Intervening factors in the care capacity beliefs of premature infants' parents

Fatores intervenientes nas crenças de capacidade de cuidado de pais de prematuros

Factores intervinientes en las creencias de capacidad de cuidado de padres de prematuros

Eloeth Kaliska Piva[1] https://orcid.org/0000-0002-6551-4630
Cláudia Silveira Viera[1] https://orcid.org/0000-0002-0900-4660
Ariana Rodrigues Silva Carvalho[1] https://orcid.org/0000-0002-2300-5096
Beatriz Rosana Gonçalves de Oliveira Toso[1] https://orcid.org/0000-0001-7366-077X

How to cite:
Piva EK, Viera CS, Carvalho AR, Toso BR. Intervening factors in the care capacity beliefs of premature infants' parents. Acta Paul Enferm. 2022;35:eAPE00596.

DOI
http://dx.doi.org/10.37689/acta-ape/2022AO005966

Keywords
Infant, premature; Child care; Parenting; Intensive care units, neonatal

Descritores
Recém-nascido prematuro; Cuidado da criança; Poder familiar; Unidades de terapia intensiva neonatal

Descriptores
Recien nacido prematuro; Cuidado del niño; Responsabilidad parental; Unidades de cuidado intensivo neonatal

Submitted
March 27, 2020

Accepted
December 7, 2021

Corresponding author
Beatriz Rosana Gonçalves de Oliveira Toso
E-mail: beatriz.oliveira@unioeste.br

Associate Editor (Peer review process):
Alexandre Pazetto Balsanelli (https://orcid.org/0000-0003-3757-1061)
Escola Paulista de Enfermagem, Universidade Federal de São Paulo, SP, Brazil

Abstract

Objective: To investigate the relationship between the beliefs of parents of premature newborns in a neonatal intensive care unit with sociodemographic and clinical variables regarding their care capacity using the Parental Belief Scale.

Methods: Cross-sectional study of 97 fathers and/or mothers of preterm infants hospitalized in the Neonatal Intensive Care Unit and Intermediate Care Unit of a medium-sized university hospital in the western region of Paraná. The data collection period was between October 2015 and May 2016 using the Parental Belief Scale validated for Brazil, and a sociodemographic instrument and of newborns' clinical variables. Descriptive and inferential statistical analyzes were performed and the association between the scale scores was evaluated using the chi-square test for independence with sociodemographic and categorical clinical variables.

Results: The scale was answered by 86 (88.7%) mothers and 11 (11.3%) fathers. A significant association with the age of the other children in addition to the premature with categories of the scale was found. An inverse relationship for scores of the scale related to family income, maternal age and schooling was found, with a statistically significant association with family income. Regarding participants' care capacity, 35 fathers and/or mothers were identified with sufficiency, 49 fathers and/or mothers with moderate sufficiency and 13 fathers and/or mothers with moderate insufficiency.

Conclusion: The scale presented appropriate application in view of the beliefs in the care capacity of parents of preterm infants, indicating the influential sociodemographic factors. Most caregivers demonstrated care capacity.

Resumo

Objetivo: Investigar a relação das crenças de pais de recém-nascidos prematuros em unidade de terapia intensiva neonatal, com variáveis sociodemográficas e clínicas, sobre sua capacidade de cuidado, utilizando-se a Escala de Crenças dos Pais.

Métodos: Estudo transversal com 97 pais e/ou mães de prematuros hospitalizados em Unidade de Terapia Intensiva Neonatal e Unidade de Cuidados Intermediários, de hospital universitário de médio porte, na região Oeste do Paraná. A coleta de dados ocorreu de outubro de 2015 a maio de 2016, utilizando-se a Escala de Crença dos Pais, validada para o Brasil, e instrumento sóciodemográfico e de variáveis clínicas do recém-nascido. A análise foi estatística descritiva e inferencial e avaliou a associação entre os escores da escala, por meio do teste de qui-quadrado para independência, com as variáveis categóricas sociodemográficas e clínicas.

Resultados: Responderam a escala 86 (88,7%) mães e 11 (11,3%) pais, sendo encontrada associação significativa para a idade dos outros filhos, além do prematuro, com as categorias da escala, e relação inversa

[1]Universidade Estadual do Oeste do Paraná, Cascavel, PR, Brazil.

Conflicts to interest: although Avelar AFM is Associate Editor of Acta Paulista de Enfermagem, she did not participate in the peer review process that resulted in her article being approved.

para os escores da escala diante da renda familiar, idade e escolaridade materna, com associação estatística significativa para a renda familiar. Dentre os participantes, quanto a capacidade de cuidado, 35 pais e/ou mães foram identificados com suficiência, 49 pais e/ou mães com suficiência moderada e 13 pais e/ou mães com insuficiência moderada.

Conclusão: A escala apresentou adequada aplicação diante das crenças na capacidade de cuidado dos pais de prematuros, indicando os fatores sociodemográficos influentes. A maioria dos cuidadores demonstrou capacidade para o cuidado.

Resumen

Objetivo: Investigar la relación entre las creencias de padres de recién nacidos prematuros en Unidad de Cuidados Intensivos Neonatales y variables sociodemográficas y clínicas, respecto a su capacidad de cuidado, utilizando la Escala de Creencias de Padres.

Métodos: Estudio transversal con 97 padres o madres de prematuros hospitalizados en Unidad de Cuidados Intensivos Neonatales y Unidad de Cuidados Intermedios, de un hospital universitario de porte mediano, en la región oeste del estado de Paraná. La recopilación de datos se realizó de octubre de 2015 a mayo de 2016 y se utilizó la Escala de Creencias de Padres validada para Brasil y el instrumento sociodemográfico y de variables clínicas del recién nacido. El análisis fue estadístico descriptivo e inferencial y evaluó la relación entre la puntuación de la escala, mediante la prueba χ^2 de Pearson para la independencia, y las variables categóricas sociodemográficas y clínicas.

Resultados: La escala fue respondida por 86 (88,7 %) madres y 11 (11,3 %) padres, donde se encontró relación significativa entre la edad de otros hijos, además del prematuro, y las categorías de la escala, y relación inversa entre la puntuación de la escala y los ingresos familiares, edad y escolaridad materna, con relación estadística significativa en los ingresos familiares. Respecto a la capacidad de cuidado, se identificaron entre los participantes 35 padres o madres con suficiencia, 49 padres o madres con suficiencia moderada y 13 padres o madres con insuficiencia moderada.

Conclusión: La escala presentó una aplicación adecuada ante las creencias de la capacidad de cuidado de los padres de prematuros y se indicaron los factores sociodemográficos influyentes. La mayoría de los cuidadores demostró tener capacidad para el cuidado.

Introduction

The hospitalization of Preterm Newborns (PTNBs) soon after birth, given their vulnerability, breaks with the idealization of the arrival of a healthy baby and makes it difficult for parents to cope with the situation,[1,2] impairing the feeling of attachment and bond with the newborn (NB).[2,3]

This is a stressful situation for parents,[3] as the hospitalization of the PTNB can last indefinitely in the Neonatal Intensive Care Unit (NICU), generating psychological burden and substantial economic expense for families and the health service.[4]

Parents who do not receive care and social support for their needs according to their parental characteristics from the health team, are more likely to develop an inadequate parental role in relation to the care of their child.[5] In addition to this, parental feelings of anxiety and depression may increase the perception of child vulnerability and promote greater use of health services.[3-6]

Thus, the importance of health professionals in the provision of embracement of needs of the neonate and parents in the NICU is key; by minimizing stressful situations through family-centered care actions with the recognition of individual parental needs, stimulating the integration of parents in the care and recovery of the baby, and developing parenting.[7]

The Brazilian version of the Neonatal Intensive Care Unit: Parental Belief Scale (NICU: PBS) of the United States of America is used to identify the parental care capacity in relation to their hospitalized PTNBs.[4] It allows to perceive parents in situations of stress who demand a more planned care.

The influence of the environment, culture, family composition, beliefs and social context in the care provided by parents to their children is known. Thus, their self-confidence will help in the development of parental competence in the care of the PTNB. This parental care is mainly guided by parents' beliefs, that is, values and goals that parents relate to their child's development.[8]

In this study, the relationship between parental beliefs of PTNBs in the NICU and sociodemographic and clinical variables in relation to their care capacity was investigated using the Parental Belief Scale.

Methods

Cross-sectional quantitative study conducted in a medium-sized university hospital located in the western region of Paraná that serves the National Health Service (Brazilian SUS). Data collection was performed between October 2015 and May 2016

by applying the NICU: PBS jointly with an instrument including sociodemographic information and clinical variables of PTNBs.

Ninety-seven fathers and/or mothers of PTNB hospitalized in the NICU and the Intermediate Care Unit (ICU) participated. They were chosen through the following inclusion criteria: a) mother or father of PTNB with gestational age of less than 37 weeks and a hospitalized child; b) participant under 18 years of age accompanied by a guardian; c) literate; d) Portuguese as the usual first language; e) visits to the child at least once before application of the instrument. Exclusion criteria: a) reporting not having emotional and physical conditions to answer the instrument; b) mentioning the use of medication for anxiety disorders; c) mothers of children destined for adoption.

The NICU: PBS scale is self-administered, intended for mothers and/or fathers of PTNBs hospitalized in NICUs, used for assessment of the role of parents' self-confidence, the interaction between parents and children and knowledge about the NICU. It consists of 18 items with five-point Likert-type responses ranging from 1 (totally disagree) to 5 (totally agree), and the sum of items leads to a value between 18 and 90 points.[6]

The values of the scale scores validated in Brazil are classified into four categories: "Sufficiency of care capacity" - 90 to 72 points; "Moderate sufficiency of care capacity" - 71 to 54 points; "Moderate insufficiency of care capacity" - 53 to 36 points; and "Insufficiency of care capacity" - 35 to 18 points.[6]

A sociodemographic and clinical questionnaire was applied together with the NICU: PBS, containing items such as: ethnicity, religion, age, occupation, education, income, among others; as well as clinical data of the PTNB. Data were organized in spreadsheets using Excel version 2013 and exported to the IBM-SPSS version 21.0 for analysis.

Data were descriptively analyzed for categorical and continuous variables. The Kolmogorov-Smirnov and/or Shapiro-Wilk tests were applied in order to test the normality of data. To assess the association of categorical variables with NICU: PBS scores, the chi-square test for independence was used together with adjusted residual analysis.

Normalized continuous variables and the NICU: PBS scores were examined using Principal Component Analysis (PCA) with Varimax rotation. After verifying the quality of data using the Kaiser-Meyer-Olkin (KMO) method, the correlation between matrixes of variables was assessed by the Bartlett's test of sphericity. Multivariate analysis of variance was performed using the Kruskal-Wallis (KW) test to assess association, followed by the Dunn's test to identify these associations. The level of significance assumed in all statistical tests was equal to 0.05.

With regard to ethical aspects, the fathers and/or mothers of the PTNB responded to the instrument only after accepting, reading and signing the Informed Consent form. The study was approved by the Research Ethics Committee under opinion number 385.370, CAAE number 16348813.7.1001.0107.

Results

Among the 97 participants, 86 (88.7%) were mothers and 11 (11.3%) were fathers. Table 1 depicts the sociodemographic characterization of parents of PTNBs.

The mean age of family members was 25 years for mothers and 30 years for fathers. Schooling was similar for both, around ten years, the average income was 2,284.00 reais, and approximately half of families had only the NB. Women had, an average, of seven antenatal consultations and visited the PTNB seven times, with visits lasting more than one hour. The predominant religion was Catholic, most were married (33%) or in a common-law marriage (58%). The morbidities presented by women during pregnancy were predominantly hypertensive disorders of pregnancy (33%) and urinary tract infection (32%). Table 2 depicts the clinical characteristics of hospitalized PTNBs.

The mean gestational age of PTNBs was 32 weeks, weighing 2,000 grams, height 42 cm, head circumference 30 cm, APGAR six at the 1 minute and eight at 5 minutes, 63.9% were male sex, 53.6% cesarean delivery, predominance of respira-

Table 1. Sociodemographic characteristics of parents of PTNBs

Variables	n(%)	Mean (Standard Deviation)	Range
Maternal age (years)		25.42 (6.28)	14 - 46
Paternal age (years)		30.84 (8.72)	17 - 55
Maternal education (years)		10.05 (2.46)	4 - 16
Paternal education (years)		9.10 (3.02)	2 - 16
Family income (reais)		2.284.66 (1.215.46)	300.00-7.500.00
Number of children (other than PTNB)		0.84 (1.10)	0 - 6
Number of antenatal consultations		7.72 (4.44)	0 - 20
Number of visits to the child		7.21 (3.57)	2 - 20
Average duration of visit (minutes)		88.87 (79.64)	15 - 300
Maternal religion			
Catholic	67(69.1)		
Evangelical	19(19.6)		
Other	2(2.1)		
None	9(9.3)		
Paternal religion			
Catholic	69(71.1)		
Evangelical	16(16.5)		
Other	3(3.1)		
None	9(9.3)		
Marital status			
Married	32(33)		
Single	6(6.2)		
Separated	1(1)		
Common-law marriage	58(59.8)		
Children's age (other RNPT)			
≤ 2 years	5(5.2)		
> 2 years	37(38.1)		
≤ 2 years and > 2 years	6(6.2)		
No other children	49(50.5)		
Health conditions during pregnancy			
Hypertensive disorders of pregnancy	32(33)		
Urinary tract infection	31(32)		
Placenta problems	19(19.6)		
None	14(14.4)		
Some type of diabetes	12(12.4)		
Others	39(40.2)		

Table 2. Clinical characteristics of PTNBs

Variables	n(%)	Mean (Standard Deviation)	Range
Gestational age (weeks)		32.59 (2.90)	22 - 36
Weight (grams)		2.016.13 (750.61)	600 - 4.185
Apgar 1 minute		6.41 (1.97)	1 - 9
Apgar 5 minutes		8.07 (1.24)	4 - 10
Height (cm)		42.20 (4.43)	30 - 53
Head circumference (cm)		30.22 (3.13)	21 - 40
NICU hospitalization time (days)		26.07 (21.80)	4 - 92
Sex			
Male	62(63.9)		
Female	35(36.1)		
Type of delivery			
Cesarean delivery	52(53.6)		
Natural delivery	45(46.4)		
NB diagnosis			
Respiratory distress	47(48.5)		
Newborn respiratory distress syndrome	20(20.6)		
Hypoglycemia	7(7.2)		
Perinatal infection	5(5.2)		
Respiratory failure	5(5.2)		
Others	12(12.3)		

Table 3. Association of parental care capacity sufficiency groups according to their sociodemographic and categorical clinical variables

Variables	Sufficiency n(%)	Moderate sufficiency n(%)	Insufficiency n(%)
Maternal religion			
Catholic	26(74.3)	31(63.3)	10(76.9)
Evangelical	6(17.1)	11(22.4)	2(15.4)
Paternal religion			
Catholic	25(71.4)	35(71.4)	9(69.2)
Evangelical	6(17.1)	9(18.4)	1(7.7)
Marital status			
Married	9(25.7)	17(34.7)	6(46.2)
Common-law marriage	24(68.6)	28(57.1)	6(46.2)
Age of children (other than PTNB)			
≤ 2 years	3(17.6)	2(8.3)	0(0)
> 2 years	9(52.9)	22(91.7)	6(85.7)
≤ 2 years and > 2 years	5(29.4)	0(0)	1(14.3)
Health conditions during pregnancy			
Hypertensive disorders of pregnancy	11(31.4)	17(34.7)	4(30.8)
Urinary tract infection	12(34.3)	15(30.6)	4(30.8)
Sex			
Male	21(60)	33(67.3)	8(61.5)
Female	14(40)	16(32.7)	5(38.5)
Type of delivery			
Cesarean	21(60)	25(51)	6(46.2)
Vaginal	14(40)	24(49)	7(53.8)
NB diagnosis			
Respiratory distress	15(42.9)	27(55.1)	5(38.5)
Newborn respiratory distress syndrome	5(14.3)	10(20.4)	5(38.5)

Tests - chi-square for independence and by Monte Carlo simulation

tory causes (> 50%) and mean length of hospital stay of 26 days. The results of the scale classified the fathers/mothers as: 35 (36.0%) - sufficiency of care capacity, 49 (50.5%) - moderate sufficiency of care capacity, 13 (13.3%) - moderate insufficiency of care capacity. The sociodemographic variables of parents and categorical clinical variables of PTNBs associated with the NICU: PBS scale scores are shown in table 3.

In the distribution of variables between categories of the scale, there was no statistically significant difference for any of them. Regarding the adjusted residual, the group of parents with Sufficiency of care capacity presented an adjusted residual of 2.6 for the category of children's age ≤ 2 years and > 2 years. On the other hand, for the group of Moderate sufficiency of care capacity, the residual was 2.4 only

in the category > 2 years. Table 4 presents the factor loadings of the principal component analysis.

Table 4. Factor loadings of the principal component analysis of continuous variables and scale scores

Variables	Characteristics of PTNBs	Characteristics of parents
NICU: PBS scores	0.163	-0.681
Maternal age	0.128	0.559
Family income	0.210	0.827
Maternal education	-0.336	0.370
gestational age at birth	0.921	0.047
Birth weight	0.881	0.209
Length of hospital stay of PTNB	-0.881	0.089

The variables included in the analysis were in accordance with the necessary assumptions, with KMO of 0.66 and Bartlett's test (Chi-square $\alpha 2$) = 213.80, $p < 0.0001$). In the scree plot evaluation, two main components were assumed and considered significant after the Varimax rotation. The two PCA components showed an accumulated variability of 60.75% (eigenvalues of 2.62 and 1.62), and the first component axis applied to the variables (37.52% of variability) was called "Characteristics of the PTNB", showing an inverse relationship between gestational age and birth weight of the PTNB with the length of hospitalization, that is, the lower the gestational age and low birth weight the longer the hospitalization time of the PTNB. Furthermore, there was no correlation between the clinical data of PTNBs and the NICU: PBS scores. As for the second axis of components applied to the variables (23.23% of variability), called "Characteristics of parents", it indicated an inverse correlation between the NICU: PBS scores and the variables of parents of PTNBs, that is, the higher the family income, maternal age and mother's education, the lower the NICU: PBS scores and vice versa. In view of the results presented for the linear combinations by PCA, the analysis of variance of the continuous variables is shown in table 5.

In analysis of variance, a statistically significant association was found only for family income in relation to the NICU: PBS scores (KW, $p = 0.012$). In the comparison by means of the Dunn test between groups of Sufficiency, Moderate sufficiency and Moderate insufficiency of care capacity in relation to family income, all showed a statistically significant difference ($p < 0.05$).

Discussion

The profile of the individuals included in the study showed total scores in the Sufficiency and Moderate sufficiency categories of care capacity, indicating positive beliefs of fathers and/or mothers in the parental role and in the behavior of the hospitalized baby.

Parental care is mainly guided by parental beliefs, that is, values and goals that they relate to the child's development, since the first interactions lead to intersubjective exchanges promoting the healthy development of the child.[9-11] Parenting involves feelings of aptitude and has implications on the individual's expectations and beliefs in their ability to perform this role effectively and competently.[12]

The NICU: PBS scores in groups of parents revealed a significant association with the age of other children in addition to the PTNB. In this sense, parents who had children aged two years or less and children older than two years old had positive beliefs and greater confidence in the care of premature infants, and were associated with the Sufficiency of care capacity group. Parents who only had children over two years old were in the group of Moderate sufficiency of care capacity, indicating less confidence in their parental role.

In the presence of prematurity, mothers with other younger children requiring care (other than

Table 5. Association of sufficiency groups of parental care capacity according to sociodemographic and continuous clinical variables

Variables	Sufficiency		Moderate sufficiency		Insufficiency	
	Mean	SD	Mean	SD	Mean	SD
Maternal age (years)	25.26	6.04	25.02	6.40	27.38	6.61
Maternal education (years)	9.80	1.92	10.16	2.56	10.31	3.35
Family income (reais)	1,951.72	1,251.95	2,352.62	1,142.59	2,884.62	1,173.20
Gestational age (weeks)	32.37	3.25	33	2.57	31.62	3.04
Weight (grams)	1,937.14	797.69	2,082.65	720.86	1,978.08	766.85
Length of hospital stay in the NICU (days)	22.20	18.44	25.47	20.72	38.77	30.06

SD - standard deviation; Kruskal-Wallis Test (KW)

the PTNB) could perceive themselves as more susceptible to stress, as prematurity interferes with family dynamics.[13] Women who have previously experienced motherhood have greater conviction in the success of performing baby care activities.[14] In the face of beliefs, the fact of having other younger children seems to have a positive influence on care, as it can provide better perceptions about the characteristics of the baby and confidence in the parenting role.

The stable marital status of PTNBs' parents is important to guarantee emotional support, and the support of the partner allows them to share difficulties and responsibilities regarding the birth of a premature baby, and can interfere with parental care and trust.[15] The support offered to mothers by multidisciplinary teams with a view to expand the object of action through insertion of the family and humanization of care is fundamental for parental competence for care.[16]

Furthermore, the parental role is influenced by the environment, beliefs, culture, family composition, social context and work circumstances, which are aspects that have an impact on health care.[11,17]

Another aspect are the health conditions faced during pregnancy, which can deplete the emotional and physical state, especially of the mother, resulting in feelings of guilt, anxiety and anguish, resulting in situations and conditions of stress that culminate in the hospitalization of the PTNB.[3] Hence the importance of appropriate antenatal care in order to alleviate the conditions of gestational risk.[13,18]

Maternal age together with schooling and family income had an inverse linear relationship with the parental care capacity, that is, positive parental beliefs, higher NICU: PBS scores was related to younger parents, lower schooling and lower family income, or else, negative beliefs with lower instrument scores was related to older parents with higher education and higher income. These results are in line with those reported by the original study of the scale.[4]

The profile of older parents with more schooling and higher incomes tends to be associated with greater knowledge about the typical development and acceptable behaviors of their children, thereby leading to broader perspectives in relation to the child.[19]

Parents with more unrealistic beliefs, greater expectations about the parenting role and the development of their children may present higher levels of stress, precisely because of the pressure generated by these expectations on the care of their children, inspiring less confidence to develop the parenting role. However, parents with more realistic parental beliefs are more confident in their role, and this protects them against stress.[4,19]

Parental beliefs have a proportionally important role on parents' feelings such as anxiety, depression and stress, that is, the more sufficiency of care the lower the possibilities for the emergence of these feelings, as evidenced in this study. It is necessary to act in order to reinforce these beliefs and allow parents to know what to expect from their children, strengthening positive beliefs about their ability to understand and predict their children's behavior, providing greater aptitude to deal with children, anticipating their needs and developing a feeling of confidence in their parenting skills.[4]

Conclusion

Positive parental beliefs with higher scores for the NICU: PBS were related to younger parents with lower education and lower family income, as well as negative beliefs and lower instrument scores were related to older parents with higher education and income, with a significant association in terms of family income. The limitations of this study include the use of a convenience sample, which highlights the need for further studies on the topic with a larger population. However, the methodological rigor used in the study and its contribution to the knowledge of parental beliefs of PTNBs at risk of stress in the NICU stand out.

Collaborations

Piva EK, Viera CS, Carvalho ARS and Toso BRGO declare that they contributed to the study design,

data analysis and interpretation, article writing, relevant critical review of the intellectual content and approval of the final version to be published.

References

1. World Health Organization (WHO). Preterm birth. Fact sheet Nº 363. Geneva: WHO; 2017 [cited 2018 Jun 13]. Available from: http://www.who.int/mediacentre/factsheets/fs363/en/
2. Carvalho LS, Pereira CM. As reações psicológicas dos pais frente à hospitalização do bebê prematuro em UTI neonatal. Rev SBPH. 2017;20(2):101-22.
3. Baseggio DB, Dias MP, Brusque SR, Donelli TM, Mendes P. Vivências de mães e bebês prematuros durante a internação neonatal. Temas Psicol. 2017;25(1):153-67.
4. Melnyk BM, Oswalt KL, Sidora-Arcoleo K. Validation and psychometric properties of the neonatal intensive care unit parental belief scale. Nurs Res. 2014;63(2):105-15.
5. Amorim M, Alves E, Barros H, Silva, S. Necessidades e papeis parentais em cuidados intensivos neonatais: revisão das guias portugueses. Cien Saude Colet. 2016;21(8):2583-94.
6. Piva EK, Toso BG, Carvalho AR, Viera CS, Guimarães AT. Validação e Categorização da Escala de Crenças dos Pais de Recém-nascidos Prematuros. Acta Colomb Psicol. 2018;21(1):139-48.
7. Kleger JJ, Neves ET, Silva AM, Jantsch LB, Bertoldo, CS, Silva JH. Stress in Parents of Newborns in a Neonatal Intensive Care Unit. Esc Anna Nery. 2019;23(1):e20180178.
8. Rodrigues OM, Campos BC, Martins JM, Padovan FH. Práticas e crenças maternas sobre cuidado e estimulação de bebês prematuros e a termo. Mudanças Psicol Saúde. 2019;27(2):1-7.
9. Field A. Descobrindo a estatística usando o SPSS. Porto Alegre: Artmed; 2009.
10. Hair JF, Black WC, Babin BJ, Anderson RE, Tatham RL. Análise multivariada de dados. 6a ed. Porto Alegre: Bookman; 2009.
11. Martinelli SC, Matsuoka EC. Um estudo sobre práticas e crenças parentais e o desempenho em escrita de crianças. Educar Rev. 2018;34(69):261-76.
12. Ferreira B, Monteiro L, Fernandes C, Cardoso J, Veríssimo M, Santos AJ. Percepção de competência parental: exploração de domínio geral de competência e domínios específicos de auto-eficácia, numa amostra de pais e mães portuguesas. Analise Psicol. 2014;32(2):145-56.
13. Ramos HA, Cuman RK. Fatores de risco para prematuridade: pesquisa documental. Esc Anna Nery. 2009;13(2):297-304.
14. Tristão RM, Neiva ER, Barnes CR, Adamson-Macedo E. validation of the scale of perceived self-efficacy of maternal parenting in brazilian sample. J Human Growth Development. 2015;25(3):282-1.
15. Fernandes RT, Lamy ZC, Morsch D, Lamy Filho F, Coelho LF. Tecendo as teias do abandono: além das percepções das mães de bebês prematuros. Cien Saude Colet. 2011;16(10):4033-42.
16. Costa R, Padilha MI. A Unidade de Terapia Intensiva Neonatal possibilitando novas práticas no cuidado ao recém-nascido. Rev Gaúcha Enferm. 2011,32(2):248-55.
17. Garg A, Dworkin PH. Surveillance and Screening for Social Determinants of Health: The Medical Home and Beyond. JAMA Pediatr. 2016;170(3):189-90.
18. Oliveira LL, Gonçalves AC, Costa JS, Bonilha AL. Maternal and neonatal factors related to prematurity. Rev Esc Enferm USP. 2016;50(3):382-9.
19. Morawska A, Winter L, Sanders MR. Parenting knowledge and its role in the prediction of dysfunctional parenting and disruptive child behaviour. Child Care Health Dev. 2009;35(2):217-26.