is crucial.

We noticed that MT had difficulties in assuming a subject in T, which enabled the understanding of her difficulties in listening to him, as a subject who announces a suffering (via language) from his reduced verbal expression. As a result, MT does not take to her the listening position, in which she could get surprised to the singularity of a speech and make the interpretation of it[18]. This is reflected in the absence of anxiety, which would be natural, front to the restriction on oral expression of her son, and also at the fact that the researcher had to ask and insist with her to talk something more about him.

The other IRDIs, absent in T., are related mainly to the theoretical axis of paternal function (PF) 2. It is known that the name of the father brings to the child some kind of psychic stabilization due to work of borromean knotof the three registers that it offers: i) a lack of symbolization, ii) a response to the real distress and iii) an imaginary suppression for the body. When the father (or the one who has this function) is present, his involvement as a mediator of the mother-baby interaction can have a direct influence on the development of the child[3]. We have to mention that T. had hyperactive behavior during his session at 24 months, as stated the study of Kupfer and Bernardino[3].

Unlike the mother of T, the mother of M makes the listening of the language symptom of her child. So, MM places herself at listening position of someone who estranges the natural speech of her son[18], and brings elements on aspects of the language functioning of M, which allows the researcher to reflect about the characteristic of a language disorder. Although the language disorder is characterized from the symptoms that may be common to several cases, it is possible to mention that, from the specific point of view, the report of this mother allows a particular hypothesis of language functioning. Nonetheless, the identification of the language symptom of M and the demand for speech therapy by mother is considered late in relation to the mother of R., but M. estranges the language functioning and, this way, she tries to find a professional who can help her to understand and help her child.

This estrangement manifests itself in a natural anxiety front to symptom and in the demand to be heard in her suffering and concern as a mother, which reduces the need of the therapist of asking lots of questions to her, and also in long and detailed statements of the mother describing the symptoms of the child.

In the case of R., the mother and the sister notice the peculiar language functioning, crediting it to a delay, explained by the prematurity of R. They also observe developments in linguistic constitution of R., due to the fact that he was under assistance at the early intervention program, since his 17 months.

In initial interactions between R and MR, we noticed the absence of IRDI 1 ("When the child cries or screams, the mother knows what the child wants.") that corresponds to the theoretical axis of the demand establishment (DE) and subject assumption (SA)[2]. The construction of a demand is the basis of all activities after the insertion of the subject in the field of language and the relationship with others. The axis of subject assumption, as already mentioned, is the anticipation and the meanings that the mother gives to the appeal of the baby, and how she faces it, which are essential to the constitution of the subject. Then, through the IRDIs evaluation of R. and the speech of his family, we noted his difficulty of establishing a subjective relationship with the world, emphasized by the relationship he had with his own body.

By identifying that something was not right, the mother asked for help, that is, at that time, it was possible to recognize a symptom, although it was not specific about language. The family, in particular the main caregivers of R. - the mother and the sister - from the follow-up in early intervention care, participated in important spaces in order that the mother would retell her history and

would reconstruct the space of her son in the family relationship.

Probably, the assistance in early intervention led to the awareness of this family for therapeutic demand in less time, but also minimized the possible effects of prematurity and risk to development present in the case in the language acquisition process. This became evident in the statements of the mother and sister of R. regarding the fact he was late. They do not observe the suffering of the child because in fact it was not in evidence. They were not anxious front to his development. Consequently, they seemed to know their role and the potential of the subject.

In general, the family of the baby has its time in identifying possible changes in the development (of the baby) and this time follows symbolic issues such as the representation of idealized child before his/her birth[19]. So, even if a professional makes sure the importance of early intervention, he needs to respect the family time to accept it, unless the child is under extreme physical risk, that is, risks prescribed in law, for example, the need to nutrition by oral means, in the case of babies with severe dysphagia.

This study shows that the establishment of therapeutic demand is as unique as the story of each subject, and, because of that, early detection policies of inclusion do not guarantee early intervention. Even when the treatment is established, it implies different levels of consciousness of its role. In this study, while MT accepted therapy, MM and MR tried to find help (in therapy or early intervention). This fact shows distinct establishment demands in each case.

Conclusion

Listening to the symptoms of development and language took place in a particular way in the studied cases, showing that the higher the difficulty of perception of language symptom of the mother and family is, the later the search for early intervention or speech therapy occurs, even in cases where the researcher had already realized the early emergence of the symptom.

The continued presence of the researcher in the follow-up of each case enabled the creation of a space for listening to the mother and other family members, assisting the family awareness in relation to the suffering of their children. This suggests the need for insertion of a longitudinal follow-up of babies, which could cover a closer analysis on the psychic constitution and on the aspects of development such as language, as well as on motor and nutritional aspects - the most traditional focus on child health policies.

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