INTERDISCIPLINARY PERSPECTIVE ON THE PLAY AND LANGUAGE OF SUBJECTS AT PSYCHOLOGICAL RISK

Intersubjetividade no olhar interdisciplinar sobre o brincar e a linguagem de sujeitos com risco psíquico

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ABSTRACT

Purpose: to analyze, in an interdisciplinary perspective, the play and language in family interection with psychological risk children, between 21 and 26 months, and the need for early intervention indicated by clinicians from different professions, comparing the look of these with their theoretical and clinical practice in childhood. **Methods:** a qualitative, longitudinal study of 16 children with psychological risk between 0 and 18 months by Child Development Risk Indices and by interviews. They were evaluated in a shoot of 20 minutes of free play interaction with their mothers when they were between 21 and 26 months. The qualitative analysis was performed by three experienced child development clinics, an occupational therapist, a speech therapist and a psychologist. **Results:** twelve of the sixteen children, despite symbolism in play, showed psychoaffective limitations in the interaction with their mothers, and had clinical intervention indication (08 children) or brief orientation (04 children). **Conclusion:** the results showed a relationship between clinical practice and training in post-graduate professionals who privileged the analysis of psychoaffective factors between the mother and the child. There was a important relation between play disorder and psychological risk.

KEYWORDS: Child Development; Risk; Play and Playthings

INTRODUCTION

Considering the importance of play in childhood clinic, both in its cognitive and psycho-affective dimensions, as well as its relation to language development, it seems critical to investigate how it can be analyzed to enable the construction of good therapeutic interventions. This article seeks to address this issue based on the choice for two play analysis, the psycho-affective and cognitive dimensions.

The psycho-affective dimension covers the psychic constitution related to the structuring of children's personality, favoring both their emotional development and their social contacts and cultural integration. This dimension is mainly theorized by Winnicott[1], who states that the initial experience of omnipotence is what triggers the play. Winnicott's understanding is that the child-mother built trust creates a potential space between them, or joins mother and baby on an intermediate playground in which the idea of magic is born[2].

On that first omnipotent moment, children play with their mothers through hallucination and, after going through the stage of transitional phenomena, they start a shared play and, thus, creative. Winnicott[1] highlights the important value assigned to the mother (or whoever is the caregiver) so that the child can be incurred. Considers that there is no possibility of babies moving from the pleasure principle to reality if their mothers are not good enough, that is, if they are not devoted to their babies, adapting to their needs and giving them the opportunity to experience creativity in interpersonal relations and also through the use of objects. Therefore, this intimate mother-baby experience, so-called "holding" in Winnicott's theory, is what enables the development of the concept of "self". Moreover, it is possible to think about the importance of an intersubjective perspective to the analysis of

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play, which regards not only children play, but also how they undergo the effects of the relationship with their maternal and paternal caregivers.

Some studies have addressed the topic play in their psycho-affective dimension in speech therapy. Among them, the studies of Graña and Ramos[3] can be highlighted. They have made a research with a group of speech therapists on the entry of play in their clinical practice, pointing out considerations about the possible playful paths that can be taken in speech therapy, especially regarding their therapeutic value. Klinger and Ramos[4] have investigated aspects such as the use of objects and their possibility of change in children of the autism spectrum in interactionist speech therapy, concluding that play is a fundamental element of childhood therapy, and that awareness and observation of object relations are important clinical indicators. The authors demonstrated the importance of changes in family-child interaction to allow for evolution. The therapist, in that research, was someone who instigated the change in family behavior, sometimes setting a model, or just by listening to the family and providing opportunities for self-reflection[5].

Pollonio and Freire[6] conducted a literature review on the play and its particularities in relation to children and the symptoms of language development, as well as its articulation to the speech therapy clinical method, with currents from Education, Linguistics and Psychoanalysis, concluding that the play is an activity that alone puts into circulation the child's functioning into language, allowing for meaning, interpretation and listening when playing at the speech therapy clinic.

In Speech Therapy, many studies have addressed the cognitive dimension of play, especially some regarding tests and assessments on the relationship between cognition and language, such as those addressing the application of PROC - (*Protocolo de observação comportamental*) Behavior observation protocol[7], conducting a baseline survey for quantitative analysis of 2-3 year-old children in cognitive and language development[8,9].

It can be stated, thus, that besides stemming from intelligence on the rise and from the establishment of relations with others, the play activity also acquires a particular function in the different stages of development and of language itself. It has been used to aid in the diagnosis of children in clinics, both in the psychoanalytic field[4,5] and in the most educational perspectives of clinic activity[8,9]. Thus, it is possible to think that the lack or the quality of the play may indicate whether the psychic structure or even the development, in a broader sense, of a baby is improving or not.

Some recent studies are already able to detect development or psychological risks based on the risk indexes discussed by Kupfer and Voltolini[10]. Such risk indexes showed evidence of association with difficulties in eating transition[11], in nursing[12], in the exercise of parental functions[13,14], in the acquisition of language[15,16], and relate to sociodemographic and obstetric aspects[17], demonstrating validity and reliability to find out when something is not going well in the development of instrumental and / or structural aspects of the baby.

Considering such studies, this article seeks to discuss the relationship between psychological risk and children's play. Therefore, we adopted an interdisciplinary approach of play from the choice of experienced clinicians, representatives of professions that drive the baby clinic from the play, namely: peech therapy, psychology and occupational therapy, to a qualitative analysis of play.

Given these assumptions the objectives of this paper were to analyze, from an interdisciplinary perspective, the play and language development in interactions between family and children with psychological risk, within the age group between 21 and 26 months, and the need for early intervention recommended by clinicians of different areas, confronting their ideas with their theoretical training and clinical practice in childhood.

METHODS

This study originated from a project called "Parental roles and risk for acquisition of language: speech therapy interventions" approved by the Ethics Committee of the Universidade Federal de Santa Maria and by the Department of Education and Research of the University Hospital, in its ethical and methodological aspects in accordance with the guidelines established in Resolution 196/96 and complementary documents of the National Health Council, under CAEE n. 0284.0.243.000-09.

This research project covered the longitudinal follow-up of a group of children based on the Child Development Risk Indexes (IRDIs - Índices de Risco ao Desenvolvimento Infantil)[10] in a medium-sized city in the state of Rio Grande do Sul. These indexes were developed by Kupfer[10] to capture risk to the development and / or psychological risk from the observation of interactions between mothers and babies during pediatric consultation. They present as inspiration the clinical experience of authors with developmental disorders, especially severe psychopathologies such as autism and psychosis, whereby symptoms that have been translated in indexes were identified. They also have a base in the theoretical axes of the freudian-lacanian psychoanalytic field

0 TO 4 MONTHS INCOMPLETE	**AXES**
1. When the child cries or screams, the mother knows what she wants.	SS / ED
2. The mother speaks to the child in a particularly directed style to it (spoiled).	SS
3. The child reacts to spoiled behavior.	ED
4. The mother offers something for children and awaiting his response.	PA
5. There is exchange of glances between the child and the mother.	SS / PA
4 TO 8 MONTHS INCOMPLETE	
6. The child uses different signals to express their different needs.	ED
7. The child reacts (smiles, vocalizes) when the mother or someone else is addressing it.	ED
8. The child actively seeks the mother's gaze.	ED / PA
8 A 12 MONTHS INCOMPLETE	
9. The mother realizes that some of the child requests may be a way to get your attention.	ED / SS
10. During physical care, the child actively seeks games and love playing with her mother.	ED
11. Mother and child share a particular language.	SS / PA
12. The child strange strangers to her.	FP
13. The child makes jokes.	ED
14. The child accepts semi-solid food, solid and varied.	ED
12 18 MONTHS	
15. The mother alternates child dedication of times with other interests.	ED / FP
16. The child and support the mother's brief absences and reacts to prolonged absences.	ED / FP
17. The mother no longer feels more obliged to meet all the child asks.	FP
18. Parents put little rules of behavior for the child.	FP

Figure 1 - Risk indices for child development

that guide the perspective on psychic constitution: the establishment demand (ED), assumption of the subject (SS), switching between absence and presence (AP) and otherness or paternal function (FP). The indexes are summarized in Figure 1.

Babies and their families were contacted during the course of neonatal hearing screening in a university hospital in the city of Santa Maria. At that time, the parents were invited to participate and had detailed explanations about the objectives and procedures of the study, their right to voluntary and identity confidentiality by signing the free informed consent form. The research excluded infants who had congenital malformations, genetic syndromes, congenital infection detected in the neonatal period, before the start of the study, as these alone would represent risk factors for their development.

Parents and infants were monitored from the first months of age, through the application of IRDIs[10] in the age groups 0-4, 4-8, 8-12 and 12-18 months and through continued interviews.

For this present study, the sample consisted of 16 children aged between 21 and 26 months, found to be at risk for development, here identified by the letter C (child) followed by a number from 1 to 16.

For this study, the children from the sample, aged between 21 and 26 months, were filmed with their mothers, but some videos show a brother, a father and an aunt in the interaction. In this film, family members were asked to play for 20 minutes with their children, just as they did at home, by offering different toys, appropriate for their age, available on a carpet in a speech therapy clinic room.

The videos were recorded on DVD and delivered to three different child clinicians, of which one was an occupational therapist, another a psychologist and a speech therapist, who were instructed to analyze the play of children. To aid the analyzes, two guiding questions were made: how they acknowledged the play of children and the babies-families in question required some type of intervention, how this intervention should be. The professionals had no prior knowledge that the children had or did not have risk to development. The selection of the professionals was based on their experience, at least five years, with babies and small children, known for having theoretical training on the play, and known in the city for using it as a primary form of intervention with children. Yet, to find more specify details on such training, an interview was made, in which they were asked to describe their theoretical and practical training with the play.

The analyzes conducted by professionals were synthesized accordingly to fit the result framework of this work and categorized according to the objectives of this research. To categorize, with regard

to the play, we sought to find out whether professionals spoke of the psycho-affective and cognitive dimensions of the play and how they addressed the topic, with more focus on the child and / or adult. As for intervention, we sought to find out whether the professionals made more general indications, such as assessments and guidance to families, which were named as brief intervention; or whether they identified the need for early intervention, given the risk of baby constitution (by serious disorder structuring of development, or even by instrumental obstacle to development), or no need for intervention. Brief intervention was considered as a possibility both in individual and collective slopes. These categories were identified in the words of professionals and have been proposed in the analysis that will be described in the results.

For the play-speech relationship, we sought to find out what the professionals pointed as language issues, if they approached grammatical categories or domains of language, that is, if they addressed more specific problems on the child's language system domain, or observed greater difficulties in the discursive domain expressed in the child-family dialog, or both. Descriptions on what was said about children's language were built based on the analyses made by the professionals. These analyzes were then compared with the results of IRDIs collected at earlier ages than those of shooting. We sought to find out whether the analysis results of the play, made by professionals from 21 to 26 months, presented symptoms that could be explained by changes in theoretical axes and their consequent impact on the psychic constitution previously found, from 1 to 18 months, in the collection of risk indexes.

RESULTS

Considering the interviews about their training on the play, performed with three professionals who analyzed the play of the 16 subjects in this study, it was observed that their qualification on the topic of playing occurred more in graduate school and also in studies that made sense to them in their clinical experience.

The occupational therapist explained that the play was approached during undergraduate course in the subject of game studies. Only graduate school initiated a deepening of the cognitive and affective dimensions of play. However, the play was still regarded as a teaching resource, because the therapeutic scene was either educational or for rehabilitation. When the therapist initiated studies on the issues of subjectivity, she transitioned from the educational perspective of the play as a means to the perspective of the play as a therapy tool intended to enable children to play freely. On the therapist's words: *"The clinic was not educational, the clinic had a subjective construction or intelligence building approach, it could even include intelligence production, subjectivity, motor condition production, not as a training [...], but instead life building in a daily basis."*

For the psychologist, the undergraduate course did not offer a very clear study on play, but Winnicott's studies had always seemed relevant to professional activities. In graduate school, she deepened her studies, acknowledging the play as a potential scenario. On the interview she stated that "*even when children are not able to play, which can be done within the Winnicott's theory, invite them to the play, make it a creative and spontaneous play; and, so when children succeed in creating, we should not interrupt this play, neither with intervention nor interpretation, not that it should never be done ... but it has to be done in the right time [...], so there we may use other sources that will add, but basically it is within Winnicott's theory, in the playful overlap, which is the overlap of play of the therapist and the child".*

The speech therapist also states that during the undergraduate course she did not received specific theoretical training on the play. According to her: *"They were basic play situations from the perspective of appropriateness. The play was used as assessment in protocols [...], but the analysis of free play was poorly explored."* The theoretical and practical knowledge that guides the clinical work of professional has been offered, actually, in the Masters' degree, with interface studies with psychoanalysis to understand the play, as he has stated: "*The assessment of children play with family and therapist is the most effective and relevant choice of clinical management."*

Nowadays, these professionals place the play activity in the category of therapeutic activity, instead of considering it a means to achieve an educational goal. Accordingly, regarding the analysis of the footage of babies at risk to development, all professionals stressed aspects of psycho-affective and cognitive dimensions of play. Speech was also observed in different manners by the three professionals.

While the psychologist treated it implicitly, observing whether or not the mother attributed verbal meaning to the child's actions during the play, the occupational therapist and the speech therapist treated language in terms of dialog support. This was directed to the child and mother - on the scene - that is, in intersubjectivity, in the analysis of those who propose and those who invest in the proposition.

Despite the intersubjective perspective of the analysis of the three professionals, the major focus was observed to be the adult/partner's actions, which shows the importance of environmental provision in child development.

In order to present data synthetically obtained, Figure 2 was organized so that the following information for each subject, represented as C (child) followed by a number 1-16, could be expressed: the indexes that appeared absent; the synthesis of the categories of the analysis made by professionals, namely: the analysis of play in the psycho-affective dimension, as evidence of risk in structuring towards a severe developmental disorder, and in the cognitive dimension, as the ability to access symbolism or stay in a sensorimotor exploration; the analysis of speech in the view of whether or not a communication deficit exists and if it concerns the area of the linguistic system (does not speak much, does not build phrases, etc.) and / or is in the process of dialog with partner, in this case the mother, that is, both in the domain of grammatical components as in the discursive domain, since they had the opportunity to analyze dialog and not only child isolated speech; and the category clinical indications, marked as: Brief intervention, when the professionals mentioned the need for some appointments to better assess and give guidance on adult encouragement of children play, speech and creativity; Early intervention that was assigned when any of the professionals recommended one or more types of intervention, in the form of therapy, particularly on speech, play and / or mental aspects.

Development risk indexes in bold are those that predict psychological risk. The syntheses described in Figure 2 were prepared from the professional analyzes about the play and speech of the 16 children, as well as on the type and necessity of intervention. There were no contradictions in the analyzes, thus, the lines of each professional were not differed, but we opted for a summary of the lines that practically coincided and, at times, are complementary. There was no disagreement in the perception of the main aspects of children play with their families by the professionals.

According to Figure 2, of the 16 children at risk to development, four children (25%) have no need for any kind of intervention. This was the case C7, C8, C9, C15.

Of the 12 children with some indication of intervention, four children (33.33%) had indication of brief intervention, focusing on improving their interaction, both in play, and speech. The brief intervention stands out in these cases, for its preventive value, as there is something not working well in the relationship, but that does not indicate a serious developmental disorder. The professionals indicated guidance to parents as the main form of intervention in these four cases (C5, C6, C10, C11).

Eight, of the sixteen children surveyed (50%) and of the twelve (66.66%) children with indication for therapy, had indications for early intervention: four (50%) focused on psychological and speech therapy (C1 to C4); two children (25%) only psychological intervention (C12 and C14); two (25%) only for intervention in speech (C13 and C16).

Thus, of the total of 12 children with any indication, six children (50%) stood out with a need for psychological aid and six (50%) in need of speech therapy.

Forwarding shows that the three professionals analyzed the psycho-affective and cognitive dimensions of play, and these dimensions related to speech. Therefore, of the children considered to have alterations pointed through the analysis of play, in the psycho-affective dimension, other's directivity appeared in four children (C1, C6, C8, C11); the lack of initiative and mother's support was observed in seven children (C2, C3 C4, C10, C13, C14, C16); the lack of initiative of the child in two (C2, C3); three (C2, C3, C4) presented an exploratory and / or unconcentrated play; and C1, an aggressive and impulsive play. Some children did not show significant changes, and may have limitations of creativity (C5, C7, C9, C15). In the case of C12, a dissociation between mother and child initiatives was noted, and C14 showed difficulty in separation from mother.

In the cognitive dimension of play, symbolism is present in all children, with more or less creative ability, but is absent in C2, C3, C4. This dimension allows us to observe the possibilities of children and how much is invested in creativity, in interface with language.

Concerning speech analysis, in the grammar domain, the professionals indicated C1, C2, C3 as having limitations for the linguistic system (spoke poorly or did not speak yet).

As for the dialog process with an adult, they indicated weaknesses in C1, C2, C3, C4, C6, C12, C13 and C16. Therefore, despite the more evident speech disorder in C1, C2 and C3, considering the lack or insufficiency of speech as more apparent in the speech therapy literature[7], eight of the sixteen children (50%) have their speech dimension compromised, captured by the analysis of the made by professional dialog.

Sub.	IRDIs	Professional Analysis	Clinical Indication
C1	**12,** 15, 16, **18**	Psycho-affective dimension - directiveness of mother, Cognitive dimension - has the potential to symbolism, but is not operated by the mother. Boy psychologically and cognitively well organized, having concepts schema and body image, but no investment breast. Mother policy and anxious, which does not interpret the manifestations of the child (physical and verbal), not allowing the emergence of a potential space. Difficulty in establishing dialogue. Girl says little for his age.	Early intervention, focusing on language and psychological evaluation.
C2	**12**	Psycho-affective dimension - child has little initiative and shows lack of interest in interaction and the mother does not support the play, showing little body availability, just presenting the toys to the child. Cognitive dimension - with no possibility of symbolism. Professionals observe mutual psychic fragility and mother unexciting; Mother with little investment in the child; Mother does not hear the speech of the boy nor gives meaning, giving up when he realizes the boy's disinterest. Sometimes he gets a refusal to the mother's speech and responds better to the sound of toys. Very quiet boy, hardly speaks.	Early intervention, focusing on language and psychological evaluation.
C3	2, 8, **14**	Psycho-affective dimension - Mother does not invest in play and child also has no initiative, being retracted. Dimension cognitiva- without possibility of symbolism and presence psychomotor slowness. Boy does not look at his mother and this does not invest and / or maintains the few attacks of the child, keeping silent; Mother and son without initiative in creative play and dialogue. Lonely boy explores objects with apparent disinterest and constant body and facial blankness and speaks virtually absent.	Early intervention, focusing on language and psychological evaluation.
C4	2, 16, **18**	Psycho-affective Dimension- Restlessness and anxiety boy related to lack of investment and mother of regulation. Cognitive dimension - Restlessness and mother struggling to open, close and invest more symbolic and creative play. According to the professionals, the boy shows agitated, restless and eager for attention; Difficulty playing creatively; There are only naming toys. Mother worried about the boy bodily control, but without organizing it. There are, however, good boy initiatives and to his brother without, however, are well developed.	Early intervention with a focus on language and psychological evaluation.
C5	**14,** 15, 17, **18**	Psycho-affective dimension - Body availability through which we see the symbolization between father, mother and child, with games involving the three and presence of spontaneity and affection. Cognitive dimension - full capacity to symbolize. Professionals do not report language changes, but note that even with cognitive and linguistic support, sometimes parents do not meet all the demand presented by the girl.	Brief intervention.
C6	17, **18**	Psycho-affective dimension: body directive mother and linguistically, but it allows the exploration of the play in parts of the scene. Cognitive dimension: symbolic play with little investment in creativity on the part of the mother, asking questions (appointment) to affirm the knowledge of the child, not bothering with a freer play. The mother does not explore stories and speech C6, has little discursive investment, but mother available and capable of applying a creative play.	Brief intervention.
C7	**14,** 15, 16, 17	Psycho-affective dimension: there is investment of mother and child in developing a creative play. Cognitive dimension: the play is symbolic. Mother and daughter interact well, either via verbal language as the involvement in the play; Mother interprets and maintains speech daughter without directivity. There spontaneity and affection, observed by professionals who do not report language disorders.	No need for clinical intervention.
C8	**12**	Psycho-affective dimension: girl has initiative and mother is policy (appointment), but allows a potential space for children to create and build your play. Cognitive dimension: the play is symbolic, but with little maternal investment; There is communication through oral language and the play, which is not hard or stereotyped; Professionals do not report language disorders.	No need for clinical intervention.
C9	**12**	Psycho-affective dimension: there is mutual investment of the dyad. Rich and healthy environment emotionally. Cognitive dimension: symbolic and creative play. Mother and daughter with spontaneity and creativity, both in play and in oral language. Professionals do not report language disorders.	No need for clinical intervention.

Sub.	IRDIs	Professional Analysis	Clinical Indication
C10	15, **18**	Psycho-affective dimension: child initiative, but the mother invests little in play (concerned to present toys and name them). Cognitive dimension: symbolic and creative capacity of the normal child. The girl shows conditions and initiative to play and for language, but there is, by the mother, lack of investment and support a creative play (girl ends up playing alone), although this well supports the language of the child. Professionals do not report language disorders.	Brief intervention.
C11	**12**	Psycho-affective dimension: anxious mother and Policy (shows many toys without waiting for answers or start a game) and boy with initiative in play. Cognitive dimension: capacity for symbolism, but limited by directivity and low maternal body disposal. Favorable environment, but requiring greater availability of mother to play freely. Professionals do not report language disorders.	Brief intervention.
C12	**12**	Psycho-affective dimension: dissociation between mother and daughter initiatives, such as the mother is not concentrated in the fun. Cognitive dimension: the child has little creativity in play. Girl styling, but mother and daughter disconnected at play; Mother gives voice to the shares but does not interpret the daughter's actions in the play, or does it disconnected. Mother shows directivity and little investment. Girl without language disorders, but there is a lack of interpretation and investment by the mother.	Early intervention, focusing on psychological aspects.
C13	15, 16, 17, **18**	Psycho-affective dimension: little mother's investment in girl's initiatives, although favorable affective environment. Cognitive dimension: this symbolism by the child with the mother's little investment. There is a totally free play, because there is little maternal investment, although the girl shows initiative and symbolism. Mother does not sequence the daughter speaks initiatives since the child starts interaction oral language, but gets no response.	Early intervention, focusing on language.
C14	**12**	Psycho-affective dimension: Boy separation difficulty with the mother (the flame all the time, even when close), which is closer in speech, but little available in play, being uninterested in play. Cognitive dimension: this symbolism in the interactions of the dyad. Favorable environment for play, but with little maternal investment and not limited by the boy's separation from the mother. Professionals do not report language disorders.	Early intervention, focusing on psychological aspects.
C15	**12**	Psycho-affective dimension: good interaction of mother, child and father, who create symbolic play together, with active creative and affective participation by the boy. Cognitive dimension: this symbolism and invested by parents and child. No language disorders.	No need for clinical intervention.
C16	1, **10,**11, **12**	Psycho-affective dimension: Mother and son playing creatively, but sometimes the mother invests little and you are away, looking away, not interpreting the child's actions. Cognitive dimension: this symbolism, but with little maternal investment. No line in the speech, that is, the boy says, but the mother does not understand; Mother with good body availability, but does not mean the actions and speech of the child via language.	Early intervention, focusing on language.

Sub = subject =.; A = absent

Figure 2 - Table of Professional Analysis Summary

Some children who demonstrate difficulties in the dialog process, in co-occurrence with exclusive psycho-affective difficulties were C4 (unconcentrated play, but with mother's initiative), C6 (maternal directivity), C12 (dissociation between mother and child initiatives) C13 and C16 (mother's lack of initiative). Significant environmental problems are clear, therefore, on these cases.

Considering the eight children in need of early intervention, some peculiarities are observed in clinical cases.

C1, with missing indexes that indicate problems in theoretical axes of paternal function and establishment of demand, this was an unplanned premature baby, breastfed up to 24 months. Although having a psycho-motor development within the expected range for the age, speech seemed to have certain stagnation, because the vocabulary did not expand as expected, and the speech was also considered slurred when evaluated. The mother perceived the child as hyperactive and naughty. The professionals found anxiety and maternal directivity in their analyses, with his potential being little

explored. They also noted that the mother does not explore the scene linguistically, which does not help the dialog with the child. The play of C1 is perceived as aggressive and impulsive and the mother does not allow a potential space.

Regarding C2, he was born from an unplanned pregnancy and lives with his parents and 13-year-old sister. The mother had depression before the boy's birth. He was breastfed until 1 year of age, when he was introduced to the bottle four times a day. The boy sat at seven months and walked at 1 year, but had a fall, and this delayed his psycho-motor development, according to the mother. He also started talking at one year but did not improve before 2 years. The mother also identifies a traumatic situation (big shock) as generating the child's development inhibition. The boy was very attached to his mother, diapers and slept on a crib in the room with parents when evaluated for this study. Prolongation of absolute dependence appears in the changing of the axis of paternal function expressed in the absence of index 12. In the reviews of professionals, the child's lack of initiative and withdrawal, accompanied by lack of support on the play by the mother. When the boy has shy initiatives, yet exploring the play, the mother cannot really understand and encourage. In terms of speech, C2 is extremely quiet.

The subject assumption theoretical axes, demand establishment and paternal function were affected in the monitoring of C3 by IRDIs. This is depicted in the boy's attaching relationship with his mother, with hypotonia and lack of initiative and also lack of body and discursive encouragement from the mother. The mother does not give meaning to the child's actions and when she does is to say the child is being spoiled when he searches for her. She does not assume that the child wants to say something. While the psychologist has called for an investigation of the family situation, the speech therapist stressed that the mother is supporting her son's silence. In terms of history, C3 was born prematurely, from an unwanted pregnancy, since the parents were drifting away. The boy was breastfed up to one month and received artificial feeding thereafter. Psycho-motor development was slower and speech emerged with a year and a half, with no improvement in vocabulary up to two years when evaluated.

The C4 boy was born also premature, unplanned, and the fifth child of a young couple (five children before turning 30 years). Had free breastfeed demand within one year. This case demonstrated changes in the discursive dimension from the first evaluations because the mother does not assign tuned meaning to the boy's actions. This emerged in IRDIs by the changing of the subject's assumption, establishment of demand and paternal function. This lack of discursive encouragement was also observed by the professionals during the play among mother, child and brother. Although the boy was beginning to talk more, the family did not interpret and nor encourage his statements.

The C12 girl, also unplanned, was born at term and was breastfed and made use of concomitant artificial milk (mixed feeding). The mother had depression and took drugs during pregnancy. Regarding the psycho-motor and speech development, no peculiarities was noted in the interview with the mother. In risk indexes, the paternal function axis was changed. In the play, professional observed that the girl takes initiative both verbal and non-verbal, but the mother did not seem to be attuned and attentive to such initiatives. The therapist noted, as well as the occupational therapist, a certain mother's directivity, and lack of discursive investment.

The C13 child, also an early and unplanned pregnancy girl, was in physical therapy at the time of collection. The feeding was mixed and the child had lactose intolerance. The mother was undergoing counseling. In risk indexes there was change in the axes establishment of demand and the paternal function, which also expressed the difficulty of the mother in giving meaning to the speech of her daughter, and to letting her talk. The professionals also observed that, despite some body availability, the mother did not also invest in free play.

C14 was planned, born at term and breastfed to up to four months. Professional observed difficulties in separation from the mother, the boy asked for her all the time, but the mother did not give too much meaning and supported his claims. The boy had a symbolic play, but that did not become very creative for lack of maternal support. In terms of altered indexes, the absence of index 12 was clear, which is evidence of paternal function impairment.

Finally, C16 was a boy born from desired pregnancy, in the right time, with adequate food developments in the first six months of life, but restrictions at 24 months. His psycho-motor and language development were adequate. In this case, the indexes showed changes in all theoretical axes (subject assumption, establishment of demand, paternal function and alternating presence and absence).

A common fact to all cases where there was an indication of early intervention by professionals is that there were difficulties both in the play, in a psycho-affective dimension, and in language development, showing a parallelism in verbal and nonverbal interactions. Difficulty from separating from the mother and following rules were also

common in some cases, which was evident in the common change of the axis of the paternal function in all cases, when IRDIs were analyzed.

Another very frequent aspect in the cases, was unplanned pregnancy in five (62.5%) of eight children. Also, of the eight children, three mothers have a history of depression. The C2 and C3 children are the most serious cases in which children were more withdrawn, had little initiative and very limited play.

DISCUSSION

The results allowed us to observe some important questions for discussion: the relationship between risk indices evaluated in the first 18 months of life and the play observed between 21 and 26 months, especially the diagnostic value of play; the important relationship between the psycho-affective dimension of play and running more prominent language of the cognitive dimension; and the disciplinary or interdisciplinary focus on the analysis of play for each professional.

As for changes in IRDIs, the paternal function was the most changed axis, and in some cases, clinically presenting as a non-detachment of the mother's body child, and in others as motor agitation. As Levin[18], psychomotor structure unites motor mechanics to discursive structure and are interrelated. Thus, it is inconceivable that affects the body and its development without also examine the structural aspects. However, this author distinguishes between two types of problems, structural, which relate directly to failures in the paternal function, interfering with the construction of subjectivity; and development problems, which affect the body, because the development is governed by imagination.

On the other hand, the autor[18] says there is an important connection between motor and anguish, saying that "one of the means by which the child has to agonize whether it is through movement" (p. 209), which also implies a subjective matter, as a call to re-establishment of the paternal symbolic function. So when the paternal function is outdated, it can be shown in both structural problems such as the non-development of subjectivity, as bodily problems such as restlessness, what we saw in some cases analyzed, as C4.

Also it can be said from the results, that the risk indices have a greater ability to predict developmental problems in some cases, risk psíquico[19] and can capture many cases early. Therefore, we are not considering it as a diagnostic test, but as an additional aid in the early detection of sense changes in child development It was pointed out that it is the observation of children's play, in relation to the other, which may in fact establish a diagnosis at a later stage to 18 months.

In the cases studied, we observed the connection between language, especially in the discursive dimension, with change in psycho-affective dimension of play, found in 50% of cases. However there have been few cases where it was possible to observe the connection between language and cognitive dimension, in the eyes of professionals.

On the other hand, the analysis of the three professionals showed that playing, in his view, provides a diagnosis of cognitive and psycho-affective dimensions allowing them to think about whether or not to intervene.

The professionals who evaluated the dyads, while the occupational therapist has established its analytical focus on psychomotor and language, turning the play to the affective and cognitive dimensions, the therapist turned to a predominantly affective analysis and language, and the psychologist directed your review for the affective and cognitive dimensions. All analyzes indicated increased focus on adult action, therefore, stressed the need to analyze the environment in which the child lives. Placed, therefore, focus on relational environment and not only on a child or adult, as is traditionally done in the clinic, criticism already held by Rechia and Souza[20] in stating that the unit of analysis of language is dialogue and not the speech of the child isolation. even before subjects with pathophysiological signs in production. Thus, it can be said that the analysis of scenes prioritized the interaction between the child and their family, not just the play or the child's language in isolation. With different resources, there was a similarity in the analysis of professionals was a look at what happened between the partners and not only in child development.

Yet it can be said that, in general, there was less change in the cognitive dimension of play and more changes in psycho size in the comments of professionals, as emerges more, the analysis, as the adult was holding the play with the child only if the child may or may not symbolize, that is, the analysis were at stake the quality of this symbolism and imaginative possibility.

The initial absolute dependence, required constituent terms and that must be overcome with the baby's integration process, indicated by classic works such as Winnicott1, is viewed as an important aspect in the cases analyzed. Set if the child may or may not represent the missing and use functional form objects is an analysis that does not provide sufficient information to decide whether early or not intervention is required in the professional vision, for

most children in this study reached this evolutionary level. Professional demonstrated in their clinical analysis, exploiting the play that occurs between children and their families, as a diagnostic element of the more general type care that family dedicated to child, and as an element for a clinical decision about the intervention.

Therefore, the play can be taken as a sign of a relationship between the child and their family. We must therefore, beyond the type of cognitive support, the type of affective relationship that the scene of the play denounces, that is, and see if a mother cannot create opportunities one play very stimulating the cognitive point of view, one must also consider how it is holding up a relationship and what kind of relationship is this, policy, or not, with or without pleasure, that complies with a place of physical and / or verbal expression for the child. Finally, analysis of the play of the operation seems to allow a look at the clinical as is the relationship in the joint body language, confirming Winnicott propositions about the importance of joint analysis of the baby's condition / child and those of exercising maternal and paternal type of care.

In the professional analysis, we can see that the analysis of play between the child and those who exercise materno1 type of care was a resource to better understand child development, and to propose early intervention, that is, an intervention that allows the child not only advance the integration process and embodiment, but also in the imaginative level and adult independence. To do so, you must include the child and those who exercise such care with her in the evaluation and therapy sessions.

In this view, it is proposed from the analyzes of professionals presented here, it is not enough clinical analysis about the instrumental aspect in play in their cognitive dimension, we must also think of the psycho dimension of play to decide by early intervention, because it is fundamental to imaginative tasks, creativity, toy, imagination and the game reported by Winnicott. According to Author2, the area of experience, which is located between the inner and the outer world psychic reality, called a potential space, where it becomes possible creativity and symbols originate. This is the space in which people express themselves and announce the location of your play, although not always this area is so available, for creativity and symbolic expression will occur when the child begins the process of separation and reunion with the mother. It is not exactly an anatomical space, but an experience in which the subject experiences ambivalent feelings between fantasizing and perceive reality, to feel united and at the same time, separate, only while accompanied. It is the space in which case the dialectic of affirmation and denial, the place of cultural experience where creativity is present in every way.

It is from the experience lived with and for each other, that the child finds alternatives that replace the missing object, though not bring the object back to the scene, intersubjectivity is possible the baby when there is a relationship between two living; where one creates another but at the same time, it allows each himself. Just as the mother creates baby and the baby creates the mother, the unconscious dialectical process installs subjectivity from the similarity and difference. Therefore, subjectivity and intersubjectivity constitute the extent that one cannot exist without the other. Winnicott[2], to highlight the value of the transitional object, emphasizes the privileged place of the mother as guiding and demarcation of the baby's existence and primitive mechanisms emanating from the archaic fantasies and annihilation of anguish. For the same author subjectivity takes place in space "between" internal and external, illusion and disillusionment, from the earliest relations between the mother and the baby[2].

The same can be said for the language, for the analysis of therapists has always been focused on dialogue and therefore they were not limited to state intervention only to children who have important limitations of grammar domain (C1 to C3), but the all children with limitations in the dialogue or discursive dimension (C12, C13, C14 and C16). Therefore, their statements show that the risk indices can predict risk of changes in development including linguagem15, cognition and psychic development of a psycho-affective point of view as other studies pointed[10,13,14,16,19].

Finally, the results showed that the look on the play suffered effects of disciplinary training, because, while the occupational therapist appreciated more psychomotor compared to other professionals, the therapist gave greater importance to the language of operation and the psychologist the emotional relationship. On the other hand, there is an interdisciplinary effect in three professional that emerged from both the clinical need, the training they received in graduate school. All show that graduation still very focused on cognitive aspects of play, and that psycho size and focus to them emerged more in continuing education in graduate level. Possibly this was because, when acting in the clinic, the demand to look at the child's relationship with his family made the professionals to seek training that prioritize the psycho in graduate school, and that allowed them to integrate it with other dimensions of play.

These results advocate then in defense of an interdisciplinary training since graduation, about the play, and that such training addresses the affective

and cognitive, verbal and nonverbal dimensions, as diagnostically and as suppliers of key points to be considered intervention as already pointed Pollonio and Freire[6] and Klinger and Ramos[4].

CONCLUSION

Considering the initial objectives of this article, it can be concluded that the missing representation process was not prevented in most cases, demonstrating that the subjects reached basic elements of symbolism in the play, despite the separation capacity (unknown strangeness) being absent from the common rate for all cases.

The quality of play indicated on the other hand, limitations in the creative potential space, which in the medium term, may bring cognitive limitations and already show psycho-affective difficulties in at least twelve of the sixteen children studied, and, more importantly, in eight children (50%) of the sample. Perhaps some of these limitations can be viewed only in the schooling process, since not all children have developed instrumental problems or even the important developmental disorders in these first two years of life.

The look of different professionals, although these have their particularities, took as its main focus the interaction between the adult and the child, not just the analysis of the behavior of the child or the isolation of adult and indicated that this is an important clinical path which may have effects both on the decision whether or not for early intervention, as in the type of intervention chosen. As the report of the professionals about their training, it was observed that such a focus during the analysis correlated with academic training in graduate and clinical experience and, to a lesser extent, with the formation of the undergraduate program, especially for the speech therapist and occupational therapist.

The results are suggestive that the risk indices can be early detection of relevant strategy and that can be inserted as children's mental health strategy, provided they are in a reality that has a reference team with an interdisciplinary approach to track development of children at risk, and propose an intervention when necessary.

RESUMO

Objetivos: analisar, em uma perspectiva interdisciplinar, o brincar e a linguagem na interação entre familiares e crianças com risco psíquico, observados na faixa etária entre 21 e 26 meses, e a necessidade de intervenção precoce indicada por clínicos de distintas profissões, confrontando o olhar destes com sua formação teórica e prática clínica na infância. **Métodos:** estudo qualitativo, longitudinal de dezesseis crianças avaliadas com risco psíquico, de um a dezoito meses, por meio dos Índices de Risco ao Desenvolvimento Infantil e entrevistas e que foram reavaliadas, por meio de filmagens de 20 minutos, quando estavam entre 21 e 26 meses, em interação lúdica livre com suas mães. A análise foi realizada por três clínicas experientes em desenvolvimento infantil, uma Terapeuta ocupacional, uma Fonoaudióloga e uma Psicóloga. **Resultados:** doze das dezesseis crianças, apesar de poderem simbolizar durante o brincar, apresentaram alterações na dimensão psicoafetiva nas interações com suas mães, e tiveram indicações de intervenção, clínica (08 crianças) ou orientações breves (04 crianças).Tais resultados foram compatíveis com a ausência de alguns índices de desenvolvimento e presença de risco psíquico. **Conclusão:** os resultados demonstraram uma relação entre a prática clínica e a formação em pós-graduação dos profissionais, que privilegiou a análise de aspectos psicoafetivos entre a mãe e a criança. Houve relação importante entre alteração do brincar e presença de risco psíquico.

DESCRITORES: Desenvolvimento Infantil; Risco; Jogos e Brinquedos

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