



INFANCIA Y ADOLESCENCIA EN UN MUNDO EN CRISIS Y CAMBIO

THE PORTUGUESE VERSION OF THE MOTHER AND BABY SCALES (MABS)

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RESUMO

Objectivos Tradução, adaptação e validação da versão portuguesa do instrumento Mother and Baby Scales (MABS).

Método Tradução, retroversão e comparação da versão original com a versão retrovertida da MABS. Aplicação a uma amostra de mães durante o segundo ou terceiro dia de vida do recém-nascido.

Amostra Mães (N = 180) internadas na Maternidade Dr. Alfredo da Costa ou no Hospital de Dona Estefânia durante o puerpério.

Tratamento estatístico Análise em componentes principais e organização dos itens de acordo com as dimensões originais do instrumento.

Resultados Após rotação Varimax, foram detectados oito componentes principais que se relacionam com a maior parte dos itens da MABS de forma semelhante à das oito dimensões originais.

Resultados adicionais Comparação dos resultados obtidos nas sub-escalas da MABS, tendo em conta as variáveis sociodemográficas e clínicas da mãe.

Palavras chave: Mother and Baby Scales, Mother perception of baby behavior; Mother perception of maternal confidence.

ABSTRACT

Objectives Translation, adaptation and validation of the Portuguese version of the Mother and Baby Scales (MABS).

Method Translation, retroversion and comparison of the original version with the retranslated version of MABS. Application to a sample of mothers during the second or third day of their newborn babies' life.



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Sample Mothers (N = 180) staying at Maternidade Dr. Alfredo da Costa or at Hospital de Dona Estefânia during puerperium.

Statistical analysis Principal components analysis and organization of items according to the original dimensions of the instrument.

Results After Varimax rotation, eight principal components were detected and seemed to relate with most part of MABS items in a way that is similar with the one observed with the eight original dimensions.

Additional results Comparison of results obtained at MABS sub-scales, taking into account sociodemographic and clinical variables of the mother.

Key words: Mother and Baby Scales, Mother perception of baby behavior; Mother perception of maternal confidence.

Efforts have been made in order to help parents to get acquainted with their babies' competences. Particularly interesting were the interventions based upon the use of the Neonatal Behavioral Assessment Scale (NBAS) designed to objectively assess and score newborn's behavior (Brazelton, 1973, 1984; Brazelton & Nugent, 1995; 2011). When parents share these neonatal observations it is possible to induce positive changes in parents' behaviors and perceptions as well as in babies' competences. This trend can be appreciated in two meta-analysis (Brit & Myers, 1994; Das Eiden & Reifman, 1996) based in research showing that positive outcomes emerge in: a) maternal responsiveness enhancement; b) increasing time spent playing with and talking to infant; c) more maternal contingent interaction and embellished involvement; d) enhancing infant's wakefulness and responsiveness; e) stimulating infant's reciprocity; f) increasing the variety of interactive behaviors of mothers with premature babies; g) promoting mothers' adaptation to their babies' communication in terms of sensitivity to cues and response to distress; h) generating more optimal scores at the NBAS interactive process as well as better interaction ratings on feeding and face-to-face situations in one month old preterm babies of adolescent mothers; i) higher motor-adaptive scores at four months and better mental development at twelve months of corrected age among preterm babies of adolescent mothers; j) increasing parents' knowledge about the infant and enhancing fathers involvement in caretaking; k) improving mothers' self-confidence and satisfaction with maternal role; l) enabling a more favorable maternal perception of infants' temperament and stimulating infants' cognitive development; m) facilitating mothers' visits to their preterm babies at the NICU as well as enhancing maternal attitudes about reciprocity and maternal perception of the infant's temperament. A similar pattern of results was found by other researchers: a) enhancing babies' interactive orientation and cuddliness performance and mothers' attitudes, perceptions and interactive skills (Gomes-Pedro, Monteiro, Patrício, Carvalho, Torgal-Garcia & Fiadeiro, 1986); b) stimulating behavior of babies with depressed mothers during NBAS social interaction and state organization (Hart, Field & Nearing, 1998); c) short-term positive outcomes in babies' neurobehavioral development and on mother-infant interaction as well as long term positive outcomes in dyadic interplay after stressful conditions (Gomes-Pedro, Patrício, Carvalho, Goldsmith, Torgal-Garcia, & Monteiro, 1995) and d) improvements in scores (orientation and state regulation) of low birth-weight and cerebral injured babies as also improvement of mothers' scores (anxiety and confidence about dealing with the infant) at six months of corrected age (Ohgi, Fukuda, Akiyama & Gima, 2004).

Although interventions with parents of neonates are very promising, it is needed to develop a strategy according to parental characteristics; the baby's behavior should not be the only basis guiding these interventions. We should realize that, in some way mothers' descriptions about babies' behavior can be understood as a consequence of maternal expectations or maternal psychological characteristics (Wolke, 1995). This influence is so strong that the prediction of mother's reports about the baby being irritable or difficult is much more accurately done by mothers' feelings about lack of confidence in caretaking than by objective observations of the neonate behavior (Wolke, 1995).



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According to Wolke (1995) the integration of maternal perceptions with NBAS demonstrations should be done in five steps: first- establishing a dialogue around parents' feelings, birth, baby's behavior and caregiving; second- parents will fill questionnaires related to perceptions about the newborn behavior and about confidence while taking care of the baby; third- the NBAS application will be conducted in order to provide working opportunities about perceptions assessed in the second moment; fourth- a discussion with parents will deal with providing individual care for the baby and fifth- a program will be negotiated about future consultations.

THE MOTHER AND BABY SCALES

In this context an instrument was designed to offer critical information that can be useful while health technicians deal with parents of newborn babies. The Mother and the Baby Scales (Wolke & St James-Roberts, 1987) is a questionnaire devoted to the assessment of mothers' perceptions about their confidence while providing for the babies' needs as well as about their perceptions about the neonate's behavior (Wolke, 1995).

The items of the MABS cover five areas of mothers' perceptions about the neonate behavior (A - Alertness-Responsiveness; UI - Unsettled-Irregular; IDF - Irritable during Feeds; ADF - Alertness during Feeds and E - Easiness) and three areas of mothers' perceptions about maternal confidence while taking care of the baby (LCC - Lack of Confidence in Caretaking; LCF - Lack of Confidence in Feeding and GC - Global Confidence. As a total, MABS integrates 64 items distributed this way: UI- 15 items; IDF- 8 items; A- 8 items; ADF- 5 items; E- 3 items; LCC- 13 items; LCF- 8 items and GC- 3 items. Item 39 is present in the questionnaire but does not relate to any dimension. In subscales A, UI, LCC, ADF, IDF and LCF, subjects answer in Likert scales ranging from "Not at all" (0 points) to "Very much/often" (5 points). In subscales E and GC, subjects answer in Likert scales ranging between extreme adjectives related to each one of the items (e.g., about the baby's temperament the scale will range from "Very irritable" to "Very calm"; about mother's confidence, the scale will range from "Very unsure" to "Very confident"). At the most negative option answers will be scored -3 and at the most positive options answers will be scored +3 (Wolke, 1995). Reliability scores for the MABS subscales can be considered very good: UI- $\alpha = .92$; IDF- $\alpha = .86$; AR- $\alpha = .83$; ADF- $\alpha = .82$; E- $\alpha = .82$; LCC- $\alpha = .93$; LCF- $\alpha = .84$ and GC- $\alpha = .81$ (Wolke, 1995).

TRANSLATION OF THE MABS IN TO PORTUGUESE LANGUAGE

The 64 items of the MABS were translated into Portuguese language by the second author in order to use it in her Master Thesis (Marques, 2008). The result of the translation was retranslated into English Language by the first author. The original version of MABS and the version resulting from retroversion were then compared by a senior colleague of the Clinical Department of the Psychological Faculty of Lisbon University and it was concluded that differences were very few and would not be an obstacle to the use of the Portuguese version.

SAMPLE

In order to recollect a sample of newly mothers, applications for authorizations were sent to the Ethical Comities of two of the most important maternities in Lisbon area: Maternidade Dr. Alfredo da



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Costa and Hospital de Dona Estefânia. Once obtained the authorizations of the Ethical Comities, a sample of newly mothers staying with their babies at the hospital's nurseries by the second or third day after delivery was contacted and invited to be a part in this study. After an explanation about the investigation mothers signed the Informed Consent declaration and received the Information for Participants declaration. As a result, 180 protocols were collected. These were from 87 (48%) mothers who gave birth by vaginal delivery and from 93 (52%) mothers who gave birth by caesarian birth. All mothers were Portuguese, gave birth at term, were breastfeeding, didn't suffer from any physical or mental serious disease that could prevent them to establish a good relationship with their newborn and their babies were not suffering from any serious disease or handicap that could prevent them to establish a good relationship with their mothers. Participants were between 20 and 44 years old, and mean age was 30. About education, they were between 4 and 20 years of study with success and their mean value was 13. Among the mothers of this study, 138 (77%) said their pregnancy was a healthy one while 42 (23%) said their pregnancy was a complicated one. In relation to parity, 110 (61%) were primiparous and 70 (39%) were multiparous. Only 56 (31%) had been involved in classes for birth preparation. The majority 169 (94%) was living with the father of the newborn and almost all of the mothers 173 (96%) considered that their relation with him was a very good one, for 6 (3%) it was a reasonable relationship while one told she had no relation at all with the father of the baby. In what concerns delivery, among the 87 participants that gave birth by vaginal delivery, 19 (22%) did not receive epidural anesthesia and 68 (78%) received epidural anesthesia. Among those 93 participants that gave birth by caesarian section, 74 (80%) received epidural anesthesia (regional) and 19 (20%) received general anesthesia. We also should mention that among these 93 caesarian sections, only 30 (32%) were planned while 63 (68%) were unplanned and also that 61 (66%) were performed by reasons related with the mother and 32 (34%) by reasons related with the baby. After birth, there were 130 (72%) mothers exclusively breast feeding their babies and 50 mothers (28%) were combining breast feeding with bottle feeding. Only 11 (6%) mothers intended to breastfeed their babies for less than three months, 30 (17%) intended to do so between three and six months and 139 (77%) intended to do it for more than six months. Finally, about the sex of the newborn, there were 82 (46%) babies of the female sex and 98 (54%) of the male sex.

DATA RESULTING FROM THE PORTUGUESE ADAPTATION OF THE MABS SCALES

A principal components analysis yielded a big number of components, among which the first 16 accounted for 67.178% of the total variance. While the first component (eigenvalue = 14.923) explained 23.317% of the total variance, the sixteenth (eigenvalue = 1.031) accounted only for 1.611%. Communalities ranged from .830 to .529. Besides reasonable values for this analysis ($KMO = .828$; Bartlett's Test of Sphericity, $\chi^2 = 6191.167$, $df = 2016$, $p = .000$), the fact was that the first component seemed to explain most part of the items not allowing for the MABS dimensions to emerge. After a Varimax rotation, again 16 factors (eigenvalues ranging from 5.243 to 1.433) emerged but now the percentages of explained variance ranged between 8.192 and 2.238. Among these components, the first eight (eigenvalues ranging between 5.243 and 2.529) seem to capture the sense of the original subscales of the MABS while explaining 44.509 of the total variance. Table 1 presents these first eight components and the MABS dimension that they seem to represent, and displays the loadings of MABS items for each one of the original dimensions. The minimum loading value accepted for this analysis was .4, except for dimensions E and GC where, due to the formulation of the items, the maximum value accepted was -.4.



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TABLE 1. Loadings for the first eight components*

	1 (IDF)	2 (UI)	3 (E)	4 (LCC)	5 (A)	6 (ADF)	7 (LCF)	8 (GC)
1					.749			
2		.642						
3				.481				
4		.626						
7					.755			
9				.512				
10				.548				
15					.666			
17		.433						
18		.560						
19				.448				
22				.572				
27				.522				
30				.628				
31		.546						
35		.405						
37			-.770					
38			-.783					
40			-.733					
41								-.535
42								-.550
43								-.761
44						.540		
45	.803							
46	.600							
47	.774							
48	.708							
49	.448							
52	.668							
54						.748		
58							.785	
59							.541	
60							.474	
61							.422	
62						.684		
63	.524							
64							.427	

*Dimensions: IDF (Irritable during Feeds), UI (Unsettled-Irregular), E (Easiness), LCC (Lack of Confidence in Caretaking), A (Alertness-Responsiveness), ADF (Alertness during Feeds), LCF (Lack of Confidence in Feeding) and GC (Global Confidence). Relatively to the first eight components, items 5, 6, 8, 11-14, 20, 21, 23-26, 28, 29, 32-34, 36, 39, 50, 51, 53 and 55-57 presented loadings < .4; item 16 loaded in a theoretically inappropriate way.



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According to data displayed in Table 1, each one of those eight components seems to relate directly with one of the original MABS dimensions. Dimension A (Alertness-Responsiveness) is present in component 5, with three items (1, 7 and 15) presenting good loadings while five items (12, 20, 24, 28 and 32) don't. Dimension UI (Unsettled-Irregular) is observable in component 2, with 6 items (2, 4, 17, 18, 31 and 35) having good loadings while 9 items (5, 8, 11, 14, 21, 25, 26, 29 and 34) don't. Dimension LCC (Lack of Confidence in Caretaking) emerges in component 4, with 7 items presenting good loadings (3, 9, 10, 19, 22, 27 and 30) while 6 items (6, 13, 16, 23, 33 and 36) don't. Dimension E (Easiness) can be detected in component 3, with all items (37, 38 and 40) presenting good loadings. Dimension GC (Global Confidence) is present at component 8, with all items (41, 42 and 43) presenting good loadings. Dimension ADF (Alertness during Feeds) may be observed in component 6, with 3 items presenting good loadings (44, 54 and 62) while 2 items (50 and 56) don't. Dimension IDF (Irritable during Feeds) seems to emerge in component 1, with 5 items (45, 47, 48, 52 and 63) presenting good loadings while 3 items (53, 57 and 60) don't; because 2 items (46 and 49) of the original LCF dimension have good loadings in component 1, and because they can be interpreted as items of mother's guilt feelings during breastfeeding we think they should be integrated in IDF dimension. Dimension LCF (Lack of Confidence in Feeding) can be detected in component 7, with 4 items (58, 59, 61 and 64) presenting good loadings while 4 items (46, 49, 51 and 55) don't; because one item (60) of the original IDF dimension has a good loading in dimension 7, and because it can be interpreted as an item of baby's disruptive behavior powerful enough to threaten mother's confidence, we think it should be integrated in LCF dimension.

According to loadings already presented, MABS' subscales of the Portuguese version are composed by the following items: A – 1, 7 and 15; UI – 2, 4, 17, 18, 31 and 35; LCC – 3, 9, 10, 19, 22, 27 and 30; E – 37, 38 and 40; GC – 41, 42 and 43; ADF – 44, 54 and 62; IDF – 45, 46, 47, 48, 49, 52 and 63; LCF – 58, 59, 60, 61 and 64. This way, internal consistencies are as follows: A – $\alpha = .712$; UI – $\alpha = .760$; LCC – $\alpha = .826$; E – $\alpha = .780$; GC – $\alpha = .755$; ADF – $\alpha = .647$; IDF – $\alpha = .855$ and LCF – $\alpha = .802$.

Table 2 displays some of the descriptive statistics for the MABS scales in our sample.

Table 2. Mean, standard deviation, variance, minimum, maximum, skewness and kurtosis for each one of the MABS scales.

	M	SD	V	Min.	Max.	Skewness	Kurtosis
A	11.48	2.86	8.17	1.00	15.00	-1.187	1.670
UI	11.84	5.56	30.94	.00	25.00	.155	-.517
LCC	11.22	7.79	60.73	.00	35.00	.798	.258
E	14.42	2.96	8.78	5.00	18.00	-.839	.593
GC	13.36	3.31	10.93	3.00	18.00	-.975	.805
ADF	7.79	3.04	9.26	.00	15.00	.153	-.126
IDF	9.69	6.90	47.62	.00	33.00	.931	.992
LCF	6.88	5.73	32.88	.00	23.00	.886	.207

MABS scales: IDF (Irritable during Feeds), UI (Unsettled-Irregular), E (Easiness), LCC (Lack of Confidence in Caretaking), A (Alertness-Responsiveness), ADF (Alertness during Feeds), LCF (Lack of Confidence in Feeding) and GC (Global Confidence).

As can be observed in Table 3, several correlations between MABS subscales are significant and important in the context of mother's perception about newborn behavior and about maternal confi-



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dence. Namely, the fact that most of these statistical associations show that maternal positive perceptions about the neonate behavior tend to correlate among them is important. Much the same way, the trend for maternal negative perceptions about the neonate behavior to correlate with perceptions of maternal lack of confidence is also very relevant. From a general point of view, we can say that MABS dimensions correlate in the expected way.

Table 3. Correlations between MABS scales^a

MABS scales	Statistics	UI	LCC	E	GC	ADF	IDF	LCF
A	Pearson Sig. (2-t) N	.032 .668 180	-.221** .003 180	.107 .154 180	.126 .092 180	.289** .000 180	-.090 .228 180	-.207** .005 180
UI	Pearson Sig. (2-t) N		.578** .000 180	-.357** .000 180	-.226** .002 180	.089 .236 180	.502** .000 180	.474** .000 180
LCC	Pearson Sig. (2-t) N			-.360** .000 180	-.465** .000 180	-.235** .001 180	.606** .000 180	.664** .000 180
E	Pearson Sig. (2-t) N				.78** .000 180	.188* .012 180	-.346** .000 180	-.351** .000 180
GC	Pearson Sig. (2-t) N					.216** .004 180	-.312** .000 180	-.369** .000 180
ADF	Pearson Sig. (2-t) N						-.196** .008 180	-.259** .000 180
IDF	Pearson Sig. (2-t) N							.689** .000 180

MABS scales: IDF (Irritable during Feeds), UI (Unsettled-Irregular), E (Easiness), LCC (Lack of Confidence in Caretaking), A (Alertness-Responsiveness), ADF (Alertness during Feeds), LCF (Lack of Confidence in Feeding) and GC (Global Confidence).

*p < .05. **p < .01.

USING MABS SCALES AS DEPENDENT VARIABLES AND SOCIODEMOGRAPHIC AND CLINICAL VARIABLES AS INDEPENDENT VARIABLES

In order to explore relations between MABS dimensions and variables related to mothers' life, we performed a series of multivariate analysis where MABS data were introduced as dependent variables and data reported by mothers while answering to the sociodemographic and clinical questionnaire were introduced as independent ones.

About mothers' age, comparing mothers aged between 20 and 30 years old, with mothers aged between 31 and 40 years old a global significant difference was not found ($F = .825$, $p = .582$).

Relatively to mother's education, comparing mothers with less than 10 years of education with



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mothers ranging from 10 to 12 years and with mothers with more than 12 years, a global significant difference as found ($F = 2.036$, $p = .011$). At the specific level, only in the A scale could we find a significant difference ($F = 3.394$, $p = .036$). In what concerns mothers' perceptions about their pregnancies, comparing mothers with "healthy" perception of pregnancy with mothers with a "complicated" perception of pregnancy, we found a global significant perception ($F = 2.090$, $p = .039$). At the specific level, only in the IDF scale could we find a significant difference ($F = 6.327$, $p = .013$).

At the domain of parity, comparing primiparous mothers with multiparous mothers, a global significant difference was found ($F = 5.999$, $p = .000$). At the specific level, significant differences were detected for seven dimensions: UI ($F = 15.344$, $p = .000$), LCC ($F = 21.137$, $p = .000$), E ($F = 8.018$, $p = .005$), GC ($F = 26.470$, $p = .000$), ADF ($F = 2.910$, $p = .090$), IDF ($F = 22.233$, $p = .000$) and LCF ($F = 13.201$, $p = .000$).

About mothers being engaged at classes of preparation for delivery and birth, comparing "prepared" mothers with "unprepared" mothers, at the global level we found a nearly significant difference ($F = 1.894$, $p = .064$). At the specific level, a significant difference was found for dimension ADF ($F = 3.932$, $p = .049$) while nearly significant differences were found for dimensions A ($F = 3.275$, $p = .072$) and E ($F = 3.529$, $p = .062$). Relatively to the type of delivery, comparing mothers who had a vaginal delivery with mothers who had a caesarean delivery, a global significant difference was found ($F = 3.005$, $p = .004$). At the specific level, significant differences were found for dimensions IDF ($F = 6.471$, $p = .012$) and LCF ($F = 12.119$, $p = .001$) while a nearly significant difference was found for dimension E ($F = 2.744$, $p = .099$).

In what concerns the type of anesthesia, comparing four groups of mothers (having vaginal delivery and no anesthesia, having vaginal delivery and epidural anesthesia, having caesarean delivery and regional anesthesia, having caesarean delivery and general anesthesia), we found a global significant difference ($F = 1.592$, $p = .038$). At the specific level, significant differences were found for dimensions IDF ($F = 2.965$, $p = .034$) and LCF ($F = 4.351$, $p = .006$) while a nearly significant difference was found for GC ($F = 2.196$, $p = .090$).

About planning for caesarean delivery, comparing mothers whose caesarean delivery was planned with mothers whose caesarean delivery was not planned, a global significant difference was not found ($F = 1.758$, $p = .097$). At the specific level, only in dimension E a nearly significant difference was observable ($F = 3.471$, $p = .066$).

Taking into account reasons for having a caesarean birth, comparing mothers whose caesarean delivery was motivated by issues related to mothers' health with mothers whose caesarean delivery was motivated by issues related to the baby's health, a global significant difference could not be found ($F = 1.120$, $p = .358$). At the specific level, nearly significant differences were detected for dimensions ADF ($F = 3.784$, $p = .055$) and LCF ($F = 3.151$, $p = .079$).

At the domain of support during labor, comparing mothers with support of the father of the child with mothers without that support, a global significant difference could not be found ($F = 1.765$, $p = .087$). At the specific level, significant differences were found for dimensions A ($F = 5.717$, $p = .018$), IDF ($F = 4.433$, $p = .037$) and LCF ($F = 4.753$, $p = .031$).

In what concerns babies' feedings, comparing mothers that exclusively breastfeed with mothers that combine breastfeeding with bottle feeding, a global significant difference was found ($F = 2.955$, $p = .004$). At the specific level, significant differences were found for dimensions A ($F = 4.519$, $p = .035$), LCC ($F = 4.480$, $p = .036$), E ($F = 5.946$, $p = .016$), ADF ($F = 13.715$, $p = .000$), IDF ($F = 4.440$, $p = .037$) and LCF ($F = 4.430$, $p = .037$).

Relatively to breastfeed planning, comparing mothers who intend to breastfeed between three and five months with mothers who intend to breastfeed during six months or more, a global significant difference could not be found ($F = .473$, $p = .874$). At the specific level, nearly significant differences were detected for dimensions LCC ($F = 2.823$, $p = .095$) and LCF ($F = 2.976$, $p = .086$).



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Finally, about the baby's sex, comparing mothers having a female baby with mothers having a male baby, a global significant difference could not be found ($F = 1.014$, $p = .428$). At the specific level, only a significant difference was found for dimension UI ($F = 5.133$, $p = .025$).

A very positive trend is observed at the differences displayed above. In a general sense, mothers with more education, mothers with a positive perception of pregnancy, multiparous mothers, mothers with vaginal delivery, mothers with no anesthesia, mothers with support during delivery, mothers breastfeeding in an exclusive way and mothers that intend to breastfeed for more than six months do get the best results in MABS subscales. It does not happen this way when we are dealing with variables as preparation for delivery. About planning for caesarean delivery, the best results in E subscale belong to mothers without planning. As for the motive for caesarean section, mothers with motives related to the baby's health get the best results. Finally, mothers with male babies find them more unsettled/irregular.

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USO DE ESTRATEGIAS COGNITIVAS DE APRENDIZAJE EN EDUCACIÓN INFANTIL: EFECTO DE LOS IGUALES

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RESUMEN

Desde edades muy tempranas los niños son capaces de poner en marcha sus propias estrategias de aprendizaje. Cada niño es actor y protagonista de su aprendizaje. No obstante, no puede olvidarse que el niño es un ser social, y especialmente en las primeras edades, el aprendizaje se potencia en función de la ayuda que las personas que rodean al niño le ofrecen. Generalmente, en el contexto escolar, el profesor es quien ofrece esta ayuda. Sin embargo, los iguales también son fuente de ayuda.

En relación con ello, el objetivo de este trabajo es conocer si existen diferencias en el tipo de estrategias de aprendizaje utilizadas por niños de 5 años en función de si se enfrentan solos a la tarea o lo hacen en compañía de un igual.

Los resultados muestran la existencia de diferencias significativas en el uso de todas las estrategias cognitivas analizadas: estrategias cognitivas de afrontamiento, de construcción, de ubicación y de apoyo/cooperación.

Estos resultados deben ser tenidos en cuenta en la planificación y puesta en marcha de la actuación educativa que impulse, guíe, sostenga y oriente al niño pero que al mismo tiempo respete su iniciativa y la realidad diferencial de su comportamiento en función de variables como la aquí abordada.

Palabras clave: Infancia; cognición; estrategias de aprendizaje; interacción entre iguales.

ABSTRACT

Children are able to implement their own learning strategies from an early age. Every child is an actor and protagonist of his learning. However, we must remember that the child is a social being and, especially in the early ages, the learning is enhanced by the people who surround him.