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Lectures

Selected Lectures of the National Congress of the Italian Society of Pediatric Psychology (S.I.P.Ped.)

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The National Congress of the Italian Society of Pediatric Psychology (*Società Italiana di Psicologia Pediatrica* – S.I.P.Ped.) is a Satellite Meeting of the 19th International Workshop on Neonatology and Pediatrics, Cagliari (Italy), October 18th-21st, 2023.

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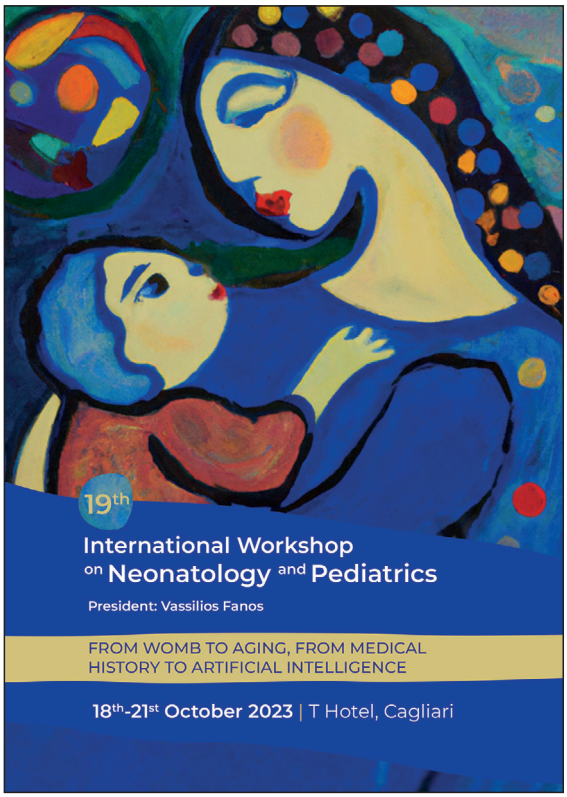

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LECT 1

HOW TO RECOGNIZE AND COPE WITH POST-PARTUM DEPRESSION. PEDIATRICIAN AND PSYCHIATRIST'S ANSWERS TO PARENTS' QUESTIONS

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Talking about postpartum depression is possible, it is not taboo, but still this issue is often neglected, sometimes misunderstood, because society believes that everything about birth should be happy "by contract", with no room for any problem. Instead, postpartum depression not only is a serious issue affecting mothers, fathers, and families, but also represents a major social problem, since it affects up to 1 in 6 mothers. Pregnancy, childbirth, and postpartum increase emotional vulnerability and the risk of onset of psychological and psychiatric disorders in women. Postpartum depression affects mothers all over the world, including wealthy and successful women. Many think that it is a problem of our time, generated by the complicated world in which we live, but in fact it is a phenomenon known since ancient times: the Romans called it the "time of tears".

Certainly many factors are among the causes of postpartum depression, including hormonal ones, but even today the pathophysiological mechanisms that determine it are not fully known. In any case, a set of factors seems to act, not only biological, but also psychological and social, so today we refer to the so-called bio-psycho-social model. We know that very stressful events can trigger postpartum depression, so much so that data from the scientific literature report significant increases in incidence during the pandemic. A particularly stressful event may be the birth of a preterm baby and its subsequent admission to the Neonatal Intensive Care Unit: there is evidence that such circumstances may be associated with the presence of postpartum depression in 1 out of 3 mothers.

If maternal postpartum depression is still little known with respect to its prevalence, even less so is postpartum depression in the father, which has the same frequency as maternal depression but manifests itself in different and peculiar ways. It is often facilitated by the onset of maternal postpartum depression and may, unfortunately, coexist with it.

Our book (*How to recognize and cope with postpartum depression. Pediatrician and psychiatrist's answers to parents' questions*) is part of a larger, multifaceted project, which includes, among other things, an educational short film (titled *The Voices of Mothers*, available on YouTube), in-person and online training meetings, research into innovative and predictive biomarkers, alongside the application of artificial intelligence to screening for postpartum depression. This project, titled *The Time of Tears*, began more than 10 years ago and has already produced another volume on postpartum depression (*Postpartum Depression. Causes, Symptoms and Diagnosis*), which is more geared toward health care providers. Now, we want to prioritize the voices, questions and concerns of moms and dads, providing concrete but still scientifically correct answers. The whole volume is organized as a series of answers to parents' (especially moms') questions, which we hope will be helpful for families.

Fighting and defeating postpartum depression and its allies (such as indifference, silence, clichés about motherhood, or the myth of perfect happiness that should accompany every birth) is possible. The first step in combating postpartum depression is to talk about it, be aware of it, and intervene early, to move from the "time of tears" to the "time of joy".

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LECT 2

FAMILY PEDIATRICS, PREVENTIVE AND SOCIAL PEDIATRICS, AND PEDIATRIC PSYCHOLOGY

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The statement by the British pediatrician and psychoanalyst Donald Winnicott has become famous: prevention of the most serious mental disorders is done in Pediatrics. Thanks to his long experience as a pediatrician in daily contact with many young patients and their families, Winnicott came to this conviction by pointing out that many pictures of mental suffering then involve the body in an important way. Moreover, Sigmund Freud had already pointed out that many neurotic disorders find their roots in childhood. Emblematic and frequent examples of conditions expressing a marked involvement of the body as a consequence of psychic suffering are anorexia and bulimia, the various psychosomatic disorders, many depressive pictures and the so-called narcissistic personality disorders. In Pediatrics, one can easily grasp how significantly psychological, emotional, and relational components influence children's well-being and health, in a somatopsychic continuum that makes body and mind inseparable, especially in young children. The relational environment in which the little one is immersed and grows up becomes, inevitably, part of him. Fundamental importance has the adult caregiver. The pediatrician must keep well in mind that family relationships have an enormous reverberation on the child's life, well-being, and psychic and somatic future. He or she must take these elements and factors into account when caring for the health of his or her patients if he or she is to make an effective impact. Caring for the child implies that the pediatrician must affect the parents, with whom it is important for him to establish a positive and cooperative relationship. In fact, this is exactly what the family pediatrician does every day: he deals with pathology, of course, but also and above all with prevention, which also involves parenting education and support, the constant invitation to families to adhere to good practices, and through the evaluation and monitoring of the social context in which the child is placed and grows up. Of course, it is not always easy for the pediatrician to distinguish between purely physical pictures and others that are more nuanced but very much influenced by emotional components that sometimes may not even belong to the children but to their parents. We know well that neglecting possible psychological distress in taking care of physical disorders can be as detrimental to the child and his or her future as the opposite, that is, focusing exaggeratedly on psychological implications of distress and neglecting possible physical causes instead (citing Balint). According to Balint's formulation, an organic disorder is often presented to the physician as an offered symptom, that is, as a request for help, which is unclear even to the patient himself. If in such particular but by no means infrequent situations the "trained" pediatrician is able to identify such a relationship between mental and organic problems early on, he or she can effectively affect the course of the problem by preventing the subject's suffering from being more structured as an organic disorder. Balint points out that much depends on how the physician will respond to the symptomatic offer that the patient presents to him. The child needs the symptom to express an obstacle in his emotional development. In fact, according to what Balint describes, when the patient is faced with a problem that is too difficult for him to solve, his equilibrium breaks down and, after a time, he expresses his discomfort with the symptoms of a given disease. In other words, the organic symptom turns out to be, despite the suffering involved, a kind of solution with respect to the difficulty behind it. The pediatrician must be able to bring out the underlying distress if he is to affect the expressed organic problem. Winnicott, too, warns against the dangers of considering purely on a somatic level a malaise presented in pediatric age: it is important that physically healthy but emotionally unstable children should not be classified as suffering from rheumatism, appendicitis, colitis, etc. Instead, it should be kept in mind that anxiety often produces physical symptoms or is accompanied by them, symptoms that speak of a suffering that lies elsewhere, even if it shows itself in the body, and he adds that knowing the way to treat an anxious child means for the physician, in many cases, hastening recovery. Obviously, Balint does not intend to downplay the existence of disorders and pathologies of a purely bodily nature in the pediatric age, but he does want to draw the pediatrician's attention to the fact that, in caring for the child, it can be extremely useful to widen the diagnostic gaze to the possible presence of other factors, in addition to biological ones, that can have an influence on the patient's health. Balint argues that in a large number of cases in which certain children, especially young children, are frequently accompanied to the doctor, the person who is really ill is the mother (less often, the father). Generally, one is able to cure the child's illness, but

only to make way for a new disorder. Thus, there is often a kind of relay race: where a symptomatic remission gives way, after a short interval, to a new disorder or a relapse into the previous one. That is why it is important for the pediatrician to be trained in Pediatric Psychology so as to work alongside and collaborate with practitioners who are interested in that branch of medicine. Such issues have greatly increased in the post-COVID era, with exponential increase in emotional distress of children, from toddlers to adolescents, but also their families. Increased irritability, sleep disorders (difficulty falling asleep and/or frequent awakenings), anxiety disorders (restlessness, separation anxiety) and mood disorders from childhood to adolescence have been reported during lockdown. Thus, specific training of the pediatrician is essential so that a commonality of purpose and mode of intervention is established between Pediatrics and Pediatric Psychology, which can and must learn to interact with each other. The common focal point between Pediatrics and Pediatric Psychology is the "developmental issue", and thus first and foremost, when possible, to get the child cured of any organic or psychic pathology, but also to realize the right of every child to grow up healthy in mind and body and to see his or her right to develop conduct and functions typical of his or her age protected and guaranteed. Fundamental is the prevention of mental suffering by promoting the path of the best possible developmental trajectories, avoiding or overcoming impairments and frailty. Common areas include attention to psychosocial development and the environmental, family, social and community factors that may contribute to the development of a disorder and the treatment of more or less interrelated medical, behavioral and emotional conditions. It must also be part of preventive and social Psychology and Pediatrics to promote appropriate pedagogical and health aspects of public policies that promote children's health. The pediatrician is in a particularly favorable position in detecting and factually affecting, at 360 degrees, such issues because he or she knows the family, the child and their problems thoroughly, has many opportunities to meet over the years so he or she may be able to detect every change, every developmental step, intercepting any possible criticality. Obviously, to do all this, proper training is essential, as it becomes easy to detect what one knows and it becomes easy to affect what one is able to detect. Pediatrics must be a vigilant observatory (also because it is privileged to do so) of monitoring, support and reporting, collaborating and interacting with the pediatric psychologist. But while the focus is undoubtedly common and widely shared, it is not always easy for practitioners, however motivated they may be, to succeed in creating shared protocols and achieving true integrated work that is coordinated but also supported and nurtured by shared visions, constant relationships, and necessary connections of meaning and operation. I believe that, for such integration, a National Network to foster "Integrated Work" is desirable and possible. In conclusion, I believe it can be said that there are many points of contact between Pediatrics and Pediatric Psychology and that they are to be considered two disciplinary fields that are not so far apart.

LECT 3

INTEGRATED WORK IN PEDIATRIC PSYCHOLOGY

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The lecture aims to frame the contextualization of Inclusive Integrated Work in the Maternal and Child Department in hospitals and territorial local services addressing its application to adolescent malaise. This is a specific condition that today constitutes a social and developmental phenomenon with implications for the developmental trajectory, as it is a fragility [1, 2] that can evolve/involve in a real risk of vulnerability characterized by numerous developmental ruptures and identifiable as a humus in which psychopathologies, dysphorias, extreme forms of social withdrawal, and violence all take root. The choice of Integrated Work is presented according to a specific motivation, both with respect to the needs of taking charge of the adolescent as a field of relationship [3], and with respect to the model of taking charge as reception, orientation, accompaniment, and coaching, as well as to the effectiveness of this taking charge, which intends to ensure a functional condition for mental health, treatment processes, therapeutic alliances. A further motivation is traced and suggested by the topicality of a phenomenon, which is that of adolescent malaise. This phenomenon, precisely

because of the very many variables and factors that define it, can only be managed through an inclusive mode of intervention that does not fall only on multiprofessional dialogue, based on the sum of specific professional interventions and specific professional practices, but that develops in constant interaction and relationship with coordination between these interventions activated while they are put into practice. In this sense, the contribution outlines the Inclusive Integrated Work model by defining it in terms of organizational energy, sense of "We", etc., highlighting aspects that characterize criteria and organizational conditions as well as spillovers, in taking care of adolescent malaise. In this sense, as an exemplification, some applications are also reported with respect to specific intervention conditions taken care of in the hospital-territory continuity. Some segments of the training in remote defined by the National Network for Inclusive Integrated Work are also presented.

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LECT 4

THE EXPERIENCE IN PEDIATRIC ONCOHEMATOLOGY

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We would like to consider a dualism from the perspectives of healthcare members, the patient and his/her family. Dualism is:

1. empathy/closeness, encouraged by smiles and kindness;
2. joy/smile, promoted by believing in what we do;
3. hope/love, offered by charting the road ahead;
4. time/professionality, expressed by giving and also protecting ourself;
5. patience/listening, supported by being a good travel companion.

All these dualisms are reported in very helpful documents [1, 2].

If we look at the best quality of life of a child and his/her family, even in front of the impending death of a child affected by a hemato-oncological disease, there are no limits to what a healthcare member can do.

It is mandatory to consider the above-mentioned dualisms for:

a. finding the modality to help the child and his/her family, regardless of the final result;
b. keeping in mind the road ahead, not limiting to only communicating the name of the disease;
c. defining the best final goal of our approach, i.e., true quality of life;
d. finding how to communicate bad news, improving clinical approach;
e. listening (even if we are not used to), which is more important than talking [3].

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LECT 5

WHEN CHRONICITY BEATS WITH A "DIFFERENT HEART" IN PREGNANCY

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Congenital heart diseases (CHD) are the most common structural abnormalities in live-born children and are responsible for about 50% of deaths secondary to congenital malformations in childhood. They recur at a frequency of 7-8 per 1,000 live births and are found 5 times more frequently in cases of intrauterine death. Fetal echocardiography is a noninvasive, high-sensitivity diagnostic tool to recognize CHD by study of cardiac anatomy and function. The role of prenatal echocardiography is to identify heart diseases

that represent an emergency, define treatment course and ultimate prognosis, plan delivery site and timing, ensure the most appropriate neonatal management, provide parents with proper counseling. We know that prenatal diagnosis of CHD is associated with a worse prognosis because most cases are referred to the cardiologist for the discovery of a structural abnormality, for the presence of associated pathologies, particularly karyotype abnormalities, higher than in postnatal cases. When a prenatal cardiac disease diagnosis is made, the parental anxiety increases greatly. Depression and traumatic stress are frequent and, if untreated, symptoms often persist and worsen long term. In such situations, what aspects of communication are particularly stressful for parents? Uncertainty, associated with both concrete questions and long-term unknown variables, was a central source of stress for parents. These findings suggest that potential future interventions should focus on managing uncertainty by parents and more appropriate information by health care providers. Families embark on an uncertain path following a fetal diagnosis of severe CHD. The challenges faced by cardiologists caring for them overlap in many ways with those experienced by pediatric palliative care professionals. Counseling parents for fetal heart disease is a complex process that requires attention and expertise. Parents need counseling, of appropriate duration and quality, conducted in a dedicated, quiet room. Written information and links to quality web sources should be provided in simple, understandable language. Counseling provided by pediatric cardiologists is most effective. Parental "perceived situational control" is often compromised; ongoing support throughout pregnancy from psychologists and social workers is needed. The extra training of professionals has a significant impact on the quality of counseling. The real problem, at least in our workplace, is that the physicians who provide prenatal counseling are typically not trained in practices to best perform this role in a manner that is informed by emotional skills or psychological expertise. The short-term goal is to design a structured follow-up program for prospective parents who receive a prenatal diagnosis of CHD. The medium-term goal is to arrive at national, evidence-based management guidelines, because effective counseling cannot be improvised counseling.

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LECT 6

MATERNAL ARCHETYPE AND POSTPARTUM DEPRESSION. A NEURO-NARRATIVE COMMUNICATION PERSPECTIVE

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Recently, in parallel with the development of the debate in the medical field on narrative medicine, research on the importance of narrative in human relationships has regained strength. It is certainly an important debate that finally restores the central position to a function that has accompanied humans throughout their journey: storytelling. Neuro-Narrative Communication (NNC) is a research and application perspective in education that combines the centrality, in the perspectives of meaning-making, of narrative, combining it with an awareness of the biological dimension of the human dimension and illuminated by neuroscience research. NNC is based on the concept of "archetypal narration", or the analysis of narrative oriented by the phenomenological analysis of archetypes. The study of archetypal narrative in NNC is based on the lessons of the masters of the Science of Archetypes: W.F. Otto, K. Kerenyi, M. Eliade, E. Zolla. Thus, we speak of mythology applied to existential analysis. From NNC's perspective, postpartum depression (PPD) is thus presented as a particular development of the maternal archetype, one of the primary archetypes, which impinges powerfully and heavily on the existential and sense-making dimension of the mother. An adequate phenomenological study of the maternal archetype thus becomes a condition for an adequate understanding of the specific determinations of PPD and for designing the most appropriate clinical and counseling pathways.

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LECT 7

EFFECTS OF MATERNAL PERINATAL DEPRESSION ON INFANT TEMPERAMENT AND FEEDING INTERACTIONS IN THE FIRST 6 MONTHS OF LIFE

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INTRODUCTION

Extensive scientific literature consistently emphasizes the significant short-, medium-, and long-term impact of maternal perinatal depression on emotional and behavioral regulation, cognitive development, and physical well-being of offspring [1]. Notably, interactions between a depressed mother and her child reveal reduced responsiveness and sensitivity to the child's needs. The mother's focus tends to revolve around personal concerns, rather than addressing the infant's expressed needs. Consequently, the child might experience challenges in interactions, increased susceptibility, sleep disturbances, various stress-related manifestations, and an inadequate internal regulation of feeding rhythms from early infancy [2].

METHOD

This study is dedicated to examining the effects of maternal perinatal depression on infant temperament and early feeding interactions within the early 6 months of life. Utilizing a longitudinal design, data collection was divided into 3 distinct phases: during the sixth month of pregnancy (T1), the third month, and the sixth month of the child's life (T2 and T3). The participants included 68 mother-child dyads, comprising 20 mothers at risk for depression and 48 mothers without such risk. Average maternal age was 34.81 years (SD = 4.66 years, range 20-44 years). All children (56% male, 44% female) were born full-term and in good health. Throughout the study, mothers completed the Edinburgh Postnatal Depression Scale (EPDS) questionnaire at T1, T2, and T3, as well as the Infant Behavior Questionnaire, (IBQ-R) at T2 and T3. Additionally, at T2 and T3, interactive dynamics during mother-child feeding were observed using the Scale for the Assessment of Mother-Infant Feeding Interaction (SVIA) [3].

RESULTS

Statistical analyses reveal that maternal depressive symptoms during both prenatal and postnatal periods correlate with temperamental challenges in children, encompassing sadness, fear, and distress. The findings underscore that the mothers at risk for depression exhibit deficiencies in synchronous and collaborative communication, displaying negative engagement marked by sadness and emotional detachment in contrast to non-depressed mothers. Furthermore, within mother-child dyads at risk for depression, frequent breakdowns in feeding interactions are observed. This scenario involves the child demonstrating food refusal behaviors coupled with oppositional attitudes and a tendency towards disengagement.

CONCLUSIONS

The data underscore the importance of identifying risk factors associated with the emergence of perinatal depressive symptoms. Such identification is pivotal in shaping interventions aimed at preventing potential negative outcomes, benefiting both mothers and children, and the broader familial context.

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LECT 8

KNOWING PEDIATRIC HEADACHES

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Primary headaches represent a problem that is still clinically neglected. The *International*

Classification of Headache Disorders (*ICHD-3*) identifies 3 main categories:
1. migraine (with and without aura);
2. tension headache;
3. cluster headache [1].

To distinguish them, it is necessary to refer to 5 fundamental questions relating to headaches:
1. How does it hurt?
2. Where does it hurt?
3. How much does it hurt?
4. When does it hurt?
5. Why does it hurt?

These 5 questions allow the clinician to be oriented quite easily on the type of primary headache, in order to identify the most appropriate diagnostic path and the appropriate treatment.

On the other hand, it is worth highlighting that in developmental age the most correct approach must be multidimensional.

In fact, the child with primary headache presents many other impairments linked to being cephalalgic (e.g., cognitive, attentional, scholastic, visuospatial, motor), as well as a greater prevalence of internalizing disorders and behavioral difficulties [2].

Therefore, the child suffering from primary headache is a child who has difficulties in all areas of functioning, significantly reducing his neuropsychological and executive skills.

Furthermore, it is necessary to consider the investigation into the sleep habits of the young patient with headache as mandatory, since regulating sleep in quantity and quality allows a notable reduction in migraine attacks.

Therefore, the evaluation of a patient in the developmental age with primary headache is divided into numerous steps such as cognitive, neuropsychological, motor, visuospatial evaluation and psychological investigation on the internal experience.

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LECT 9

PEDIATRICIANS AND PSYCHOLOGISTS IN THE MANAGEMENT OF CHILD NEGLECT ASSESSMENT

C. Polizzi and S.I.P.Ped. Research Group: "A Dysregulation of Parenting Competence: Neglect"

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Pediatric contexts, both territorial and hospital, certainly represent privileged "spy" contexts in which it is also possible to intercept early signs and predictors of very dangerous conditions for the health of children's development, that are the conditions characterized by child neglect. This is an omissive form of maltreatment [1], considered according to the ecological-transactional model we have assumed, as an outcome of a serious condition of dysregulation of parental competence [2, 3], which leads to an omission in intercepting the child's needs. Child neglect is the more "silent", latent and insidious among the forms of child maltreatment, often not perceived by the community with the same seriousness as abuse or physical maltreatment, and yet, by far the most widespread form, and it seems that the pandemic for COVID-19 has only increased the phenomenon, given the widespread and increasingly worrying condition of dysregulation of parental competence. We are faced with a true evolutionary emergency condition, which can orient a true traumatic developmental disorder. For all these reasons, pediatricians and psychologists cannot fail to be "equipped" to know how to recognize such conditions, even in its earliest and most predictive forms, to be able to activate as soon as possible interventions to support a parental competence more appropriate to the promotion of the child's development.

In this sense, S.I.P.Ped. (*Società Italiana di Psicologia Pediatrica* – Italian Society of Pediatric Psychology) has been engaged in recent years in the definition of a specific model for reading child neglect as an outcome of dysregulation, in the hypo but also in the hyper sense, of parenting competence, and in the development, in light of the model, and validation of an assessment technique of this dysregulation: the Child Neglect Assessment (CNA) technique [2, 3]; this technique traces its strengths and originality in the detection of the signs of child neglect in the here and now of the time in which the neglect and omission take place, and in being a technique that can be used not only by psychologists, but also by other professionals, such as pediatricians, according to an integrated working model, in the daily routine of their service. The

CNA technique is split into two specific observation tools: a child neglect risk sheet and a coding scheme of the indicators of child neglect, applied to the contents of a specific narrative interview, and as of today it was developed to assess child neglect in parents of children aged 3-9, in family of Italian culture. Most importantly, the technique involves an articulated specific integrated procedure between a psychologist and, for example, a pediatrician, in which it is possible to trace some crucial steps, such as: the selection of parents to be involved, the integrated administration of the two tools, and the intervention hypotheses. It is precisely the integrated nature of the procedure of this technique that can be a strategic step for the protection and for the support of the child's well-being in pediatric settings.

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LECT 10

PSYCHOLOGY, CHILDREN, NUTRITION

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Recent literature highlights how food is not simply nourishment: the act of feeding the child has multiple meanings not strictly linked to the satisfaction of a primary need. In fact, feeding the child is connected to the construction of the self, the construction of the relationship with food and the construction of an emotional relationship. The first nourishment act takes place within an emotional relationship where, together with breast milk, the baby experiences the acceptance or rejection, the attention and emotions that a parent gives to the baby. There is, therefore, a close relationship between the nutritional dimension and the emotional dimension. Since pregnancy, the way in which a future mother nourishes herself has a profound impact on the physical and emotional growth of the fetus. And as the child grows, reference figures convey implicit messages in which food can become a symbol of family union, pleasure in relationships, the search for socialization. Alternatively, food can become a blackmail or power play strategy by the parent or a tool for the child to oppose adults. Nutrition education shapes the child's socialization, as during meals they experience the same social rules, autonomy and a more or less trusting attitude towards the world. Before thinking about what they want from children at the table, parents need to think about what they are willing to do. On the other hand, when it comes to nutrition, parents often let children decide for them and dictate the rules. Furthermore, clinical studies demonstrate that 25% to 35% of children up to 10 years of age have feeding difficulties from the early stages of weaning with the introduction of solid food [1]. In fact, there is a classification of early childhood eating disorders proposed by Chattor. These disorders are: childhood anorexia, food selectivity, post-traumatic eating disorder, children who overeat and mixed eating disorders [2].

So, how can you help parents and children develop good relationships at the dinner table?

1. Having the child eat with the rest of the family helps to create a healthy curiosity about food.
2. Avoid offering too many courses at once and help the child recognize hunger or satiety by serving meals at regular times.
3. Don't try to convince him, don't threaten him or force him to eat more or less.
4. Don't praise or criticize the child when he eats a lot or little.
5. Don't use food as a reward or as a way to express affection.
6. Don't allow distractions during meals.

Through these behaviors, the child will be able to experience the sense of hunger or satiety, of fullness and emptiness, building pleasant moments together with the parents. Even moments of difficulty and mistakes on the part of parents can be food for thought and can be opportunities for growth for children and parents.

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