CHAPTER 2

Prenatal Development and the Newborn Period

JOSE ORTEGA, Mother and Child

Prenatal Development
Hazards to Prenatal Development
The Birth Experience  The Newborn Infant

picture the following scenario: a developmental psychologist is investigating a very young research participant’s ability to learn. First, she plays a recording of a nonsense word for the young participant (tatata). The participant hears this word multiple times a day, for several months. The psychologist wants to use brain responses to find out whether the participant has learned the novel word. But before the psychologist can measure the participant’s brain waves, something very important has to happen: the participant has to be born!

This scenario is not at all fanciful. Indeed, as you will discover later in this chapter, it describes one of many studies that has revolutionized our understanding of prenatal development (Partanen, Kujala, Tervaniemi et al., 2013). Fetuses can detect and learn from a range of stimuli coming from both the outside world and inside the mother’s body, and they are affected by these stimuli after birth.

This chapter will examine prenatal development—a time of astonishingly rapid and dramatic change. We will also consider some of the ways in which these processes can be disrupted by environmental hazards. Then, we will explore the birth process and some of the most salient aspects of neonatal behavior. Finally, we will outline issues associated with low birth weight and premature birth.

Most of the themes described in Chapter 1 play prominent roles in our discussion of the earliest periods of development. The most notable will be nature and nurture, because prenatal development relies on the continual interplay of biological and environmental factors. The active child theme will also be featured: the activity of the fetus contributes in numerous vital ways to its development. Another theme we will highlight is the sociocultural context of prenatal development and birth. There is substantial cultural variation in how the birth process unfolds. The theme of individual differences comes into play throughout prenatal development and early postnatal life. Continuity/discontinuity is also prominent: despite the dramatic contrast between prenatal and postnatal life, the behavior of newborns shows clear connections to their experience inside the womb. Finally, the theme of research and children's welfare is central to our discussion of how poverty can affect prenatal development and birth outcomes, as well as to our description of intervention programs designed to foster healthy development for preterm infants.

**Prenatal Development**

Hidden from view, the process of prenatal development has always been mysterious and fascinating, and beliefs about the origins of human life and development before birth are an important part of the lore and traditions of all societies. (Box 2.1 describes one set of cultural beliefs about the beginning of life that is quite unlike those of Western societies.)
Few topics have generated more intense debate and dispute in the United States in recent decades than the issue of when life begins—at the moment of conception, the moment of birth, or sometime in between. The irony is that few who engage in this debate recognize how complex the issue is or the degree to which societies throughout the world have different views on it.

Consider, for example, the perspective of the Beng, a people in the ivory Coast of West Africa. According to the Beng, every newborn is a reincarnation of an ancestor (Gottlieb, 2004). In the first weeks after birth, the ancestor’s spirit, its wru, is not fully committed to an earthly life and therefore maintains a double existence, traveling back and forth between the everyday world and wrugbe, or “spirit village.” (The term can be roughly translated as “afterlife,” but “before-life” might be just as appropriate.) It is only after the umbilical stump has dropped off that the newborn is considered to have emerged from wrugbe and become a person. If the newborn dies before this point, there is no funeral, for the infant’s passing is perceived as a return to the wrugbe.

These beliefs underlie many aspects of Beng parenting practices. One is the frequent application of an herbal mixture to the newborn’s umbilical stump to hasten its drying out and dropping off. In addition, there is the constant danger that the infant will become homesick for its life in wrugbe and decide to leave its earthly existence. To prevent this, parents try to make their babies comfortable and happy so they will want to stay in this life. Among the many recommended procedures is elaborately decorating the infant’s face and body to elicit positive attention from others. Sometimes diviners are consulted, especially if the baby seems to be unhappy; a common diagnosis for prolonged crying is that the baby wants a different name—the one from its previous life in wrugbe.

So when does life begin for the Beng? Because each infant is a reincarnation of an ancestor, in one sense, an individual’s life begins well before birth. In another sense, however, life begins sometime after birth, when the wru commits to life and the individual is considered to have become a person.

In the fourth century B.C.E., Aristotle posed a fundamental question that influenced Western thought for the next 15 centuries: Does prenatal life start with a fully formed individual, composed of a full set of tiny parts, or do the many parts of the human body develop in succession? Aristotle argued in favor of the latter, which he termed epigenesis—the emergence of new structures and functions during development (we will revisit this idea in Chapter 3 in its more modern form, epigenetics). Seeking support for his idea, he took what was then a very unorthodox step: he opened chicken eggs to observe organs in various stages of development.

Conception

Each of us originated as a single cell that resulted from the union of two highly specialized cells—a sperm from our father and an egg from our mother. These gametes, or germ cells, are unique not only in their function but also in the fact that each one contains only half the genetic material found in other cells. Gametes are produced through meiosis, a form of cell division in which the eggs and sperm receive only one member from each of the 23 chromosome pairs contained in all other cells of the body. This reduction to 23 chromosomes in each gamete is necessary for reproduction, because the union of egg and sperm must contain the normal amount of genetic material (23 pairs of chromosomes).

The process of reproduction starts with the launching of an egg (the largest cell in the human female body) from one of the woman’s ovaries into the adjoining fallopian tube (see Figure 2.1). As the egg moves through the tube toward the
uterus, it emits a chemical substance that acts as a sort of beacon, a “come-hither” signal that attracts sperm toward it. If an act of sexual intercourse takes place near the time the egg is released, conception, the union of sperm and egg, is possible. In every ejaculation, as many as 500 million sperm are pumped into the woman’s vagina. Each sperm, a streamlined vehicle for delivering the man’s genes to the woman’s egg, consists of little more than a pointed head packed full of genetic material (the 23 chromosomes) and a long tail that whips around to propel the sperm through the woman’s reproductive system.

To be a candidate for initiating conception, a sperm must travel for about 6 hours, journeying 6 to 7 inches from the vagina up through the uterus to the egg-bearing fallopian tube. The rate of attrition on this journey is enormous: of the millions of sperm that enter the vagina, only about 200 ever get near the egg (see Figure 2.2). Many of the sperm get tangled up with other sperm milling about in the vagina; others wind up in the fallopian tube that does not currently

conception the union of an egg from the mother and a sperm from the father

FIGURE 2.1 Female reproductive system A simplified illustration of the female reproductive system, with a fetus developing in the uterus (womb). The umbilical cord runs from the fetus to the placenta, which is burrowed deeply into the wall of the uterus. The fetus is floating in amniotic fluid inside the amniotic sac.

FIGURE 2.2 (a) Sperm nearing the egg Of the millions of sperm that enter the vagina, only a few ever get near the egg. The egg is the largest human cell (the only one visible to the naked eye), but sperm are among the smallest. (b) Sperm penetrating the egg This sperm is whipping its tail around furiously to drill itself through the outer covering of the egg.
Do Girls Outnumber Boys? Because the answer to that question depends on the various forces that influence development and survival, it ultimately depends on when in the lifecycle you ask. There are slightly more male newborns (51.3%) across generations and around the world. This is the case, despite the fact that male fetuses are more susceptible to spontaneous abortion than females in both the 1st week and last several weeks of pregnancy (though it is worth noting that female fetuses are more susceptible in weeks 10–15) (Orzack et al., 2015).

The apparent frailty of male fetuses, paired with the fact that males outnumber females at birth, would seem to imply that male embryos must significantly outnumber female embryos (Austad, 2015). In fact, conception is equally likely to result in male and female embryos (Orzack et al., 2015). Researchers took advantage of the increased use of reproductive technologies and prenatal genetic tests to determine the sex of nearly 140,000 3- to 6-day-old fetuses, and they found an almost exact 50-50 split between males and females. It appears that female fetuses are actually less likely than male fetuses to survive early gestation, resulting in the slight male bias at birth.

Females win the next big competition—birth. During labor and delivery, males are more likely to experience fetal distress than females, even controlling for the males’ larger size and head circumference (DiPietro, Costigan, & Voegtline, 2015). Indeed, for decades, and across many cultural contexts, infant mortality rates have been higher for boys than for girls (Drevenstedt et al., 2008). Male fetuses are more sensitive than females are to teratogens (harmful external agents), including opioids and alcohol, which affects their viability and ability to thrive after birth (e.g., DiPietro & Voegtline, 2017). Male infants’ heightened vulnerability is not limited to the immediate postnatal period. Males are also more likely than females to die from sudden infant death syndrome (SIDS, discussed in more detail in Box 2.3; Mage & Donner, 2014) and have higher rates of incidence of a wide range of developmental disabilities, including attentional disorders and autism spectrum disorders.

Societal and cultural forces also play a role, sometimes to devastating effect. In many societies, both historically and currently, male offspring are more highly valued than female offspring, and parents resort to infanticide to avoid having daughters. For example, Inuit families in Alaska traditionally depended on male children to help in the hunt for food, and in former times, Inuit girls were often killed at birth. Until 2015, the Chinese government strictly enforced a “one-child” policy, a measure designed to reduce population growth by forbidding couples to have more than one child. This policy resulted in many parents killing or abandoning their female babies (or giving them up for adoption to Western families) in order to make room for a male child.

A more technological approach is currently practiced in some countries that place a premium on male offspring: prenatal tests are used to determine the gender of the fetus, and male fetuses are selectively aborted. These cases dramatically illustrate the sociocultural model of development described in Chapter 1: cultural values, government policy, and available technology all affect developmental outcomes. Though not addressed in the studies cited here, it is important to note that not every individual can be categorized as male or female, and that an infant’s designated sex at birth may differ from their eventual gender identity. These issues are addressed more fully in Chapter 15.

It is important to remember that our understanding of the effects of environmental forces on developmental outcomes is far from complete. New research is exploring the impact of climate change on sex ratios—both in terms of higher temperatures, which may increase the ratio of boys conceived compared to girls, and stress-related teratogens as a result of extreme weather events and subsequent environmental effects, which may negatively affect the number of male fetuses that survive through birth (Fukuda et al., 2014). Evidence at this point does not support definitive statements about the impact of climate change on birth sex ratios, but emerging research in this area reminds us of the complex network of forces at play.

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**BOX 2.2 INDIVIDUAL DIFFERENCES**

Do Girls Outnumber Boys?

<table>
<thead>
<tr>
<th>zygote</th>
<th>a fertilized egg cell</th>
</tr>
</thead>
<tbody>
<tr>
<td>embryo</td>
<td>the developing organism from the 3rd to 8th week of prenatal development</td>
</tr>
<tr>
<td>fetus</td>
<td>the developing organism from the 9th week to birth</td>
</tr>
<tr>
<td>mitosis</td>
<td>cell division that results in two identical cells</td>
</tr>
</tbody>
</table>

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Developmental Processes

Four major developmental processes underlie the transformation of a zygote into an **embryo** and then a **fetus**. The first is **cell division**, known as **mitosis**. Within about 12 hours after conception, the zygote divides into two equal parts, each...
containing a full complement of genetic material. These two cells then divide into four, those four into eight, those eight into sixteen, and so on. Through continued cell division over the course of 38 weeks, the barely visible zygote becomes a newborn consisting of trillions of cells.

A second major process is cell migration, the movement of newly formed cells away from their point of origin. Among the many cells that migrate are the neurons that originate deep inside the embryonic brain and then, like pioneers settling new territory, travel to the outer reaches of the developing brain.

The third process in prenatal development is cell differentiation. Initially, all of the embryo’s cells, referred to as embryonic stem cells, can give rise to any of the more than 200 possible cell types in the human body. (It is this unique flexibility that makes embryonic stem cells the focus of a great deal of research in regenerative medicine.) After several cell divisions, however, these cells start to specialize. Since all cells in the body share an identical set of genes, what factors determine which type of cell a given stem cell will become? While much about this process remains unknown, it is clear that the cell’s location influences its future development via chemical and cell-to-cell contact with neighboring cells, and that gene expression—which genes in the cell are switched on—distinguishes one type of cell from another.

The fourth developmental process is something you would not normally think of as developmental at all—death. The role of this genetically programmed “cell suicide,” known as apoptosis, is readily apparent in hand development: the formation of fingers depends on the death of the cells in between the ridges in the hand plate, as seen in Figure 2.3. In other words, death is preprogrammed for the cells that disappear from the hand plates. Apoptosis has been referred to as a “tick-ing death timer” because it follows a specific timeline, programmed into the cells themselves.

Finally, hormones have a major influence throughout prenatal development. For example, hormones play a crucial role in sexual differentiation. All human fetuses, regardless of the genes they carry, can develop either male or female genitalia. The presence of androgens, a class of hormones that includes testosterone, leads to the development of male genitalia. If androgens are absent, female genitalia develop. The source of androgens is the male fetus itself, at around the 8th week after conception. This is just one of the many ways in which the fetus influences its own development. Other important hormones include steroids such as glucocorticoids, which limit fetal growth and help fetal tissues mature. Toward the end of gestation, the fetus increases production of these hormones in order to facilitate maturation of key organs, such as the lungs, that are needed for life outside the womb. Later in this chapter, we will discuss the role played by glucocorticoids in the influence of maternal stress on the fetus.

We now turn our attention to the general course of prenatal development.

Early Development
On its journey through the fallopian tube to the womb, the zygote doubles its number of cells roughly twice a day. By the 4th day after conception, the cells arrange themselves into a hollow sphere with a bulge of cells, called the inner cell mass, on one side.
This is the stage at which **identical (monozygotic) twins** most often originate. They result from a splitting in half of the inner cell mass, thus they have exactly the same genetic makeup. In contrast, **fraternal (dizygotic) twins** result when two eggs happen to be released from the ovary into the fallopian tube and both are fertilized. Because they originate from two different eggs and two different sperm, fraternal twins are no more alike genetically than non-twin siblings with the same parents.

By the end of the 1st week following conception, if all goes well (which it does for less than half the zygotes that are conceived), the zygote embeds itself in the uterine lining and becomes dependent on the mother for sustenance. The embedded ball of cells then starts to differentiate. The inner cell mass becomes the embryo, and the rest of the cells become an elaborate support system—including the **amniotic sac** and **placenta**—that enables the embryo to develop. The inner cell mass is initially a single layer thick, but during the 2nd week, it folds itself into three layers, each with a different developmental destiny. The top layer becomes the nervous system, the nails, teeth, inner ear, lens of the eyes, and the outer surface of the skin. The middle layer becomes muscles, bones, the circulatory system, the inner layers of the skin, and other internal organs. The bottom layer develops into the digestive system, lungs, urinary tract, and glands. A few days after the embryo has differentiated into these three layers, a U-shaped groove forms down the center of the top layer. The folds at the top of the groove move together and fuse, creating the **neural tube** (Figure 2.4). One end of the neural tube will swell and develop into the brain, and the rest will become the spinal cord.

The elaborate support system that develops along with the embryo is essential to the embryo’s survival. The **amniotic sac** is a membrane filled with a clear, watery fluid in which the fetus floats. The amniotic fluid operates as a protective buffer for the developing fetus, providing it with a relatively even temperature and cushioning it against jolting. The **placenta** is a rich network of blood vessels, weighing roughly one pound, that extends into the tissues of the mother’s uterus. While we might assume that the placenta comes from the mother, 90% of the cells in the placenta come from the fetus itself. Far from just being afterbirth, the placenta is a complex organ that plays a critical role in the healthy development of the fetus.

Crucially, the placenta is semipermeable: it permits the exchange of materials carried in the bloodstreams of the fetus and its mother, but it prevents the blood of the mother and fetus from mixing. Oxygen, nutrients, minerals, and some antibodies—all of which are just as vital to the fetus as they are to you—are transported to the placenta by the mother’s circulating blood. They then cross the placenta and enter the fetal blood system. Waste products (e.g., carbon dioxide and urea) from the fetus cross the placenta in the opposite direction and are removed from the mother’s bloodstream by her normal excretory processes. The placental membrane also serves as a defensive barrier against a host of dangerous toxins and infectious agents that can inhabit the mother’s body but would be harmful or even fatal to the fetus. Unfortunately, being semipermeable, the placenta is not a perfect barrier, and, as you will see shortly, a variety of harmful elements can cross it and attack the fetus. These support system structures are illustrated in Figure 2.1.

The amniotic sac is connected to the placenta via the **umbilical cord**, which is a tube containing the blood vessels that run to the fetus.
An Illustrated Summary of Prenatal Development

The course of prenatal development from the 4th week post-conception onward is illustrated in Figures 2.5 through 2.11, and significant milestones are highlighted in the accompanying text. Notice that earlier development takes place at a more rapid pace than later development and that the areas nearer the head develop earlier than those farther away (e.g., head before body, hands before feet)—a general tendency known as cephalocaudal development.

Figure 2.5: At 4 weeks after conception, the embryo is curved so tightly that the head and the tail-like structure at the other end are almost touching. The round area near the top of the head is where the eyes will form, and the round gray area near the back of the “neck” is the primordial inner ear. A primitive heart is visible; it is already beating and circulating blood. An arm bud can be seen in the side of the embryo; a leg bud is also present but less distinct.

Figure 2.6: (a) In this 5½-week-old fetus, the nose, mouth, and palate are beginning to differentiate into separate structures. (b) Just 3 weeks later, the nose and mouth are almost fully formed. Cleft palate, one of the most common birth defects worldwide, involves malformations of this area and originates sometime between 5½ and 8 weeks prenatally, as these structures are developing.

Figure 2.7: The bulging forehead of this 9-week-old fetus reflects extremely rapid brain growth. Rudimentary eyes and ears are forming. All the internal organs are present. Sexual differentiation has started. Ribs are visible, fingers and toes have emerged, and nails are growing.

Figure 2.8: This image of an 11-week-old fetus clearly shows the heart, which has achieved its basic adult structure. You can also see the developing spine and ribs, as well as the major divisions of the brain.

Figure 2.9: During the last 5 months of prenatal development, the growth of the lower part of the body accelerates. At this age, the external genitalia are substantially developed, and a different camera angle would have revealed the sex of this fetus.
Figure 2.10: This 18-week-old fetus is covered with very fine hair, and a greasy coating protects its skin from its long immersion in liquid. The components of facial expressions are present—the fetus can raise its eyebrows, wrinkle its forehead, and move its mouth.

Figure 2.11: The brain and lungs of a 28-week-old fetus are sufficiently developed that it would have a chance of surviving on its own, without medical intervention. The eyes can open, and they move, especially during periods of rapid eye movement (REM) sleep. The auditory system is functioning, and the fetus reacts to a variety of sounds.

During the last 3 months of prenatal development, the fetus grows dramatically in size, essentially tripling its weight. It also develops a wide repertoire of behaviors and learns from its experiences, as described in the next section. Table 2.1 summarizes the major milestones in prenatal development.
TABLE 2.1  Milestones in Prenatal Development

<table>
<thead>
<tr>
<th>Trimester</th>
<th>Weeks</th>
<th>Major Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>Zygote travels from fallopian tube to womb and embeds in uterine lining; cells arrange into a ball and begin to form embryo and support system.</td>
</tr>
<tr>
<td>2–3</td>
<td></td>
<td>Embryo forms three layers, which will become the nervous system and skin; muscles, bones, and circulatory system; and digestive system, lungs, and glands; neural tube also develops.</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>Neural tube continues to develop into the brain and spinal cord; primitive heart is visible, as are leg and arm buds.</td>
</tr>
<tr>
<td>5–9</td>
<td></td>
<td>Facial features differentiate; rapid brain growth occurs; internal organs form; fingers and toes emerge; sexual differentiation has started.</td>
</tr>
<tr>
<td>10–12</td>
<td></td>
<td>Heart develops its basic adult structures; spine and ribs develop more fully; brain forms major divisions.</td>
</tr>
<tr>
<td>2</td>
<td>13–24</td>
<td>Lower body growth accelerates; external genitalia are fully developed; body develops hairy outer covering; fetus can make basic facial expressions; fetal movements can be felt by mother.</td>
</tr>
<tr>
<td>3</td>
<td>25–38</td>
<td>Fetus triples in size; brain and lungs are sufficiently developed at 28 weeks to allow survival outside of womb; visual and auditory systems are functional; fetus is capable of learning and behaviors begin to emerge.</td>
</tr>
</tbody>
</table>

Fetal Experience and Behavior

Is the womb a haven of peace and quiet? Although the uterus and the amniotic fluid buffer the fetus from much of the stimulation impinging on the mother, the fetus still experiences an abundance of sensory stimulation and is capable of learning and developing behaviors.

Studies of fetal behavior reveal many results consistent with the themes laid out in Chapter 1. Prenatal experiences shape the developing fetus (nature and nurture). The fetus participates in, and contributes to, its own development: the formation of organs and muscles depends on fetal activity, and the fetus rehearses the behavioral repertoire it will need at birth (the active child). There is also evidence for both continuity and discontinuity. To give just one striking example, 32-week-old fetuses whose heart rates were generally slower and who moved less were more behaviorally inhibited at 10 years of age (DiPietro et al., 2018). Despite their very different environments (discontinuity), fetuses and children show surprising similarities (continuity).

Movement

From 5 or 6 weeks after conception, the fetus moves spontaneously. One of the earliest distinct patterns of movement to emerge (at around 7 weeks) is, remarkably enough, hiccups. Although the reasons for prenatal hiccups are unknown, one theory posits that they are a burping reflex, preparing the fetus for eventual nursing by removing air from the stomach to make more room for milk (Howes, 2012).

Swallowing is another important reflex that helps to prepare the fetus for survival outside the womb. Fetuses swallow amniotic fluid, most of which is excreted back out into the amniotic sac. The tongue movements associated with swallowing promote the normal development of the palate. In addition, the
passage of amniotic fluid through the body helps the digestive system mature properly.

Another form of fetal movement anticipates breathing after birth. For breathing to occur, the respiratory system must be mature and functional. Beginning as early as 10 weeks after conception, the fetus promotes its respiratory readiness by exercising its lungs through "fetal breathing," moving its chest wall in and out. No air is taken in, of course; rather, small amounts of amniotic fluid are pulled into the lungs and then expelled. Fetal breathing is initially infrequent and irregular but then increases in rate and stability. By the third trimester, fetuses “breathe” roughly once per second (Ulusar, Sandhal, & Mendilcioglu, 2017).

Touch
The fetus experiences tactile stimulation as a result of its own activity. Fetuses have been observed not only grasping their umbilical cords but also rubbing their face and sucking their thumbs. Indeed, the majority of fetal arm movements during the second half of pregnancy result in contact between their hand and mouth (Myowa-Yamakoshi & Takeshita, 2006), as the fetus in Figure 2.12 demonstrates. Remarkably, fetuses' choice of thumb to suck predicts later handedness; fetuses who suck their right thumb are more likely to be right-handed adolescents, whereas fetuses who suck their left thumb are more likely to be left-handed adolescents (Hepper, Wells, & Lynch, 2005).

As the fetus grows larger, it bumps against the walls of the uterus increasingly often. By full term, fetal heart rate responds to maternal movements, suggesting that their vestibular systems—the sensory apparatus in the inner ear that provides information about movement and balance—is also functioning before birth (Cito et al., 2005; Lecanuet & Jacquet, 2002).

Sight
Although it is not totally dark inside the womb, the visual experience of the fetus is minimal. Despite minimal stimulation, fetuses can process visual information by the third trimester of pregnancy, and, much like newborn infants, fetuses have visual preferences. In a recent study, researchers used 4-D ultrasound to measure what third-trimester fetuses preferred to look at by projecting light patterns onto pregnant women's abdomens (see Figure 2.13; Reid et al., 2017). Fetuses preferred light displays that are top-heavy (resembling correctly oriented faces) over those that are bottom heavy (resembling inverted faces). These data suggest that infants' predispositions to look toward face-like stimuli may not require postnatal experience (though see Scheel et al., 2018, for an alternative view). We continue the discussion of face perception and preference in infants in Chapter 5, Box 5.1.

Taste
The amniotic fluid contains a variety of flavors, and fetuses like some better than others. Indeed, the fetus has a sweet tooth. The first evidence of fetal taste preferences came from a study performed more than 60 years ago (described by Gandelman, 1992). A physician named DeSnoo (1937) devised an ingenious treatment for women with excessive amounts of amniotic fluid. He injected saccharin into their amniotic fluid, hoping that the fetus would help the mother out by ingesting increased amounts of the sweetened fluid, thereby diminishing the excess. And, in fact, tests of the mothers' urine showed that the fetuses ingested...
more amniotic fluid when it had been sweetened, demonstrating that flavor preferences exist before birth.

**Smell**

Amniotic fluid takes on odors from what the mother has eaten. Obstetricians have long reported that during birth they can smell scents like curry and coffee in the amniotic fluid of women who had recently consumed them. Smells can be transmitted through liquid, and amniotic fluid comes into contact with the fetus's odor receptors through fetal breathing, providing fetuses with the opportunity for olfactory experience. Prenatal scent learning plays an important role in many species' early developmental processes, demonstrating the principle of **phylogenetic continuity**: humans share many characteristics and developmental processes with nonhuman animals due to our shared evolutionary history. For example, during the birth process in rats, the nipples on the underside of the mother rat's belly are smeared with amniotic fluid. The scent of the amniotic fluid is familiar to the rat pups from their time in the womb, and it lures the babies to the mother's nipples for nursing. When the mother rat's nipples are washed immediately after birth, newborn rats fail to attach to her nipples (Teicher & Blass, 1977). This classic finding clearly demonstrates that nurture begins prenatally: experiences before birth play an important role in post-natal developmental processes.

**Hearing**

The prenatal environment is surprisingly noisy. Fetuses float in a soundscape dominated by their mother's heartbeat, blood flow, and breathing. From the fetuses' vantage point, digestive sounds occur roughly 5 times per second (Parga et al., 2018). The noise level in the uterus ranges from about 70–95 decibels (roughly the noise level of a vacuum to a lawnmower). The mother's voice is particularly prominent. We know that the fetus hears its mother because its heart rate changes when the mother starts speaking (Voegtline et al., 2013).

During the last trimester, external noises elicit changes in fetal movements and heart rate as well, suggesting that the fetus also perceives sounds outside the mother's body. For instance, fetal heart rate increases when recordings of the mother's or father's voices are played near the pregnant mother's abdomen (Lee & Kisilevsky, 2014). Similarly, changes in heart-rate patterns suggest that fetuses can distinguish between music and speech played near the mother's abdomen (Granier-Deferr et al., 2011).

The uterine auditory experience appears to be particularly well-suited to early brain development. In a study by Webb and colleagues (2015), a group of hospitalized preterm infants spent several hours each day listening to recordings of their mothers' uterine sounds (including voices and heartbeats).

**phylogenetic continuity** the idea that because of our common evolutionary history, humans share many characteristics, behaviors, and developmental processes with non-human animals, especially mammals.
At 1 month of age, their brain development was compared to another group of preterm infants who were only exposed to regular hospital sounds. The preterm infants exposed to womb sounds had larger auditory cortices than the control group, suggesting that maternal sounds may facilitate brain development before full gestation.

Because sound is such a prevalent feature of the fetal environment, it plays a major role in prenatal learning, as we discuss next.

**Fetal Learning**

To this point, we have emphasized the impressive behavioral and sensory capabilities of the fetus. Even more impressive is the extent to which the fetus learns from its experiences in the last 3 months of pregnancy, after the central nervous system is adequately developed to support learning.

In the example of fetal learning that opened this chapter, infants remembered specific prenatal auditory experiences that were presented via audio speakers adjacent to the mother’s abdomen, such as repetitions of a single nonsense word (Partanen, Kujala, Tervaniemi et al., 2013) or a melody like *Twinkle Twinkle Little Star* (Partanen, Kujala, Näätänen et al., 2013). More direct evidence for fetal learning comes from studies of habituation, one of the simplest forms of learning. Much like adults and children, fetuses grow bored if a stimulus is repeated over and over again. This process is called **habituation**: a decrease in response to repeated or continued stimulation (see Figure 2.14). Habituation provides evidence of learning and memory: the stimulus loses its novelty (and becomes boring) only if the stimulus is remembered from one presentation to the next. When a perceptible change in the stimulus occurs, it becomes interesting again—a process known as **dishabituation**. Fetuses as young as 30 weeks gestation show habituation to both visual and auditory stimuli, indicating that their central nervous systems are sufficiently developed for learning and short-term memory to occur (Matuz et al., 2012; Muenssinger et al., 2013).

Fetuses also learn from their extensive experience with their mother’s voice. Kisilevsky and colleagues (2003) tested term fetuses in one of two conditions. Half of the fetuses listened to a recording of their mother reading a poem, played through speakers placed on their mother’s abdomen. The other half listened to recordings of the same poem read by another woman. Fetal heart rate increased in response to the mother’s voice but decreased in response to the other woman’s voice. These findings suggest that the fetuses recognized (and were aroused by) the sound of their own mother’s voice relative to a stranger’s voice. For this to be the case, fetuses must be learning and remembering the sound of their mother’s voice.

After birth, do newborns remember anything about their fetal experience? The answer is a resounding yes! They still prefer to listen to their own mother’s voice rather than to the voice of another woman (DeCasper & Fifer, 1980). Furthermore, newborns prefer to listen to a version of their mother’s voice that has been filtered to sound the way it did in the womb, rather than to another woman’s filtered voice (Moon & Fifer, 1990; Spence & Freeman, 1996). Newborns prefer to listen to the language they
heard in the womb over another language (Mehler et al., 1988; Moon, Cooper, & Fifer, 1993). Finally, newborns remember the sounds of specific stories heard in the womb (DeCasper & Spence, 1986). Figure 2.15 describes the technique these researchers used to study prenatal learning.

Fetuses also learn from the tastes and smells they encounter in the womb. Like the rat pups discussed earlier, newborn humans remember the scent of amniotic fluid. They orient to their own amniotic scent and prefer scents reflecting flavors that their mother ate while she was pregnant, like anise (licorice) or garlic (for a review, see Anzman-Frasca et al., 2018). Long-lasting taste preferences have also been observed. In one study, pregnant women drank carrot juice for three weeks near the end of their pregnancy (Mennella, Jagnow, & Beauchamp, 2001). When tested at around 5½ months of age, their babies reacted more positively to cereal prepared with carrot juice than to the same cereal prepared with water. These flavor preferences suggest a persistent effect of prenatal learning that may shed light on the origins and strength of cultural food preferences. A child whose mother ate a lot of chili peppers, ginger, and cumin during pregnancy, for example, might be more favorably disposed to Indian food than would a child whose mother’s diet lacked those flavors.

Does this evidence of fetal learning suggest that there is a benefit to “prenatal education” programs, where specific music, languages, voices, or other experiences can be used to enhance cognitive abilities after birth? Probably not. In the first place, the fetal brain is unlikely to be sufficiently developed to process much about language meaning. In addition, the liquid environment in the womb filters out detailed speech and music sounds, leaving only pitch contours and rhythmic patterns. In short, the fetus learns about general sounds but not any specific content.

**REVIEW QUESTION**

Fetal development includes periods of rapid change, as well as periods of slower growth. Throughout the gestation process, the fetus goes through phases during which different organs and systems develop. How do the different periods of fetal development illustrate aspects of continuity and discontinuity? 

**Hazards to Prenatal Development**

Regrettably, prenatal development is not always free of error or misfortune. The most dire, and by far the most common, misfortune is spontaneous abortion—commonly referred to as miscarriage. Most miscarriages occur before the woman even knows that she is pregnant. The majority of embryos that are miscarried very early have severe defects, such as a missing chromosome or an extra one, that make further development impossible. In the United States, about 15% of clinically recognized pregnancies end in miscarriage (Rai & Regan, 2006). This number is similar to the rate in a very different culture, rural Kenya (18.9%), suggesting that the factors that influence miscarriage are present across a wide range of life circumstances (Dellicour et al., 2016).

Across their childbearing years, at least 25% of women—and possibly as many as 50%—experience at least one miscarriage. Few women realize how common
this experience is, making it all the more painful if it happens to them. Yet more agonizing is the experience of the approximately 1% of women who experience recurrent miscarriages, or the loss of three or more consecutive pregnancies. Encouragingly, though, many women who have had recurrent miscarriages successfully carry subsequent pregnancies to term (Cohain, Buxbaum, & Mankuta, 2017).

For fetuses that survive the danger of miscarriage, there is still a range of factors that can lead to unforeseen negative consequences. Here, we consider some of the many environmental risk factors. Genetic factors will be discussed in Chapter 3.

**Teratogens**

A vast number of environmental agents, called teratogens, have the potential to harm the fetus. The effects of potential teratogens are heavily influenced by timing (one of the basic developmental principles discussed in Chapter 1). Many teratogens cause damage only if they are present during a sensitive period in prenatal development. The major organ systems are most vulnerable to damage at the time when their basic structures are being formed. Because the timing is different for each system, the sensitive periods are different for each system, as shown in Figure 2.16.

The most dramatic illustration of the importance of timing comes from the use of the drug thalidomide in the early 1960s. Thalidomide was prescribed to treat morning sickness (among other things) and was considered to be so safe that it was sold over the counter. At the time, it was believed that such medications would not cross the placental barrier. However, many pregnant women who took this new, presumably safe drug gave birth to babies with major limb deformities; some babies were born with no arms and with flipperlike hands growing out of their shoulders. In a striking illustration of sensitive period effects, serious defects occurred only if the pregnant woman took the drug between the 4th and 6th week after conception—the time when her fetus’s limbs were emerging and developing (look again at Figures 2.5 to 2.11). Taking thalidomide either before the limbs started to develop or after they were basically formed had no harmful effect.

As you can see in Figure 2.16, the sensitive periods for many organ systems occur before the woman might realize she is pregnant. Because a substantial number of pregnancies are unplanned, sexually active people of childbearing age should be aware of factors that could compromise the health of a child they might conceive.

Another crucial factor influencing the severity of teratogenic effects is the amount and duration of exposure. Most teratogens show a dose–response relation: the greater the fetus’s exposure to a potential teratogen, the more likely it is that the fetus will suffer damage and the more severe any damage is likely to be.

Teratogens frequently occur in combination, making it difficult to separate out their effects. For families living in poverty, for example, it is hard to tease apart the effects of poor maternal nutrition, exposure to pollution, inadequate prenatal care, and psychological stress. The presence of multiple risk factors can have a cumulative impact on development, as we discuss further at the end of this chapter in the section on multiple-risk models.

**teratogen** an external agent that can cause damage or death during prenatal development

**sensitive period** the period of time during which a developing organism is most sensitive to the effects of external factors

**dose–response relation** a relation in which the effect of exposure to an element increases with the extent of exposure (prenatally, the more exposure a fetus has to a potential teratogen, the more severe its effect is likely to be)
Negative effects of prenatal experience may not be immediately evident. *Fetal programming* refers to the belated emergence of effects of prenatal experience that "program the physiological set points that will govern physiology in adulthood" (Coe & Lubach, 2008). For instance, in the case of inadequate prenatal nutrition, the fetus's metabolism adjusts to the level of nutritional deficiency experienced in the womb and does not reset itself after birth. In a postnatal environment with abundant food, this programming sets the stage for the development of overweight and obesity issues.

Evidence comes from studies of individuals who were conceived in the Netherlands in 1944, during what was known as the Dutch Hunger Winter (Schulz, 2010). At this point in World War II, the German occupying force in the Netherlands limited rations to as little as 400 to 800 calories per day. Women in the earlier stages of pregnancy during the famine had babies of normal birth weights. However, these infants grew up to have high rates of obesity. The fetuses' metabolisms were apparently set prenatally, while they were experiencing undernutrition, and were not reset when nutrition reached normal levels. Thus, the physiology of these individuals was a poor match for the food-rich environment available later in their lives, leading to an increased risk of obesity.

![FIGURE 2.16 Sensitive periods of prenatal development](image-url)
The effects of teratogens can also vary according to individual differences in genetic susceptibility (probably in both the mother and the fetus). Thus, a substance that is harmless to most people may trigger problems in individuals whose genes predispose them to be affected by it. Identifying teratogens is further complicated by the existence of sleeper effects, in which the impact of a given agent may not be apparent for many years. For example, between the 1940s and 1960s, the hormone diethylstilbestrol (DES) was commonly used to prevent miscarriage and had no apparent ill effects on babies born to women who had taken it. However, in adolescence and adulthood, these offspring turned out to have elevated rates of cervical and testicular cancers. An enormous number of potential teratogens have been identified, but we will focus only on some of the most common ones.

**Drugs**

In 2015, 4.7% of pregnant women in the United States reported that they used illicit drugs during their pregnancy (Slater & Haughwout, 2017). Almost all drugs of abuse—both legal and illegal—have been shown to be, or are suspected of being, dangerous for prenatal development. And though many prescription and over-the-counter drugs are perfectly safe for pregnant women, some are not. Pregnant women (and women who have reason to think they might soon become pregnant) should take medications only under the supervision of a physician. Some prescription drugs that are in common use by women of childbearing age, such as the acne medication isotretinoin (Accutane), are known human teratogens that cause severe birth defects or fetal death. Indeed, because of the unambiguous relationship between Accutane and birth defects, physicians require women to comply with multiple contraceptive measures and ongoing pregnancy tests before prescribing the drug.

**Antidepressants** Antidepressant medications raise particularly challenging issues for women contemplating pregnancy. These medications can be hugely beneficial for individuals experiencing depression. Treatment for depression during pregnancy can help reduce the risk of postpartum depression, which affects 10% to 30% of new mothers, and which is especially likely for women with previous histories of depression (Brummelte & Galea, 2016). In the United States, roughly 7% of pregnant women take antidepressant medication (Yonkers et al., 2014). Evidence regarding whether or not these medications are harmful to the fetus is inconclusive (Lusskin et al., 2018), raising difficult questions for pregnant women who are depressed. Should they choose a pharmaceutical intervention for their depression and risk negative outcomes from the medication? Or should they choose not to treat their mood disorder and risk negative outcomes from the depression itself?

One potential solution to this issue is the use of non-pharmaceutical treatments for depression, which many pregnant women say they would prefer (Dimidjian & Goodman, 2014). Behavioral interventions, including cognitive behavior therapy and mindfulness-based cognitive therapy, hold promise as ways to treat perinatal depression without the use of medication (e.g., Dimidjian et al., 2017).

**Opioids** Another issue of increasing concern is the use of prescription opioid medications (e.g., Vicodin, Percocet, Oxycodone, Fentanyl) and the related use of illicit opioids, such as heroin. Because they are designed to mimic the effects of neurotransmitters, they have the potential to wreak havoc on the developing brain. Prescribed for pain management or used illegally, opioids can be highly damaging...
to fetuses, who can become addicted themselves. Neonatal abstinence syndrome (NAS) is a form of drug withdrawal seen when fetuses exposed to opioids in the womb are born. The increased prevalence in NAS has been dramatic, especially in rural areas of the United States, which saw a 700% increase between 2004 and 2013 (Villapiano et al., 2017). West Virginia, the U.S. state most impacted by the opioid crisis, reported an NAS incidence rate of over 5% of all live births in 2017 (National Institute of Drug Abuse, 2018).

Common effects of NAS include low birth weight, problems with breathing and feeding, and seizures. Treatment for these newborns often requires medications such as methadone or morphine to manage withdrawal symptoms. As we mentioned earlier, teratogens often occur in clusters. In the case of opioids, the co-presence of other maternal drug use (e.g., antidepressants or marijuana) increases the likelihood that the newborn will have NAS (Sanlorenzo, Stark, & Patrick, 2018).

**Marijuana**

Marijuana is of particular interest to researchers because it is so frequently used by women of reproductive age in the United States, and its usage is likely to increase as it becomes legal in more states. Even prior to legalization, marijuana use among pregnant women nearly doubled from 2002 to 2014, with the highest rate (7.5%) among 18- to 25-year-olds (Brown et al., 2017). Data on the effects of marijuana on fetal development are inconclusive because many users of marijuana also smoke cigarettes and/or use alcohol, and the effects of each drug are difficult to tease apart; some studies suggest that the combination of marijuana and tobacco is particularly problematic (Ryan et al., 2018). Prenatal exposure to marijuana is also associated with a range of problems involving attention, impulsivity, learning, and memory in older children (Behnke et al., 2013).

The effects of opioids and marijuana on fetal development can be devastating, but the two drugs that wreak the most widespread havoc on fetal development are cigarettes (nicotine) and alcohol, which we turn to next.

**Cigarette smoking**

When a pregnant woman smokes a cigarette, both she and her fetus get less oxygen. Indeed, the fetus makes fewer breathing movements while its mother is smoking, and the fetuses of smokers metabolize some of the cancer-causing agents contained in tobacco. Secondhand smoke has an indirect effect on fetal oxygen as well, through the mother’s intake of cigarette gases when someone is smoking nearby.

The main developmental consequences of maternal smoking are slowed fetal growth and low birth weight, both of which compromise the health of the newborn. In addition, smoking is linked to increased risk of sudden infant death syndrome (SIDS) (discussed in Box 2.3) and a variety of other problems, including lower IQ, hearing deficits, ADHD (see Box 9.3), and cancer. As with other teratogens, there is a dose–response relationship: greater smoking intensity (as measured in the number of cigarettes per day) predicts worse outcomes, including stillbirths (e.g., Marufu et al., 2015). And, as with other teratogens, timing matters: the effects of smoking are greatest early in gestation (e.g., Behnke et al., 2013). However, in spite of the well-documented and widely advertised negative effects of maternal smoking on fetal development, 7.2% of pregnant women in the United States smoked in 2016 (Martin, Hamilton, Osterman et al., 2018).
Sudden Infant Death Syndrome

For parents, nothing is more terrifying to contemplate than the death of their child. New parents are especially frightened by the specter of sudden infant death syndrome (SIDS). SIDS refers to the sudden, unexpected, and unexplained death of an infant younger than 1 year. The most common SIDS scenario is that of an apparently healthy baby, usually between 2 and 5 months of age, put to bed for the night and found dead in the morning. In 2016, 1,500 infants in the United States died of SIDS, making it the leading cause of infant mortality unrelated to congenital issues or prematurity (Xu et al., 2018).

The causes of SIDS are not well understood, but they likely involve an interaction between an underlying biological issue that places the infant at risk and an environmental stressor—for example, limited access to oxygen due to an obstruction of the nose and mouth. Recent research suggests that at least some infants who succumbed to SIDS had altered levels of serotonin, a neurotransmitter (Haynes et al., 2017). Decreased serotonin may make it more difficult for young infants to detect and respond to a lack of oxygen by turning their head away from bedding or other soft materials, especially during sleep.

A subset of cases result from a rare genetic mutation in the breathing muscles that puts infants at greater risk of respiratory challenge in situations that impair breathing (Männikkö et al., 2018). Researchers studying SIDS hope to identify biomarkers, like neurotransmitters or genetic mutations, that will help physicians flag infants at heightened risk for SIDS (Bright, Vink, & Byard, 2018).

To decrease the risk of SIDS, the most important steps that parents can take entail removing any barriers to their baby’s breathing. First, putting infants to sleep on their backs reduces the possibility of breathing obstructions. Sleeping on the stomach increases the risk of SIDS more than any other single factor. A campaign encouraging parents to put their infants to sleep on their back—the “back to sleep” movement—contributed to a dramatic reduction in the number of SIDS victims. Second, parents should not smoke because it decreases the oxygen available in the infant’s environment. If they do smoke, they should not smoke around the baby. Third, bedding should be firm; soft bedding can trap air around the infant’s face, causing the baby to inhale carbon dioxide instead of oxygen. For more recommendations, the Centers for Disease Control posts resources for parents and caregivers and the American Academy of Pediatrics regularly updates their Recommendations for a Safe Infant Sleeping Environment.

One unanticipated consequence of the “back to sleep” movement has been that North American infants are now beginning to crawl slightly later than those in previous generations, presumably because of reduced opportunity to strengthen their muscles by pushing up off their mattress. Parents are encouraged to give their babies supervised “tummy time” to exercise their muscles during the day.

E-cigarettes (e-cigs) are becoming increasingly prevalent as an alternative to conventional cigarettes. Many pregnant women believe that vaping is healthier for their fetuses than cigarette smoking (Wagner, Camerota, & Propper, 2017). While e-cigs avoid some of the issues related to smoke exposure, the use of nicotine in any form is a risk factor for fetal development and can affect fetal cardiac, respiratory, and nervous systems. In addition, because e-cigs are largely unregulated, they range greatly in the amount of nicotine they contain, with some brands containing far more nicotine than cigarettes do (Jiang et al., 2018). Thus, the perception of the benefits of e-cigs relative to traditional cigarettes may lead pregnant women to overlook the risks.

Alcohol Maternal alcohol use is the leading cause of fetal brain injury and is generally considered to be the most preventable cause. Between 2011 and 2013, 1 in 10 pregnant women in the United States reported consuming alcohol in the prior month (Tan et al., 2015). This rate is similar to the worldwide estimate of

sudden infant death syndrome (SIDS) the sudden, unexpected death of an infant less than 1 year of age that has no identifiable cause
the prevalence of alcohol use during pregnancy, but there are substantial cultural differences (Popova et al., 2017). Rates are highest in European countries (25% overall, with the highest rate in Ireland at 60%), and lowest in countries in the Middle East, where Saudi Arabia, Qatar, and Oman report rates of 0% (though it is worth noting that stigma may lead women in some countries to underreport alcohol use). These data suggest that alcohol use during pregnancy reflects broader cultural views about the use of alcohol, especially by women.

When a pregnant woman drinks, the alcohol in her blood crosses the placenta into both the fetus's bloodstream and the amniotic fluid. Thus, the fetus gets alcohol both directly—in its bloodstream—and indirectly, by drinking an amniotic-fluid cocktail. Concentrations of alcohol in the blood of mother and fetus quickly equalize, but the fetus has less ability to metabolize and remove alcohol from its blood, so it remains in the fetus's system longer.

Maternal drinking can result in fetal alcohol spectrum disorder (FASD), which comprises a continuum of alcohol-related birth defects. Babies born to alcoholic women often exhibit extreme negative outcomes, known as fetal alcohol syndrome (FAS). The most obvious symptoms of FAS are characteristic facial structures, like the eyes, nose, and lips shown in Figure 2.17. Other forms of FAS can include varying degrees of intellectual disability, attention problems, and hyperactivity. Recent analyses suggest that the rates of FAS in the United States are much greater than previously suspected: between 1.1% and 5% of schoolchildren tested in a large population sample met diagnostic criteria for the disorder (May et al., 2018).

Even moderate drinking during pregnancy (i.e., less than one drink per day) can have both short- and long-term negative effects on development. So can occasional drinking if it involves binge drinking (four drinks or more on a single occasion). Between 2011 and 2013, 3% of pregnant women in the United States reported at least one incident of binge drinking during the previous month (Tan et al., 2015). The negative effects can include low birth weight, increased risk for ADHD, and delays in cognitive development and school achievement (e.g., Behnke et al., 2013). Given the research to date, the American Academy of Pediatrics recommends that pregnant women avoid alcohol altogether (Williams et al., 2015).

Environmental Pollutants

The bodies and bloodstreams of most Americans (including women of childbearing age) contain a noxious mix of toxic metals, synthetic hormones, and various ingredients of plastics, pesticides, and herbicides that can be teratogenic (Moore, 2003). These substances often have significant negative effects on the fetus. For instance, mothers whose diet was high in Lake Michigan fish, which contain high levels of polychlorinated biphenyls (PCBs), had newborns with smaller heads. Air pollution from the burning of fossil fuels is associated with low birth weight and neurotoxicity and disproportionately affects low-income populations, both in North America and around the world (Perera, 2016). Often, different forms of pollution act in combination. For example, China's rapid industrialization has led to a dramatic increase in pollution-related birth defects due to the unregulated burning of coal, water pollution, and pesticide use (e.g., Ren et al., 2011).

While progress has been made in eradicating some pollutants in the United States, the 2014 water crisis in the city of Flint, Michigan, provides clear evidence

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fetal alcohol spectrum disorder (FASD) the harmful effects of maternal alcohol consumption on a developing fetus.
Fetal alcohol syndrome (FAS) involves a range of effects, including facial deformities, intellectual disabilities, attention problems, hyperactivity, and other defects. Fetal alcohol effects (FAE) is a term used for individuals who show some, but not all, of the standard effects of FAS.
that environmental hazards continue to pose risks. In an attempt to save money, a policy change that year led to a situation in which water from the Flint River corroded residential pipes, leading to high levels of lead in the local water supply. These increased lead levels disproportionately affected families living in poorer neighborhoods (Hanna-Attisha et al., 2016). Lead is a potent neurotoxin; its effects are most prominently observed on measures of intelligence and academic achievement (Amato et al., 2012), and lead exposure is linked to the development of ADHD symptoms (Nigg et al., 2016).

In terms of pregnancy risk, there is a dose–response relationship: higher lead levels in the mother increase the risk of miscarriage, preterm birth, and low birth rate (Ettinger & Wengrovitz, 2010). Such incidents highlight the impact that decisions by individuals, groups, and local governments can have on environmental factors, which can in turn have significant and sometimes disastrous consequences on fetal and child development. And these issues are not easily remedied; as of October 2018, many Flint residents were still relying on bottled water because the local water supply remained contaminated (Shapiro & Gringlas, 2018). A similar health crisis is emerging in Newark, New Jersey, where lead was found to be leaching into the local water supply (Leyden, 2018). As with many other pollutants, lead disproportionately impacts poorer communities, such as those in Flint and Newark.

**Maternal Factors**

Because the mother-to-be provides the most immediate environment for her fetus, some of her characteristics can affect prenatal development. These characteristics include age, nutritional status, health, and stress level.

**Age**

A pregnant woman's age is related to the outcome of her pregnancy. Infants born to girls 15 years or younger are 3 to 4 times more likely to die before their 1st birthday than are those born to mothers who are between 23 and 29 (Phipps, Blume, & DeMonner, 2002). However, the rate of teenage pregnancy in the United States is declining, and in 2017, the teen birth rate for teenagers fell to the lowest recorded level (18.8 births per 1000 females younger than 20; Martin, Hamilton, & Osterman, 2018).

The increasing age at which many women become pregnant is also cause for concern. In recent decades, many women in industrialized countries wait until their 30s or 40s to have children. In the United States, this is especially true of women with college degrees, who have their first child an average of 6 years later than women without college degrees (Bui & Miller, 2018). Techniques to treat infertility have continued to improve, increasing the likelihood of conception for older parents. Like many other risk factors, there is a dose–response relationship, with risk of negative outcomes for both mother and fetus increasing with maternal age. For example, children born to older mothers and/or older fathers are at heightened risk for developmental disorders such as autism spectrum disorder (ASD; Sandin et al., 2016).

The causal pathways linking older mothers and fathers to their infants’ developmental outcomes are likely different, since only mothers contribute to prenatal environments and birth circumstances (Lee & McGrath, 2015). Fathers’ contributions may lie more in mutations and other chromosomal abnormalities, as we will discuss in Chapter 3.
Nutrition
The fetus depends on its mother for all its nutritional requirements. If a pregnant woman has an inadequate diet, her unborn child may also be nutritionally deprived. An inadequate supply of specific nutrients can have dramatic consequences. For instance, women who get too little folic acid (a form of B vitamin) are at high risk for having an infant with a neural-tube defect such as spina bifida (see Figure 2.4). While prenatal vitamins are frequently used to address these concerns, many women do not know they are pregnant during the crucial early periods of gestation. Many processed foods, such as breakfast cereals, are fortified with folic acid to help ensure that women receive adequate nutrition during the early weeks of pregnancy.

Because malnutrition is more common in impoverished families, it often coincides with the host of other risk factors associated with poverty, making it difficult to isolate its effects on prenatal development. However, one unique study of development in extreme circumstances made it possible to assess certain effects of malnutrition independent of socioeconomic status. As we discussed earlier, people of all income and education levels suffered severe famine in parts of the Netherlands during World War II. Children conceived during the Dutch Hunger Winter have been followed into adulthood. In late middle age, individuals who had experienced malnutrition as fetuses showed impaired performance on attentional tasks and had prematurely aged brains, compared with those who had not (de Rooij et al., 2010; Franke et al., 2018).

Disease
Although most maternal illnesses that occur during a pregnancy have no impact on the fetus, some do. For example, if contracted early in pregnancy, rubella (also called the 3-day measles) can have devastating developmental effects, including major malformations, deafness, blindness, and intellectual disabilities. The Centers for Disease Control recommends that women who do not have immunities against rubella be vaccinated before becoming pregnant.

Sexually transmitted infections (STIs) are also quite hazardous to the fetus. Cytomegalovirus (CMV), a type of herpes virus that is present in 50% to 70% of women of reproductive age in the United States, is the most common cause of congenital infection (affecting 1% to 5% of births; Manicklal, 2013). CMV can damage the fetus’s central nervous system and cause a variety of other serious defects, including hearing loss. Genital herpes can also be very dangerous: if the infant comes into contact with active herpes lesions in the birth canal, blindness or even death can result. HIV infection is sometimes passed to the fetus in the womb or during birth, but the majority of infants born to women who are HIV-positive or who have AIDS do not become infected themselves. HIV can also be transmitted through breast milk after birth, but research suggests that breast milk contains a carbohydrate that may actually protect infants from HIV infection (Bode et al., 2012).

Zika, a mosquito-borne viral infection, burst onto the world scene in 2016. While the illness itself is mild and often goes undetected, it can cause a serious birth defect called microcephaly, a condition in which the baby’s head is much smaller than expected. Depending on the severity of the problem, issues can range from hearing and vision loss to seizures and intellectual disability. Microcephaly occurs in roughly 6% of fetuses whose mothers were infected by Zika (Honein et al., 2017). Consistent with our earlier discussion of sensitive periods, higher rates of microcephaly are observed for women whose Zika infections occurred...
The virus appears to infect fetuses’ cortical–neural progenitor cells, resulting in stunted brain growth (Tang et al., 2016). The only preventative option is to avoid mosquito bites in areas where the virus has spread. Women of reproductive age should also take heed of the fact that Zika can be transmitted sexually and through body fluids (Kim et al., 2018).

**Maternal Emotional State**

Effects of maternal stress during pregnancy have been observed on myriad aspects of infant and child development, ranging from infant cognitive development to later psychiatric diagnoses (for review, see Van den Bergh et al., 2017). Brain-imaging studies with infants and young children reveal both structural and functional effects of prenatal maternal state on the developing brain (Van den Bergh, Dahnke, & Mennes, 2018). A primary mechanism for these effects is alternations in the hypothalamic–pituitary–adrenal (HPA) axis and the hormone cortisol, a glucocorticoid which helps regulate stress in both the mother and the fetus. As discussed earlier in this chapter, glucocorticoids slow the growth of the fetus. The concept of fetal programming, also discussed previously, shapes research in this area and suggests that the altered hormonal environment for the fetus may lead to long-term changes in how children and adults cope with stress via disrupted HPA axis functioning.

In wealthy countries like the United States, pregnant women from minority ethnic groups report greater rates of prenatal stress than do women in majority ethnic groups (Liu et al., 2016). Pregnant women in less wealthy countries report even greater levels of stress (Glover et al., 2018). Their anxiety may relate to scarcity of resources, as in cases of high food insecurity, or to war or domestic violence. Women in developing countries may also have increased fears about the outcomes of their pregnancies due to high rates of infant and maternal mortality where they live. For instance, researchers in rural Nigeria found that in a group of 262 women giving birth, 5 women died and 52 experienced severe complications (Mbachu et al., 2017). These sorts of statistics, combined with their firsthand knowledge about the dangers of childbirth, likely add yet another layer of stress for many women in developing countries.

Like other types of teratogens, it is difficult to tease apart the specific effects of maternal stress from other factors that often co-occur with stress. For example, expectant mothers who are stressed during pregnancy are likely to still be stressed after giving birth. Genetic factors may also link both maternal stress and postnatal outcomes. One clever study took advantage of the increased use of assistive reproductive technology—*in vitro* fertilization (IVF)—to attempt to tease apart these factors (Rice et al., 2010). In this study, mothers were either genetically related or unrelated to their fetuses. The results revealed effects of maternal stress on birth weight and later antisocial behavior, in both related and unrelated mother–fetus pairs, suggesting that the prenatal environment, not shared genetics, was the strongest predictor of later outcomes. However, for measures of child anxiety, the results suggest that postnatal maternal stress, not prenatal maternal stress, was the strongest predictor of later outcomes.

This area of research reveals a complex interplay between prenatal and postnatal factors in developmental outcomes. It also points to the importance of...
finding ways to help minimize maternal stress both pre- and postnatally. The increased popularity of prenatal yoga and meditation classes suggests that there may be straightforward ways to reduce at least some aspects of pregnancy-related stress, with potential benefits for both mother and fetus.

**REVIEW QUESTION**

A wide variety of environmental agents can have a negative impact on prenatal development, from drugs to pollution to maternal factors like stress, illness, or nutrition. How can research into these hazards be used to influence public policy aimed at reducing their prevalence and impact?

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**The Birth Experience**

Approximately 38 weeks after conception, contractions of the muscles of the uterus begin, initiating birth. Typically, the fetus has already contributed to the process by rotating into the normal head-down position. In addition, the maturing lungs of the fetus may release a protein that triggers the onset of labor. Uterine contractions, as well as the baby’s progress through the birth canal, are extremely painful for the mother.

Is birth as painful for the newborn as for the mother? Actually, there is good reason to believe that birth is not particularly painful for the baby. Compare how much pain you feel when you pinch and pull on a piece of skin on your forearm versus when you wrap your hand around your forearm and squeeze as tightly as you can. The stretching is painful, but the squeezing is not. The mother’s pain comes from her tissues being greatly stretched, but the baby experiences squeezing.

The squeezing that the fetus experiences during birth serves several important functions. First, it temporarily reduces the overall size of the fetus’s disproportionately large head, allowing it to pass safely through the mother’s pelvic bones. This is possible because the skull is composed of separate plates that can overlap one another slightly during birth (see Figure 2.18). The squeezing of the fetus’s head during birth also stimulates the production of hormones that help the fetus...
withstand mild oxygen deprivation during birth and help regulate breathing after birth. The squeezing of the fetus’s body forces amniotic fluid out of the lungs, in preparation for the newborn’s first, crucial gasp of air.

Diversity of Childbirth Practices

Although the biological aspects of birth are pretty much the same everywhere, childbirth practices vary enormously. All cultures pursue the dual goals of (1) safeguarding the survival and health of both mother and baby and (2) ensuring the social integration of the new person. Groups differ, however, regarding the relative importance they give to these goals. An expectant mother on the South Pacific island of Bali assumes that her husband and other kin, along with any children she may already have, will all want to be present at the joyous occasion of the birth of a new child. Her female relatives, as well as a midwife, actively help her throughout the birth, which occurs in her home. Having already been present at many births, the Balinese woman knows what to expect from childbirth, even when it is her first child (Diener, 2000).

A very different scenario unfolds in twenty-first century North America, where the woman in labor usually withdraws almost totally from her everyday life. In most cases, she enters a hospital to give birth, typically attended by a small group of family or close friends. The birth is supervised by a variety of medical personnel, most of whom are strangers. Unlike her Balinese counterpart, the first-time U.S. mother has probably never witnessed a birth, so she may not have very realistic expectations about the birth process. Also, unlike her counterparts in most societies, a U.S. woman in labor has a 32% chance of having a surgical delivery by cesarean (also called C-section)—a rate that is high relative to other countries but has been in decline for the past few years (Martin, Hamilton, & Osterman, 2018).

C-sections are intended to assist infants and mothers facing birth complications, and indeed they have saved untold numbers of lives. However, there are other reasons for the high number of surgical deliveries in the United States, including a vastly increased rate of multiple births (discussed in the next section), scheduling convenience for the physician and/or the parents, maternal obesity, prior C-sections (which may necessitate future C-sections), and physicians’ attempts to decrease risk of lawsuits concerning medical malpractice should problems arise from a vaginal birth (e.g., Yang et al., 2009). Indeed, one study found that among a sample of women who had a C-section, nearly half did not appear to have any pregnancy complications (Witt et al., 2015).

The Balinese approach to childbirth emphasizes the social goal of immediately integrating the newborn into the family and community—hence the presence of many kin and friends to support mother and baby. In contrast, the belief that childbirth is safer in a hospital setting outweighs the resulting social isolation of mother and baby. And indeed, while the rates of home births are increasing in the United States (1% of all births in 2016; Martin et al., 2018), they remain riskier than hospital births (Snowden et al., 2015). One recent study found that in the United States, infant mortality in hospital births attended by certified midwives was significantly lower than infant mortality in home births attended by certified midwives (Grünebaum et al., 2016). It is worth noting, however, that in Ontario, Canada,
where home births are more common (20% of all births) and well-integrated into the healthcare system, the mortality rates for home and hospital births are equivalent, possibly because it is standard practice to transfer home-birthing mothers to the hospital when complications arise (as was the case for 25% of home births in this Canadian sample; Hutton et al., 2015).

The practices in both the United States and Bali have been changing to some degree. In the United States, the social dimensions of birth are increasingly recognized by doctors and hospitals, which often now employ certified midwives for expectant parents who prefer a less medicalized birth plan. As in Bali, various family members—sometimes even including the parents’ other children—are encouraged to be present to support the laboring mother and to share a family experience. Another increasingly common practice in the United States is the use of doulas, individuals trained to assist women in terms of both emotional and physical comfort during labor and delivery. This shift has been accompanied by decreased use of delivery drugs, enhancing the woman’s participation in childbirth and her ability to interact with her newborn, including engaging in activities such as skin-to-skin contact, which promotes stabilization of physiological processes in the transition from the womb to the outside world (e.g., Rutgers & Meyers, 2015).

In addition, many expectant parents attend childbirth education classes through their birth center or educational organizations like Lamaze, where they learn some of what their Balinese counterparts pick up through routine attendance at births. Social support is a key component of these programs; the pregnant woman’s partner, or some other supportive person, is trained to assist her during the birth. Such childbirth programs are generally beneficial, and obstetricians routinely advise expectant couples to enroll in them. At the same time that these changes are occurring in the United States, Western medical practices are being increasingly adopted in societies like Bali, in an effort to improve newborn survival rates.

As a final example of alternate birthing practices, let’s consider the Ju’/hoansi women of rural Botswana and Namibia, who often give birth outdoors and alone despite the dangers posed by animal predators, including lions. This practice is deeply intertwined with spiritual and cultural beliefs that have endured for centuries and reflects a specific view of individual development that sees the birth experience as a key event in a person’s maturation (Biesele, 1997). Though extreme when viewed from other cultural perspectives, and dangerous from a modern medical standpoint, the birthing traditions of the Ju’/hoansi illustrate the complex ways that childbirth, among other aspects of child development, are linked to the greater social and cultural context.

**REVIEW QUESTIONS**

The diverse range of birthing practices highlights the influence of sociocultural context, and these practices can have a direct impact on the newborn. Consider the birth experiences that you have encountered: In what ways did these experiences reflect cultural practices that are beneficial to the newborn and mother? What alternate practices should have been implemented for the benefit to the newborn and mother? ■
The Newborn Infant

Healthy newborns begin interacting with their new environment right away, exploring and learning about newfound physical and social entities. Newborns’ exploration of this uncharted territory is very much influenced by their state of arousal.

State of Arousal

State refers to a continuum of arousal, ranging from deep sleep to intense activity. As you well know, your state dramatically affects your interaction with the environment—with what you notice, do, learn, and think about. It also affects the ability of others to interact with you.

Figure 2.19 depicts the average amount of time in a 24-hour period that newborns typically spend in each of six states, ranging from quiet sleep to crying. Within this general pattern, however, there is a great deal of individual variation.

To appreciate how these differences might affect parent-infant interactions, imagine yourself as the parent of a newborn who cries more than the average baby, sleeps little, and spends less time in the awake-alert state. Now imagine yourself with a baby who cries relatively little, sleeps well, and spends an above-average amount of time quietly attending to you and the rest of his or her environment (see Figure 2.20). Clearly, you would have many more opportunities for pleasurable interactions with the second newborn.

The two newborn states that are of particular concern to parents—sleeping and crying—have both been studied extensively.

Sleep

Two facts about sleep and its development are of particular importance. First, the average newborn sleeps twice as much as young adults do. Second, the pattern of two different sleep states—REM sleep and non-REM sleep—changes dramatically with age. Rapid eye movement (REM) sleep is an active sleep state associated with dreaming in adults; it is characterized by quick, jerky eye movements under closed lids, a distinctive pattern of brain activity, body movements, and irregular heart rate and breathing. Non-REM sleep, in contrast, is a quiet sleep state characterized by the absence of motor activity or eye movements and more regular, slow brain waves, breathing, and heart rate. REM sleep constitutes fully 50% of a newborn’s total sleep time. The proportion of REM sleep declines quite rapidly to only 20% by 3 or 4 years of age and remains low for the rest of life.

Why do infants spend so much time in REM sleep? Some researchers believe that it helps develop the infant’s visual system. Because newborns spend so much time asleep, they do not have much opportunity to amass waking visual experience. The high level of internally generated brain activity that occurs during REM sleep may help to make up for the natural deprivation of visual stimulation, facilitating the early development of the visual system in both fetus and newborn. Another way in which REM sleep may be adaptive for neonates is that the natural jerking movements (called myoclonic twitching) that occur exclusively during REM sleep may give infants opportunities to build sensorimotor maps (Blumberg, 2015). These twitching movements are most frequent
during early development and may help the infant with the difficult problem of linking motor patterns with the specific sensations that they evoke.

Another distinctive feature of sleep in the newborn period is that neonates’ slumbering brains do not become disconnected from external stimulation to the same extent that the brains of older individuals do. This stimulation allows newborns to learn during sleep. In one study, infants were exposed to recordings of foreign vowel sounds while they slumbered in the newborn nursery. When tested in the morning, their brain activity revealed that they recognized the sounds they had heard while asleep (Cheour et al., 2002).

Although newborns are likely to be awake during part of their parents’ normal sleep time, they gradually develop the more mature pattern of sleeping through the night. Nighttime awakenings typically diminish over the course of the first postnatal year. However, there is a subset of infants who continue to wake regularly. Roughly one-third of parents of 6-month-olds in the United States report that their infants continued to wake up at least once every night (Weinraub et al., 2012). Even by 12 months of age, only about half of the infants in a Canadian study slept for at least 8 hours at a stretch (Pennestri et al., 2018).

A number of sleep techniques have been proposed to help parents and infants who are struggling with sleep. A recent randomized-control study was designed to determine whether behavioral sleep interventions work and whether they cause undue stress for parents and infants (Gradisar et al., 2016). The results suggest that, compared with a sleep-education control group, infants in a graduated-extinction group—in which parents slowly increased their delays in responding to their crying infant—showed greater improvement in sleep behaviors, with no negative effects on infant stress (cortisol levels) or infant–mother attachment. The study also demonstrated successful effects of another behavioral method, bedtime fading, in which the infant’s bedtime is shifted later to ensure sleepiness, and then gradually moved earlier. Both groups showed large decreases in nocturnal wakefulness, with concomitant positive effects on maternal stress.

In contrast with U.S. parents, Kipsigis parents in rural Kenya are relatively unconcerned about their infants’ sleep patterns. Kipsigis babies are almost always with their mothers. During the day, infants are often carried on their mother’s back as she goes about her daily activities; at night they sleep with her and are allowed to nurse whenever they awaken. As a consequence, these babies distribute their sleeping throughout the night and day for several months (Harkness & Super, 1995; Super & Harkness, 1986). Thus, cultures vary not only in terms of where babies sleep, as you learned in Chapter 1, but also in terms of how strongly parents attempt to influence when their babies sleep.

Crying

Infants cry for many reasons—including illness, pain, and hunger—that require the attention of caregivers. As unpleasant as it is, crying is a normal behavior. Rather than diminishing over the first few months, as many new parents expect, it actually increases, peaking around 6 to 8 weeks of age. Crying behavior tends to decrease in frequency around 3 to 4 months of age, potentially because infants now have somewhat more control over their environment. During this period, crying bouts tend to increase in the late afternoon and evening, a phenomenon familiar to most caregivers of young infants.
Parents, especially first-timers, are often puzzled and anxious about why their baby is crying, and especially why their infants’ crying bouts increase in frequency—and sometimes intensity—over the first 2 months. In extreme cases, caregivers may react with a form of child abuse known as shaken baby syndrome, which can result in severe head trauma or death (e.g., Barr et al., 2015). Relatively minimal parental education, developed by the National Center on Shaken Baby Syndrome and provided in hospitals after birth and via public-educational outreach programs, can play an important role in demystifying infant crying. This informational intervention can be highly effective in decreasing emergency room visits based on parental concerns about crying (Barr et al., 2015). More significantly, the intervention decreased the number of infants admitted to the hospital for abusive head trauma (Barr et al., 2018). Understanding that crying is a normal developmental process can significantly decrease parental stress and—in extreme cases—parent-caused injury to infants.

**Soothing** What are the best ways to console a crying baby? Most of the traditional standbys—rocking, singing lullabies, stroking the baby, holding the baby up to the shoulder, giving the baby a pacifier, distracting the baby—work reasonably well. Many effective soothing techniques involve moderately intense and continuous or repetitive stimulation. One very common soothing technique is **swaddling**, which involves wrapping a young baby tightly in cloths or a blanket, thereby restricting limb movement. The tight wrapping provides a constant high level of tactile stimulation and warmth. This technique is practiced in cultures as diverse and widespread as those of the Navajo and Hopi in the American Southwest (Chisholm, 1983), the Quechua in Peru (Tronick, Thomas, & Daltabuit, 1994), and rural villagers in Turkey (Delaney, 2000). It is also increasing in popularity in North America; numerous popular baby-carrying devices compress the infant close to the caregiver’s body, leaving the caregiver’s hands free for daily activities.

One question that often concerns parents is whether or not to respond to their infant’s signals of distress. Will quick and consistent supportive responses reward the infant for fussing and crying and hence increase these behaviors? Or will a rapid response give the infant a sense of security that leads to less fussing and crying? The literature suggests that both perspectives are valid. In one classic study, Bell and Ainsworth (1972) found that prompt responding to infant cries predicted less crying several months later. Yet in another classic study, Hubbard & van IJzendoorn (1991) found that infants whose cries were ignored during the first 9 weeks cried less during the next 9 weeks.

While most research in this area has focused on Western families, there are substantial cultural differences in parental responding that may influence these patterns. For example, mothers in the rural island communities of Fiji are more likely to rapidly respond to their infant’s negative facial displays of affect than are urban mothers in the United States (Broesch et al., 2016). As with many aspects of parenting, there is likely not one “right” answer to the question of how and when to respond to infant distress. Cultural norms and individual differences among infants jointly influence families’ preferred responses to parenting challenges.

**Colic** No matter how or how much their parents try to soothe them, some infants are prone to excessive, inconsolable crying for no apparent reason during the first few months of life, a condition referred to as **colic**.

Indeed, one of your authors was a colicky baby who resisted being held. The

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**Terms**

- **Swaddling**: A soothing technique, used in many cultures, that involves wrapping a baby tightly in cloths or a blanket.
- **Colic**: Excessive, inconsolable crying by a young infant for no apparent reason.
causes of colic are unknown and may include allergic responses to the mother’s diet (ingested via breast milk), formula intolerance, immature gut development, and/or excessive gassiness. Unfortunately, colic is not a rare condition: more than 1 in 10 young U.S. infants—and their parents—suffer from it. Fortunately, it typically ends by about 3 months of age and has no long-term effects. One of the best things parents with a colicky infant can do is seek social support, which can provide relief from the stress, frustration, and sense of inadequacy they may feel because they are unable to relieve their baby’s distress.

**Negative Outcomes at Birth**

Neonatal caregivers worldwide use an evaluation tool called the *Apgar score* to quickly assess the health of newborn infants immediately following birth. A cumulative score is derived from ratings on skin tone, pulse rate, facial responses (typically grimacing), arm and leg activity, and breathing strength. Perfect scores are rare, reflecting the traumatic effect that even a normal birth can have on the newborn, but a consistently low score can indicate serious health problems.

Although most clinically recognized pregnancies in an industrialized society result in the full-term birth of a healthy baby, sometimes the outcome is less positive. The worst result, obviously, is the death of an infant. A much more common negative outcome is low birth weight, which can have long-term consequences.

**Infant Mortality**

*Infant mortality*—death during the first year after birth—is now relatively rare in the industrialized world, thanks to decades of improvements in public health and general economic levels. In the United States, the 2016 infant mortality rate was 5.87 deaths per 1000 live births, the lowest in U.S. history (Kochanek et al., 2017).

Although the U.S. infant mortality rate is at an all-time low in absolute terms, it is far higher than that of other industrialized nations, such as Canada, Japan, and Australia (Central Intelligence Agency [CIA], 2018). The relative ranking of the United States has generally gotten worse over the past several decades because the infant mortality rates in many other countries have had a higher rate of improvement.

Why do so many babies die in the United States—the richest country in the world? There are many reasons, most having to do with poverty. For example, many low-income mothers-to-be have no health insurance and thus limited access to good medical and prenatal care—though access for this group has improved with the 2014 passage of the Affordable Care Act. It will be interesting to see whether increased access to prenatal care decreases the U.S. infant mortality rate, bringing it up to the level of other countries that guarantee prenatal care at low or minimal cost.

In less developed countries, especially those suffering from a breakdown in social organization due to war, famine, or persistent extreme poverty, the infant mortality rates can be staggering. In Afghanistan and Somalia, for example, roughly 1 of every 10 infants dies before age 1 (CIA, 2018).

**Low Birth Weight**

The average newborn in the United States weighs 7½ pounds (most are between 5½ and 10 pounds). Infants who weigh less than 5½ pounds (2500 grams) at birth are considered to be of *low birth weight (LBW)*. Many LBW infants are *premature*, or preterm; that is, they are born at 35 weeks or earlier after conception.
One out of 10 babies born in the United States in 2017 was premature (Martin, Hamilton, & Osterman, 2018). Other LBW infants are referred to as small for gestational age: they may be either preterm or full-term, but they weigh substantially less than is normal for their gestational age, which is based on weeks since conception.

In 2017, 8.3% of U.S. newborns were LBW (Martin, Hamilton, & Osterman, 2018). As a group, LBW newborns have a heightened level of medical complications, as well as higher rates of neurosensory deficits, more frequent illness, lower IQ scores, and lower educational achievement. Very LBW babies (VLBW; those weighing less than 1500 grams, or 3.3 pounds) are particularly vulnerable; these infants accounted for 1.4% of live births in the United States in 2017 (Martin, Hamilton, & Osterman, 2018).

There are numerous causes of LBW and prematurity, including several discussed in the section on teratogens: smoking, alcohol, and environmental pollutants such as small for gestational age. Babies who weigh substantially less than is normal for whatever their gestational age.
as lead and mercury. In some rapidly developing countries, such as China, high levels of airborne pollution have been linked to both LBW and preterm birth, likely due to impaired oxygen transport across the placenta (Fleischer et al., 2015). Another cause is the skyrocketing rate of twin, triplet, and other multiple births as a result of the development of increasingly successful treatments for infertility. (The use of fertility drugs typically results in multiple eggs being released during ovulation; the use of in vitro fertilization [IVF] usually involves the placement of multiple laboratory-fertilized embryos in the uterus.) In 1980, 1 in every 53 infants born in the United States was a twin; in 2017, 1 in every 30 infants was a twin (Martin, Hamilton, & Osterman, 2018). The numbers for higher-order births (triplets and up) have also increased dramatically in recent years. This is a concern because the rates of LBW among multiples are quite high: 55% for twins and higher than 95% for triplets and above (Martin et al., 2018).

**Long-term outcomes**  As a group, children who were LBW infants have a higher incidence of developmental problems: the lower their birth weight, the more likely they are to have persistent difficulties. For example, 8-year-old Australian children who were born LBW showed a greater incidence of sensory impairments, poorer academic achievement, and more behavior problems than their term-birth peers (Hutchinson et al., 2013). Other studies suggest links between VLBW and childhood psychiatric issues, especially those involving inattention, anxiety, and social difficulties (e.g., ADHD, autism; Johnson & Marlow, 2011). The hypothesized pathways between LBW and these negative outcomes include white-matter reduction, ventricular enlargement, and other abnormal brain development outcomes.

However, it is important to note that these comparisons often confound SES with birth-weight status. For example, in the aforementioned study by Hutchinson and colleagues (2013), the sample of term-birth families had higher educational attainment and employment status than the preterm sample. Indeed, a German study demonstrated that the strongest predictor of outcomes for VLBW infants is maternal education (Voss et al., 2012). The authors concluded that special services and additional support may be especially important for families of at-risk infants with less educational background.

The good news is that for the majority of LBW children, the negative effects of their birth status gradually diminish, generally ending up within the normal range on most developmental measures. Figure 2.21 depicts a particularly striking example (Teoh et al., 2006). Indeed, one follow-up study of extremely LBW infants (<1000 grams) found that by 18 to 22 months of age, 16% were unimpaired and 22% were only mildly impaired (Gargus et al., 2009).

**Intervention programs**  Supporting LBW newborns and their families is a prime example of our theme about the role of research in improving the welfare of children. Until relatively recently, hospitals minimized parents’ contact with their LBW infants, mainly because of fear of infection. Parents are now encouraged to have as much physical contact and social interaction with their hospitalized infant as the baby’s condition allows. Indeed, kangaroo care—a variant of the skin-to-skin care discussed earlier, in which caregivers act as incubators to help maintain infants’ skin temperature and to promote breast-feeding—decreases mortality and increases growth, breast-feeding,
and attachment (Conde-Agudelo & Díaz-Rossello, 2014). Recent data suggest that breast milk, in and of itself, promotes healthy brain development in preterm infants (Blesa et al., 2019); we will return to the topic of breast-feeding in Chapter 3.

Being touched—cuddled, caressed, and carried—is a vital part of a newborn’s life. Many LBW infants experience little stimulation of this kind because of the precautions that must be taken with them, including keeping them in special isolettes where they are hooked up to life-support machines. Because LBW infants are often premature, they may spend weeks or months in the neonatal intensive care unit (NICU). For these infants, their exposure to touch in the hospital affects how they respond to touch later on. As one study showed, babies who experienced more gentle touching by caregivers in the NICU later showed stronger neural responses to touch than did babies who had less experience with gentle touching in the NICU. In contrast, babies who experienced more painful experiences in the NICU later showed decreased brain responses to touch than did babies who experienced less pain in the NICU (Maitre et al., 2017). Thus, early atypical experiences in the NICU can shape infants’ later responses to something as ubiquitous as touch, as shown in Figure 2.22.

Hospitals have designed education programs to help parents of preterm infants learn about the revised timetable of their baby’s early development: developmental milestones will be delayed, often linked more tightly to gestational age at birth than to chronological age after birth. For example, their preterm infant will not begin to smile at them at around 6 weeks of age, the time when full-term infants usually reach this milestone. Instead, they may have to wait several more weeks for their baby to look them in the eye and break into a heart-melting smile. Thus, preterm infants are potentially more challenging to care for while being less rewarding to interact with.

One consequence of these challenges is that children who were born preterm are more likely to be victims of parental child abuse than are full-term infants. Indeed, a recent study of infant hospitalizations due to child abuse found that the two strongest predictors were preterm birth and extended stay in the NICU (Mason et al., 2018). Interventions that provide parents with training in child development, and/or focus on helping parents to become more responsive to their LBW infants, have yielded numerous positive effects, including improved behavioral outcomes, greater weight gain, higher IQs, and myriad other improved outcomes relative to their LBW peers (Nordhov et al., 2012; Wassenaer-Leemhuis et al., 2016). Successful intervention programs also include support sessions, in the hospital and during home visits, designed to encourage parents to talk about their experiences and express their feelings.

Though these interventions can improve outcomes for specific conditions, it is important to note the impact of cumulative risk: the more risks the infant endures, the lower the chances of a good outcome. Because this principle is so important for all aspects of development, we examine it in greater detail in the following section.

**Multiple-Risk Models**

Risk factors tend to occur together. For example, a pregnant woman who engages in substance abuse is also likely to be under a great deal of stress and unlikely to eat well, take vitamins, seek prenatal care, have a strong social support network,
or take good care of herself in other ways. Furthermore, whatever the cumulative effects of these prenatal risk factors, they will likely be compounded after birth if the mother continues her unhealthy lifestyle.

As you will see repeatedly throughout this book, a negative developmental outcome—whether in terms of prenatal or later development—is more likely when multiple risk factors are involved. In a classic demonstration of this fact, Michael Rutter (1979) reported a heightened incidence of psychiatric problems among English children growing up in families with four or more risk factors (including marital distress, low SES, paternal criminality, and maternal psychiatric disorder; Figure 2.23). Thus, the likelihood of developing a disorder is slightly elevated for the child of parents who fight a lot; but if the child’s family is also poor, the father engages in criminal behavior, and the mother suffers from emotional problems, the child’s risk is multiplied nearly tenfold. Across numerous developmental domains, there are cumulative effects of risk factors: the more risk factors, the worse the potential outcomes. These cumulative risk effects impact aspects of child functioning, ranging from attachment to language development to well-being (Evans, Li, & Whipple, 2013).

Consider some of the risk factors for fetal development that we have discussed: inadequate prenatal care, poor nutrition, illness, emotional stress, cigarette smoking, drug abuse, and exposure to environmental and occupational hazards. All these factors are more likely to be experienced by a woman living below the poverty line than by a middle-class woman. It is no wonder, then, that on the whole, the outcome of pregnancy is less positive for infants of lower-SES parents than for babies born to middle-class parents. This is not just the case in the United States. In Japan, which has far less income disparity than the United States, there is a link between income and birth outcomes (Fujiwara, Ito, & Kawachi, 2013).

Structural racism—which describes behaviors and beliefs that harm specific racial and ethnic groups and can result in residential segregation, uneven access to healthcare, and high rates of incarceration—also impacts fetal and newborn health (Bailey et al., 2017). For example, African American infants born in communities with higher levels of structural racism are more likely to be small for gestational age than African American infants born in communities with lower levels of structural racism (Wallace et al., 2015). Consistent with research on the role of maternal stress in fetal development, pregnant women in minority communities who report higher levels of concern about racial discrimination are more likely to have preterm infants than those who report lower levels of concern (Braveman et al., 2017). Improving the quality of hospitals and other medical facilities that serve minority communities is one promising approach currently being taken to address pregnancy-related health disparities (Howell, 2018). We will return to these issues in Box 3.4: Poverty and Health Disparities.

Much of the discussion in this chapter has focused on the many ways in which early developmental processes can go wrong. There are, of course, individuals who, faced with multiple and seemingly overwhelming developmental hazards, even beginning before birth, nevertheless do well. In studying such children, researchers employ the concept of developmental resilience (Masten, Best, & Garmezy, 1990; Sameroff, 1998). Resilient children—like those in the Kauai study discussed in Chapter 1—often have two factors in their favor: (1) certain personal characteristics, especially intelligence, responsiveness to others, and a sense of being capable of achieving their goals; and (2) responsive care from someone.
to our theme of individual differences, personal traits combined with a supportive environment can help us understand remarkable successes in the face of developmental challenges.

**REVIEW QUESTION**

A central theme in child development is the ways in which nature and nurture work together to shape developmental processes. How do nature and nurture interact in experiences such as newborn sleep patterns, crying, and the effects of multiple risks that an infant might face?

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**CHAPTER SUMMARY**

**Prenatal Development**

- Nature and nurture combine forces in prenatal development. Much of this development is generated by the fetus itself, making the fetus an active player in its own progress. Substantial continuity exists between what goes on before and after birth in that infants demonstrate the effects of what has happened to them in the womb.
- Prenatal development begins at the cellular level with conception, the union of an egg from the mother and a sperm from the father to form a single-celled zygote. The zygote multiplies and divides on its way through a fallopian tube.
- The zygote undergoes the processes of cell division, cell migration, cell differentiation, and cell death. These processes continue throughout prenatal development.
- When the zygote becomes implanted on the uterine wall, it becomes an embryo. From that point, it is dependent on the mother to obtain nourishment and oxygen and to get rid of waste products through the placenta.
- Fetal behavior begins 5 or 6 weeks after conception with simple movements, undetected by the mother, that become increasingly complex and organized into patterns. Later, the fetus practices behaviors vital to independent living, including swallowing and a form of intrauterine “breathing.”
- The fetus experiences a wealth of stimulation both from within the womb and from the external environment. The fetus learns from this experience, as demonstrated by studies showing that both fetuses and newborns can discriminate between familiar and novel sounds, especially in speech, and exhibit persistent taste preferences developed in the womb.

**Hazards to Prenatal Development**

- There are many hazards to prenatal development. The most common fate of a fertilized egg is spontaneous abortion (miscarriage).
- A wide range of environmental factors can be hazardous to prenatal development. These include teratogens from the external world and certain maternal characteristics, such as age, nutritional status, physical health, behavior (especially the use of legal or illegal drugs), and emotional state.

**The Birth Experience**

- Approximately 38 weeks after conception, the baby is ready to be born. Usually, the behavior of the fetus helps to initiate the birth process.
- Being squeezed through the birth canal has several beneficial effects on the newborn, including preparing the infant to take his or her first breath.
- Cultural practices surrounding childbirth vary greatly and are in part related to the goals and values emphasized by the culture.

**The Newborn Infant**

- Newborns’ states of arousal range from deep sleep to active crying.
- The amount of time infants spend in the different arousal states varies greatly, both across individuals and across cultures.
- REM sleep seems to compensate for the lack of visual stimulation that results from the darkness of the womb, and for the fact that newborns spend much of their time with their eyes shut, asleep.
- The sound of a baby crying can be very aversive, and adults employ many strategies to soothe distressed infants.
- The infant mortality rate in the United States is high relative to that of other developed countries. It is much higher for babies born to low-SES parents.
A variety of intervention programs have been designed to improve the course of development of LBW babies, encompassing time in the hospital as well as after the infant returns home.

Test Yourself

1. The single cell that forms when two gametes merge during conception is called the
   a. zygote.
   b. ova.
   c. sperm.
   d. embryo.
2. Which process of prenatal development is critical to the specialization of cells?
   a. Cell division
   b. Synaptogenesis
   c. Cell differentiation
   d. Apoptosis
3. Harry and Ron are genetically identical twins and are referred to as ___________. Althea (a genetic female) and Stephen (a genetic male) are also twins but are clearly ___________ twins.
   a. monozygotic; identical
   b. dizygotic; fraternal
   c. dizygotic; monozygotic
   d. monozygotic; dizygotic
4. Which of the following systems protects the developing embryo from dangerous toxins?
   a. Amniotic sac
   b. Placenta
   c. Umbilical cord
   d. Neural tube
5. The disproportionately large head of a 5-month-old fetus is a typical result of the normal process of
   a. cephalocaudal development.
   b. proximal–distal development.
   c. lateral development.
   d. bottom-up development.
6. Which of the following senses is the least active while the fetus is in the womb?
   a. Hearing
   b. Smell
   c. Taste
   d. Sight
7. Logan's dad is thrilled as Logan laughs each time he shows him a new toy: a monkey that squeaks when he pushes on its belly. After repeated exposure to the squeaking monkey, Logan becomes bored and no longer laughs. This process is known as
   a. habituation.
   b. dishabituation.
   c. classical conditioning.
   d. operant conditioning.
8. The DeCasper and Spence study, in which pregnant women read aloud twice a day from the same book during their last 6 weeks of pregnancy, was designed to assess
   a. fetal attention.
   b. fetal learning.
   c. infant attention.
   d. infant learning.
9. Which of the following does not influence the severity of the effect of a teratogen on a developing fetus?
   a. Timing of exposure
   b. Quantity of exposure
   c. Duration of exposure
   d. Number of previous pregnancies of the mother
10. Which is not a symptom of fetal alcohol syndrome?
    a. Facial deformities
    b. Intellectual disability
    c. Underactivity
    d. Attention problems
11. Studies suggest that the squeezing that a fetus experiences during delivery serves several important functions. Which of the following is not one of them?
    a. It temporarily reduces the size of the infant's head, allowing it to pass safely through the pelvic bones.
    b. It squeezes fluid from the ear canals, allowing the baby to hear.
    c. It stimulates the production of hormones that help the fetus withstand mild oxygen deprivation.
    d. It forces amniotic fluid out of the lungs, in preparation for the baby's first breaths.
12. Which of the following is a characteristic of non-rapid eye movement (non-REM) sleep?
    a. Irregular heart rate
    b. Irregular breathing
    c. Quick, jerky eye movements
    d. Slow brain waves
13. Which of the following describes an infant who is most likely suffering from colic?
   a. Vivian cries for several hours a day for unexplained reasons.
   b. Jeremy cries loudly when he is hungry.
   c. LaTosha cries when she is placed in her crib.
   d. Emelie rarely cries.

14. What intervention program, involving direct skin-to-skin contact, are parents of low-birth-weight infants encouraged to use to support development and promote survival?
   a. Swaddling care
   b. Massage care
   c. Kangaroo care
   d. Pouch care

15. What does the multiple-risk model suggest about negative developmental outcomes?
   a. Each risk factor will produce a unique negative outcome.
   b. The presence of one risk factor increases the likelihood that another risk factor will emerge in the future.
   c. The more risk factors that are present, the more likely and worse the potential outcomes will be.
   d. The presence of more risk factors increases the likelihood that a child will develop resilience.

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**Critical Thinking Questions**

1. A recent cartoon showed a pregnant woman walking down a street carrying an MP3 player with a set of very large headphones clamped around her protruding abdomen. What point was it making? What research might have provided the basis for the woman’s behavior, and what assumptions is she making about what the result might be? If you or your partner were pregnant, do you think you would do something like this?

2. We hear a great deal about the terrible and tragic effects that illegal drugs like cocaine can have on fetal development. In this chapter, tobacco and alcohol use are identified as two of the most common harmful behaviors in the United States. How do the effects of these various substances differ from each other, and should that influence how we as a society perceive their use by pregnant women?

3. Suppose you were in charge of a public-health campaign to improve prenatal development in the United States and you could focus on only one factor. What would you target and why?

4. Pick a country or culture that you are not very familiar with and research the common beliefs and practices with respect to conception, pregnancy, and childbirth. Do their practices appeal to you more than the practices with which you are familiar? Are there beliefs or practices that could be used beneficially with the ones that you are familiar with?

5. Speculate on why the infant mortality rate in the United States has steadily gotten worse compared with that of other countries. Suggest some potential policy changes or health-care initiatives that might help to address these causes.

6. Explain the basic idea of the multiple-risk model and how it relates to poverty in terms of prenatal development and birth outcomes.

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**Key Terms**

- amniotic sac, p. 46
- Apgar score, p. 69
- apoptosis, p. 45
- cephalocaudal development, p. 47
- colic, p. 68
- conception, p. 43
- developmental resilience, p. 73
- dishabituation, p. 52
- dose–response relation, p. 54
- embryo, p. 44
- embryonic stem cells, p. 45
- epigenesis, p. 42
- fetal alcohol spectrum disorder (FASD), p. 59
- fetus, p. 44
- fraternal ( dizygotic) twins, p. 46
- gametes (germ cells), p. 42
- habituation, p. 52
- identical (monozygotic) twins, p. 46
- infant mortality, p. 69
- low birth weight (LBW), p. 69

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meiosis, p. 42
mitosis, p. 44
neural tube, p. 46
non-REM sleep, p. 66
phylogenetic continuity, p. 51
placenta, p. 46

premature, p. 69
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sensitive period, p. 54
small for gestational age, p. 70
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sudden infant death syndrome (SIDS), p. 58
swaddling, p. 68
teratogen, p. 54
umbilical cord, p. 46
zygote, p. 44

Answers to Test Yourself

1. a, 2. c, 3. d, 4. b, 5. a, 6. d, 7. a, 8. b, 9. d, 10. c, 11. b, 12. d, 13. a, 14. c, 15. c