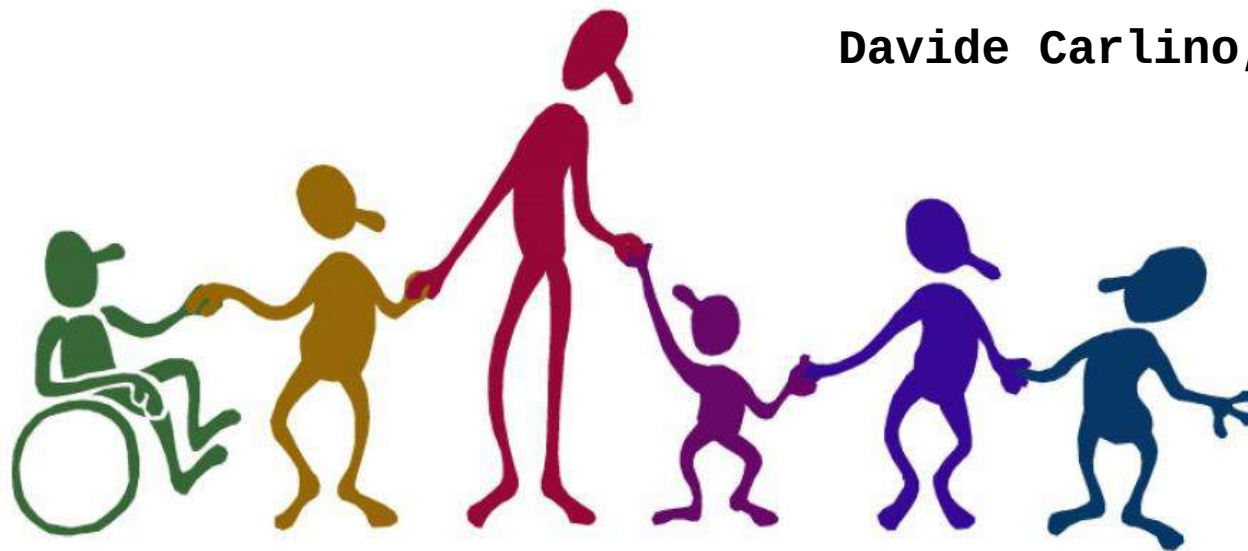


Psicopatologia applicata dell'adulto disabile

Davide Carlino, MD, PhD



SABATO **28** NOVEMBRE
2015

Centro Culturale
Casa "A. Zanussi"
PORDENONE (PN)

**DISABILITÀ
ADULTA
E VITA
INDIPENDENTE:**
*un lavoro di rete
sul territorio
per il benessere
delle persone*

Scienze di base vs scienze applicate

Utile a trovare
soluzioni pratiche e
specifiche



Applicare concetti
della scienza in
oggetto ad altri campi
di studio



REMARKS CONCERNING THE DEVELOPMENT OF APPLIED PSYCHOPATHOLOGY.

By ERWIN STRANSKY, M. D.,

Professor of Psychiatry and Neurology, University of Vienna, Austria.

In the year 1920 a new step was inaugurated by me in this direction. I founded, here in Vienna, the Association for Applied Psychopathology and Psychology, with special aid of Dattner and Roffenstein. This was dedicated to the idea of clarifying the methods by which the results of psychopathological research could be applied to research in other directions ; we held scientific lectures and discussions ¹ on the one hand, and on the other, we intended to create a sort of seminars and research collaborations between psychopathologists and psychologists, as well as between psychopathologists and research workers in other fields.



*"Mi sembra che i ricercatori
americani tendano
costantemente a spiegare come
il bambino diventa ciò che
egli è: qui nell'URSS ci
sforziamo di scoprire non come
il bambino diventa ciò che è,
ma come può diventare ciò che
non è ancora".*

Alexis Nikolaevich Leontiev (1903-1979)

L'insieme di consigli,
suggerimenti, norme di vita sia a
livello individuale che collettivo,
che servono a prevenire e/o
attenuare danni allo stato
psicofisico della persona in
un'ottica "real world",
permettendogli di sviluppare le
personali potenzialità di autonomia
creativa e di relativo equilibrio
nel proprio contesto sociale.

Mental illness, challenging behaviour, and psychotropic drug prescribing in people with intellectual disability: UK population based cohort study

Rory Sheehan,¹ Angela Hassiotis,¹ Kate Walters,² David Osborn,¹ André Strydom,¹ Laura Horsfall²

Cite this as: *BMJ* 2015;351:h4326
doi: 10.1136/bmj.h4326

DESIGN

Cohort study.

SETTING

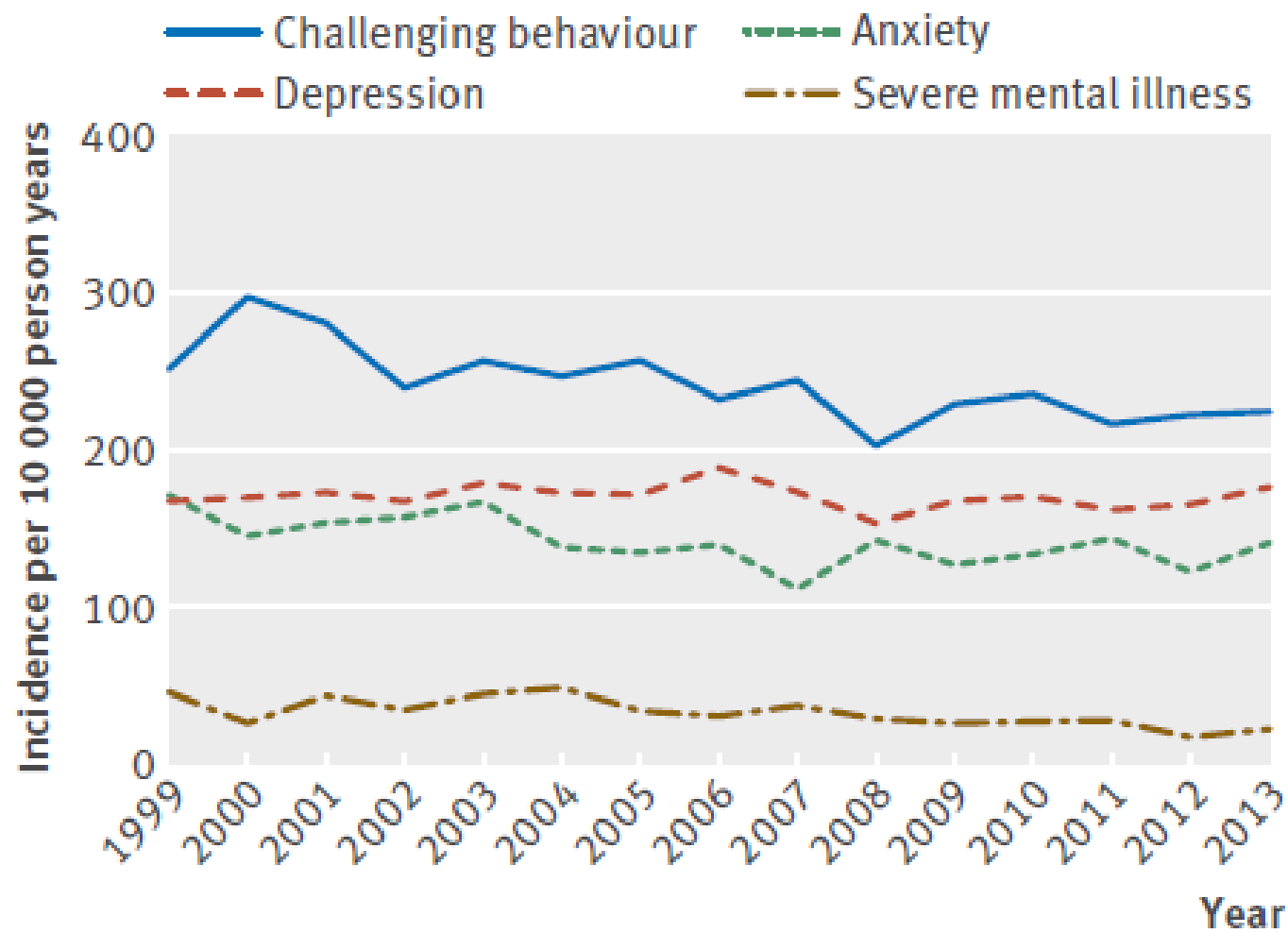
571 general practices contributing data to The Health Improvement Network clinical database.

PARTICIPANTS

33 016 adults (58% male) with intellectual disability who contributed 211793 person years' data.

MAIN OUTCOME MEASURES

Existing and new records of mental illness, challenging behaviour, and psychotropic drug prescription.



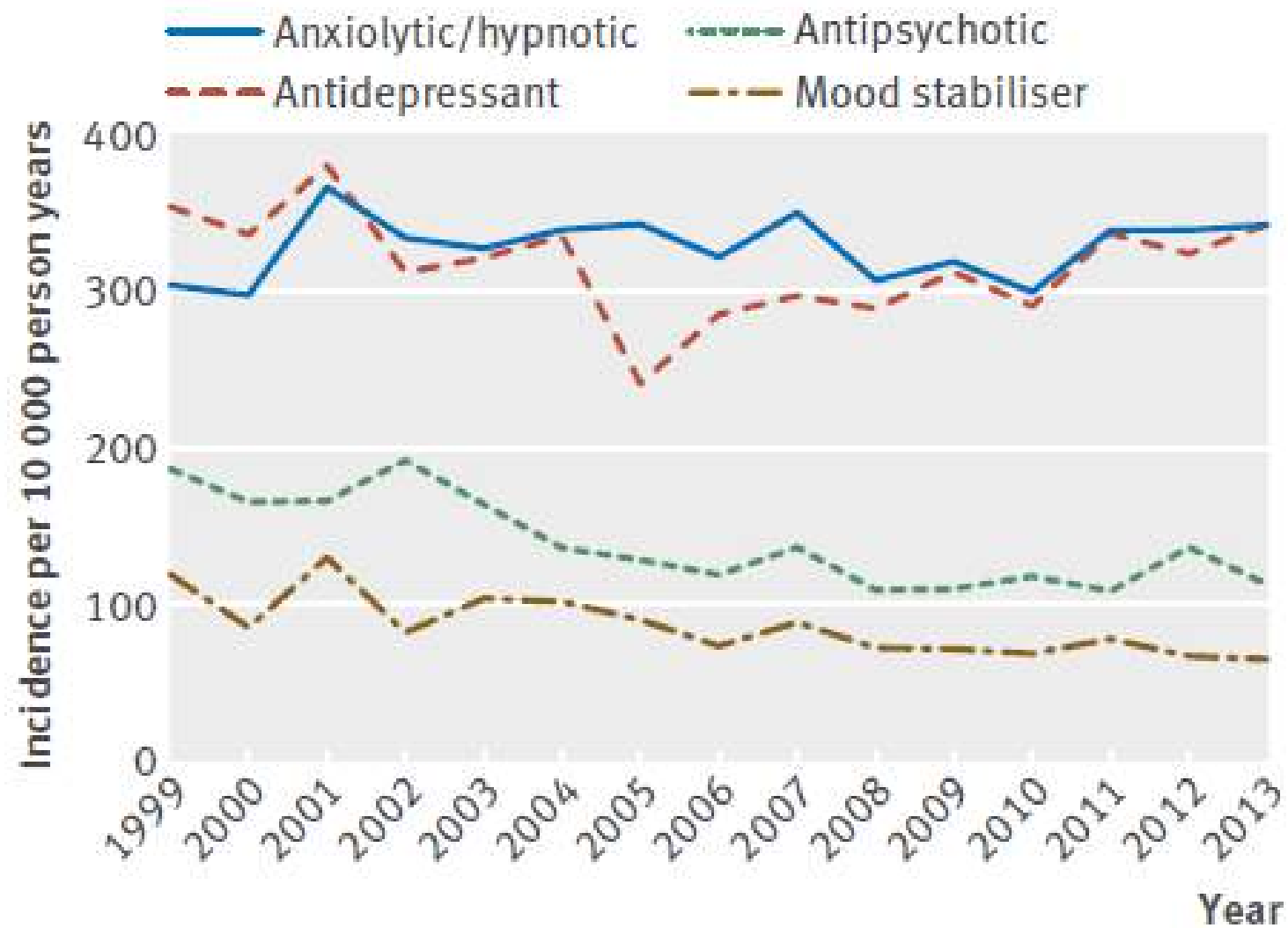


Table 3 | Associations with new recording of challenging behaviour in adults with intellectual disability in UK primary care, 1999-2013

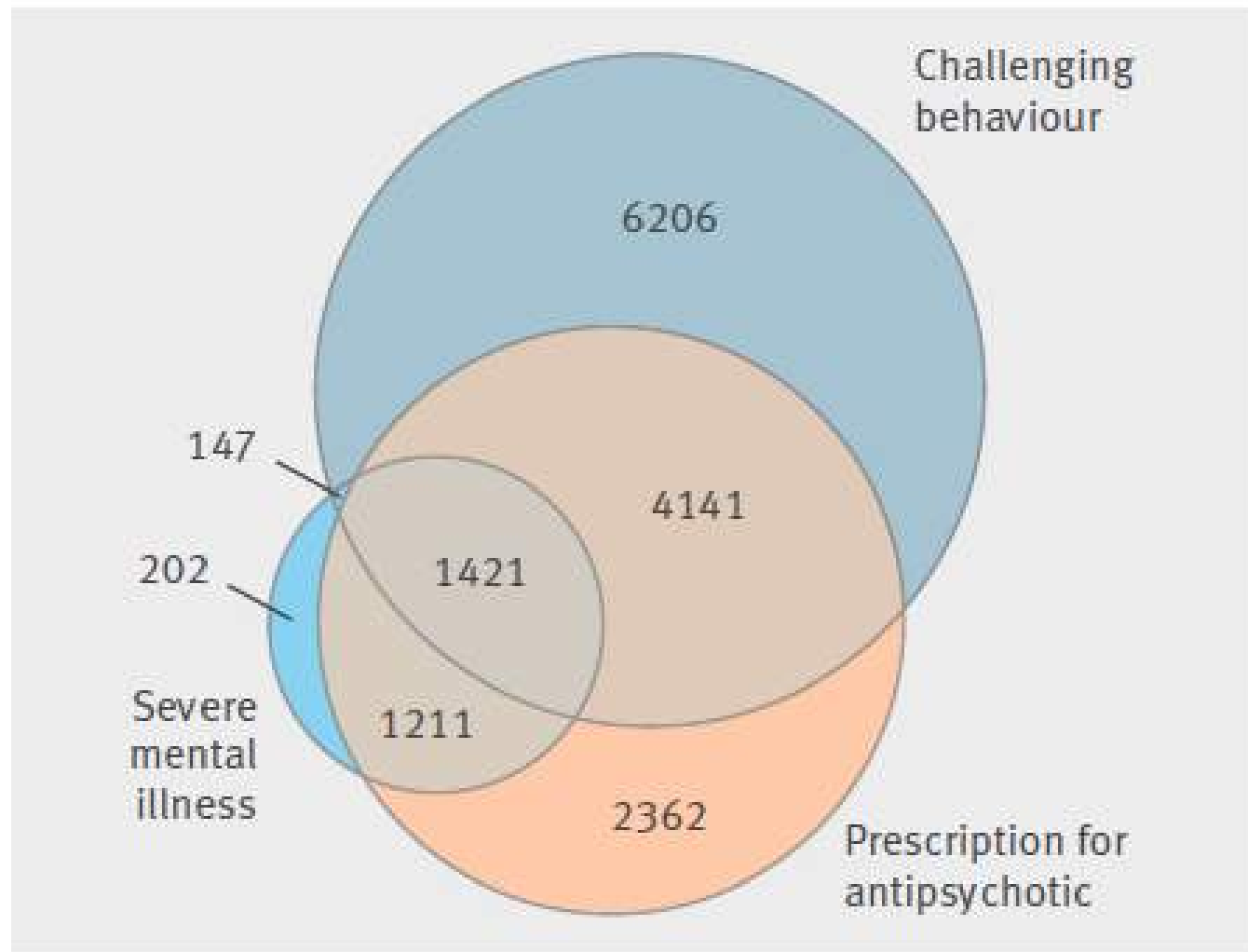
Factor	Rate (per 10 000 patient years) (95% CI)	Incidence rate ratio* (95% CI)	P value
Sex:			
Male	243 (231 to 255)	1 (reference)	NS
Female	235 (225 to 246)	0.97 (0.91 to 1.04)	
Age group, years:			
18-29	218 (204 to 234)	1 (reference)	<0.001
30-39	220 (204 to 237)	1 (0.90 to 1.11)	
40-49	226 (211 to 242)	1.01 (0.91 to 1.12)	
50-59	260 (241 to 282)	1.13 (1.02 to 1.26)	
60-69	286 (259 to 316)	1.27 (1.12 to 1.45)	
70-79	304 (262 to 351)	1.40 (1.18 to 1.65)	
≥80	382 (302 to 483)	1.78 (1.38 to 2.30)	
Townsend deprivation fifth:			
1 (least deprived)	230 (212 to 251)	1 (reference)	NS
2	247 (229 to 267)	1.06 (0.95 to 1.20)	
3	226 (210 to 244)	1.02 (0.90 to 1.14)	
4	225 (210 to 242)	0.97 (0.87 to 1.10)	
5 (most deprived)	264 (246 to 282)	1.10 (0.98 to 1.25)	
Missing	247 (212 to 288)	1.08 (0.89 to 1.32)	

Factor	Rate (per 10 000 patient years) (95% CI)	Incidence rate ratio* (95% CI)	P value
Neuropsychiatric diagnosis:			
No severe mental illness	224 (216 to 232)	1 (reference)	<0.001
Severe mental illness	442 (403 to 484)	1.69 (1.53 to 1.88)	
No depression	201 (193 to 209)	1 (reference)	<0.001
Depression	399 (376 to 423)	1.71 (1.58 to 1.86)	
No anxiety	209 (201 to 217)	1 (reference)	<0.001
Anxiety	384 (360 to 409)	1.44 (1.33 to 1.57)	
No autism	227 (219 to 235)	1 (reference)	<0.001
Autism	380 (346 to 418)	1.83 (1.64 to 2.03)	
No dementia	233 (225-240)	1 (reference)	<0.001
Dementia	482 (416 to 558)	1.71 (1.45 to 2.01)	
No epilepsy	225 (217 to 234)	1 (reference)	<0.001
Epilepsy	287 (270 to 306)	1.41 (1.30 to 1.52)	

Table 5 | Associations with new antipsychotic drug prescription in adults with intellectual disability in UK primary care, 1999-2013

Factor	IRR* (95% CI)	P value	IRR† (95% CI)	P value
Sex:				
Male	1 (reference)	NS	1 (reference)	NS
Female	1.04 (0.95 to 1.12)		1.01 (0.93 to 1.11)	
Age group, years:				
18-29	1 (reference)	<0.001	1 (reference)	<0.001
30-39	0.95 (0.84 to 1.07)		0.99 (0.88 to 1.13)	
40-49	0.91 (0.80 to 1.03)		0.96 (0.85 to 1.10)	
50-59	1.01 (0.88 to 1.16)		1.08 (0.93 to 1.25)	
60-69	1.14 (0.97 to 1.35)		1.32 (1.11 to 1.57)	
70-79	1.65 (1.34 to 2.02)		1.81 (1.46 to 2.24)	
≥80	2.39 (1.82 to 3.13)		2.72 (2.06 to 3.61)	
Townsend deprivation fifth:				
1 (least deprived)	1 (reference)	NS	1 (baseline)	NS
2	1.02 (0.88 to 1.19)		0.96 (0.82 to 1.12)	
3	1.03 (0.89 to 1.19)		0.97 (0.83 to 1.13)	
4	1.03 (0.89 to 1.19)		0.94 (0.81 to 1.09)	
5 (most deprived)	0.94 (0.81 to 1.10)		0.81 (0.69 to 0.95)	
Missing	1.21 (0.96 to 1.52)		1.1 (0.87 to 1.39)	

Factor	IRR* (95% CI)	P value	IRR† (95% CI)	P value
Neuropsychiatric diagnosis:				
Severe mental illness	8.87 (7.76 to 10.15)	<0.001	6.69 (5.83 to 7.68)	<0.001
Challenging behaviour	2.51 (2.30 to 2.76)	<0.001	2.08 (1.90 to 2.27)	<0.001
Autism	1.87 (1.66 to 2.12)	<0.001	1.79 (1.56 to 2.04)	<0.001
Depression	2.49 (2.27 to 2.72)	<0.001	1.79 (1.62 to 1.98)	<0.001
Anxiety	2.36 (2.15 to 2.60)	<0.001	1.63 (1.47 to 1.81)	<0.001
Dementia	1.91 (1.54 to 2.40)	0.003	1.42 (1.12 to 1.81)	0.003
Epilepsy	1.04 (0.94 to 1.15)	NS	1.15 (1.04 to 1.28)	0.007



✓ Le "severe mental illness" rimangono stabili nel tempo -> fanno parte del quadro sindromico

✓ Le tecniche comportamentali e il miglioramento dell'assistenza comunitaria possono aver ridotto l'emergere di comportamenti problema (challenging behaviours)

Comportamento Problema (CP) corrisponde a *challenging behaviour*, termine proposto dall'Associazione Americana per la Persone con Grave Disabilità:

“un comportamento culturalmente anormale di tale intensità, frequenza e durata da porre in serio rischio la sicurezza fisica della persona o degli altri, oppure un comportamento che presumibilmente limita in modo grave o fa sì che alla persona sia negato l'accesso alle ordinarie situazioni della vita sociale”

✓ Le "severe mental illness" rimangono stabili nel tempo -> fanno parte del quadro sindromico

✓ Le tecniche comportamentali e il miglioramento dell'assistenza comunitaria possono aver ridotto l'emergere di comportamenti problema (challenging behaviours)

✓ L'interesse per gli interventi riabilitativi, terapeutici in senso lato e clinici diminuisce con l'età del disabile, in particolare dopo i 50 aa

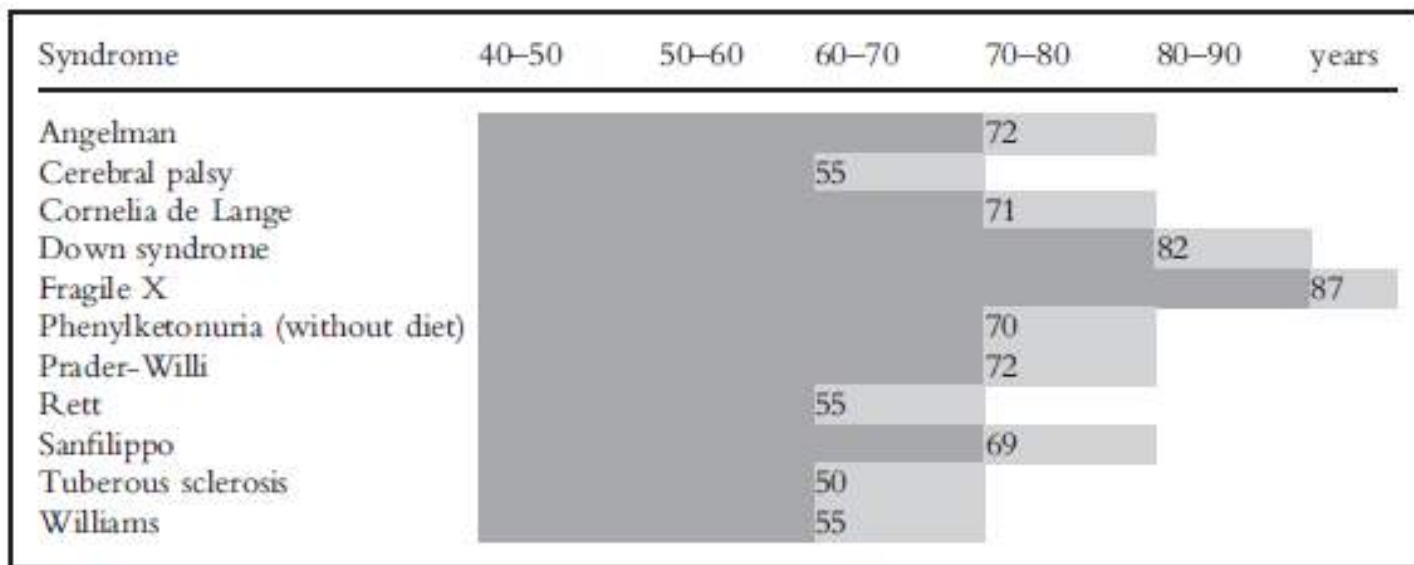
PEOPLE WITH INTELLECTUAL DISABILITY: WHAT DO WE KNOW ABOUT ADULTHOOD AND LIFE EXPECTANCY?

A.M.W. Coppus^{1,2,3*}

¹Dichterbij, Center for the Intellectually Disabled, Medical Center, Gennep, The Netherlands

²Nijmegen Department of General Medicine, Radboud University Medical Center, Nijmegen, The Netherlands

³Department of Epidemiology, Erasmus University Medical Center, Rotterdam, Rotterdam, The Netherlands



✓ Le "severe mental illness" rimangono stabili nel tempo -> fanno parte del quadro sindromico

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✓ L'interesse per gli interventi riabilitativi, terapeutici in senso lato e clinici diminuisce con l'età del disabile, in particolare dopo i 50 aa

✓ Le direttive sull'appropriatezza prescrittiva "riducono l'insorgenza di comportamenti problema"

Table 2. Variables Associated With Ill Health, Reduced Life Expectancy, and Causes of Death in Selected Rare Syndromes

Syndrome	Factors That May Lead to Adult Ill Health, Reduced Life Expectancy, and Common Causes of Death
Angelman syndrome	Severe epilepsy; dysphagia; ataxic gait and falling; immobility; severe scoliosis; aspiration; sudden deaths related to infections, seizures and complications of anesthesia; attraction to water and accidental drowning (Clayton-Smith and Laan, 2003)
Rett Syndrome	Dyspraxia; reduced mobility; hand stereotypies and mouthing; seizures; breathing disturbances; impaired sleep; scoliosis; poor growth and wasting; malnutrition; aspiration pneumonia (Percy, 2008)
Williams syndrome	Cardiovascular, endocrine and renal disease; hypertension; sensorineural hearing loss; elevated anxiety, phobias; risks for social exploitation; diabetes; joint contractures; hyperreflexia; cardiovascular disease major cause of death (Poher, 2010)
Prader-Willi syndrome	High rates of obesity; Type II diabetes; cardiovascular disease; hormonal deficiencies; sleep apnea and daytime sleepiness; leg ulcerations and edema; fractures; temperature instability; high pain threshold; psychosis primarily in mUPD; respiratory infections; gastric rupture and necrosis; accidental choking; complications of obesity major cause of death in adults (Cassidy and Driscoll, 2009)
Cri du Chat syndrome	Upper respiratory infections; larynx anomalies; cardiac, muscular or skeletal problems; hyperactivity; self-injury-head banging and self-biting; increased fragility and death in infants with unbalanced translocations or severe organ involvement (Maindri et al, 2006)
Rubinstein-Taybi syndrome	Gastroesophageal reflux; feeding difficulties; constipation; hypotonia; congenital heart disease; renal anomalies; problems with anesthesia; ophthalmologic and orthopedic problems; benign and malignant tumors; leukemia and lymphoma; immune dysfunction (Wliey et al, 2003)
Smith-Magenis syndrome	Inverted circadian rhythm of melatonin and sleep disturbances; elevated cholesterol and triglycerides, ocular problems; hearing loss; velopharyngeal insufficiency; scoliosis; self-injury-inserting objects into bodily orifices and nail yanking; peripheral neuropathy (Shelley and Robertson, 2005)
Cornelia de Lange syndrome	Limb, digital and dental abnormalities; feeding (chewing, swallowing) and gastrointestinal problems (reflux, vomiting); respiratory infections; severe hearing loss; ophthalmologic problems; hyperactivity; self-injury (Jackson et al, 1993)

Elisabeth M. Dykens

**DEVELOPMENTAL DISABILITIES
RESEARCH REVIEWS 18:75-83 (2013)**

- ✓ Doppia diagnosi – dual diagnosis
- ✓ Sanità fatta per prestazioni e non per giudizio clinico
- ✓ Ragionare per progetti e non per persone
- ✓ Aspetti antropologici
 - ✓ ruolo del malato/malattia
 - ✓ uomo postmoderno che si alterna nella dicotomia capace vs incapace
 - ✓ le caratteristiche della disabilità vengono considerate come elementi che definiscono altri aspetti della vita e della salute del ragazzo



Health promotion and disease prevention strategies in older adults with intellectual and developmental disabilities

Eli Carmeli^{1*} and Bitá Imam²

¹ Department of Physical Therapy, Faculty of Social Welfare and Health Sciences, University of Haifa, Haifa, Israel

² Rehabilitation Research Lab, GF Strong Rehab Centre, University of British Columbia, Vancouver, BC, Canada

MENTAL HEALTH PROMOTION AND PREVENTION

WORK OPPORTUNITIES TO PROMOTE HEALTH

MANAGEMENT STRATEGIES – FOCUSING ON DEMENTIA

PHYSICAL HEALTH PROMOTION

SOCIAL OPPORTUNITIES

ASSISTIVE TECHNOLOGY

NUTRITION

RECREATIONAL OPPORTUNITIES

PRINCIPLES OF HEALTH PROMOTION AND DISEASE PREVENTION

- Early detection and accurate bio-socio-psycho model diagnosis, identifying impairments and functional decline, setting health priorities.
- Identifying certain concerns, needs, and expectations also of the paid (i.e., therapists) and unpaid care givers (family).
- Determining variety or option of interventions, and defining the optimal outcome. Look for the issues, barriers, and risk factors that might cause or influence the outcomes.
- Evaluating the success or failure and the impact of the intervention.
- Keep integrity in paperwork reports and documents (be precise and be honest).
- Developing and increasing access to health, social, leisure, job, transportation, and community services.
- Maintain personal and professional ethics all time.

PRACTICAL RECOMMENDATIONS

- Early detection by health check (fecal occult blood, bone density, cervical/breast/prostate cancer).
- Promotes the engagement in PA, outdoor recreational activities, and social opportunities.
- Support for healthy behavior in life style: personal hygiene, balanced diet, avoid smoking and alcohol.
- Social and recreational resources should be constructed. Young volunteers between the ages of 15 and 21 years old should be recruited from neighboring schools to increase function and fun and to socialize with the individual and their families.
- Multisensory environment such as Snoezelen using lighting effects, color, sounds, music, scents, etc. relaxing atmosphere should be provided.

Development of a frailty index for older people with intellectual disabilities: Results from the HA-ID study

Josje D. Schoufour^{a,*}, Arnold Mitnitski^b, Kenneth Rockwood^b,
Heleen M. Evenhuis^a, Michael A. Echteld^a

^a *Intellectual Disability Medicine, Department of General Practice, Erasmus University Center Rotterdam, P.O. Box 2040, 3000 CA Rotterdam, The Netherlands*

^b *Department of Medicine (Geriatric Medicine), Dalhousie University, Halifax, Nova Scotia, Canada*

Research in Developmental Disabilities 34 (2013) 1541–1555

- (1) physical activity and fitness,**
- (2) nutrition and nutritional state,**
- (3) mood and anxiety.**

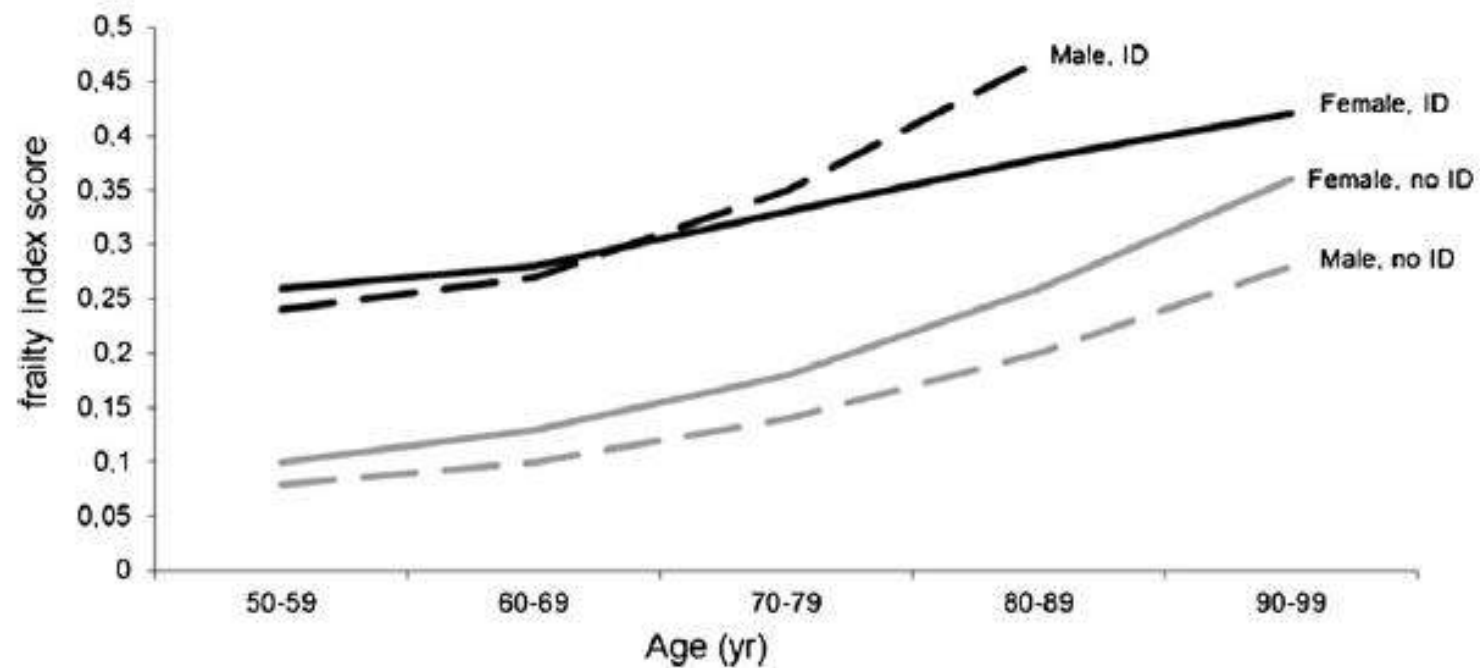


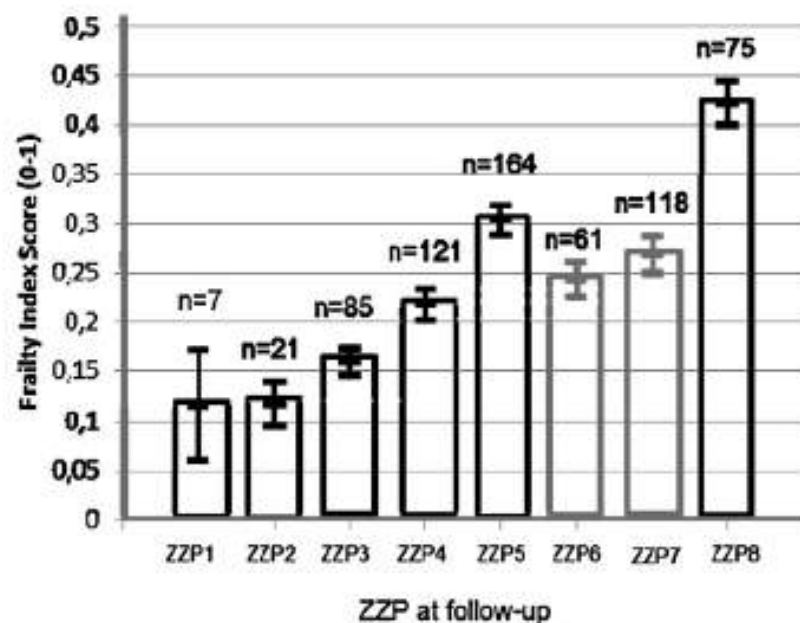
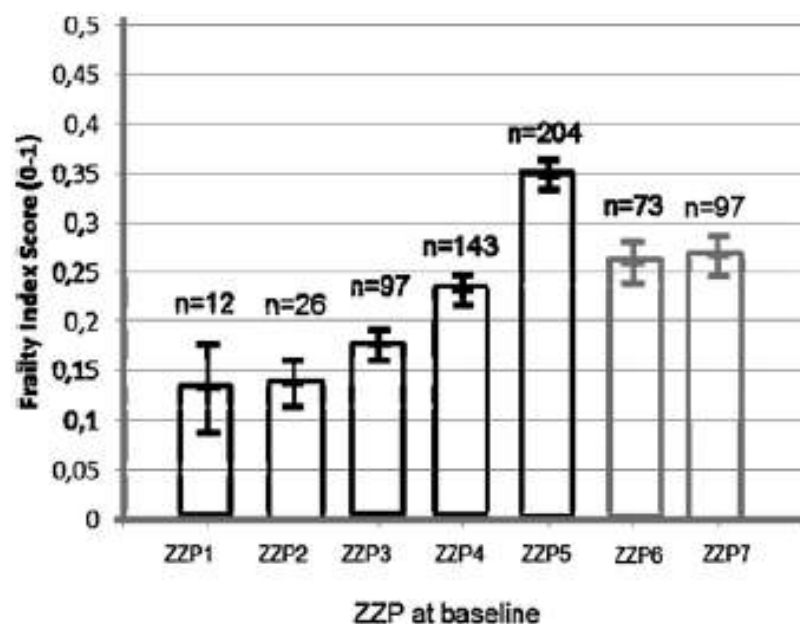
Table 1

ZZP classification in intellectual disability care (College voor Zorgverzekeringen, 2013; Per Saldo 2012).

ZZP	Content ZZP classification	Allocated annual budget (2013) ^a
ZZP 1 VG	Residence with minimal support	€30,768–
ZZP 2 VG	Residence with support	€36,671–
ZZP 3 VG	Residence with support and care	€42,040–
ZZP 4 VG	Residence with support and intensive care	€46,286–
ZZP 5 VG	Residence with intensive support and intensive care	€59,415–
ZZP 6 VG	Residence with intensive support, care and regulation of behavior	€55,776–
ZZP 7 VG	Residence (if necessary enclosed) with very intensive support, care and regulation of behavior	€74,530–
ZZP 8 VG	Residence with support and full care and nursing	€65,509–

Note. ZZP (in Dutch = Zorg Zwaarte Pakket) are care intensity packages.

^a Gross personal budget per person per year without transport costs.



The use of a frailty index to predict adverse health outcomes (falls, fractures, hospitalization, medication use, comorbid conditions) in people with intellectual disabilities

Josje D. Schoufour^{a,*}, Michael A. Echteld^a, Luc P. Bastiaanse^{a,b},
Heleen M. Evenhuis^a

^a *Intellectual Disability Medicine, Department of General Practice, Erasmus University Center Rotterdam, P.O. Box 2040, 3000 CA Rotterdam, The Netherlands*

^b *Ipse de Bruggen, P.O. Box 2027, 2470 AA Zwammerdam, The Netherlands*

Research in Developmental Disabilities 38 (2015) 39–47

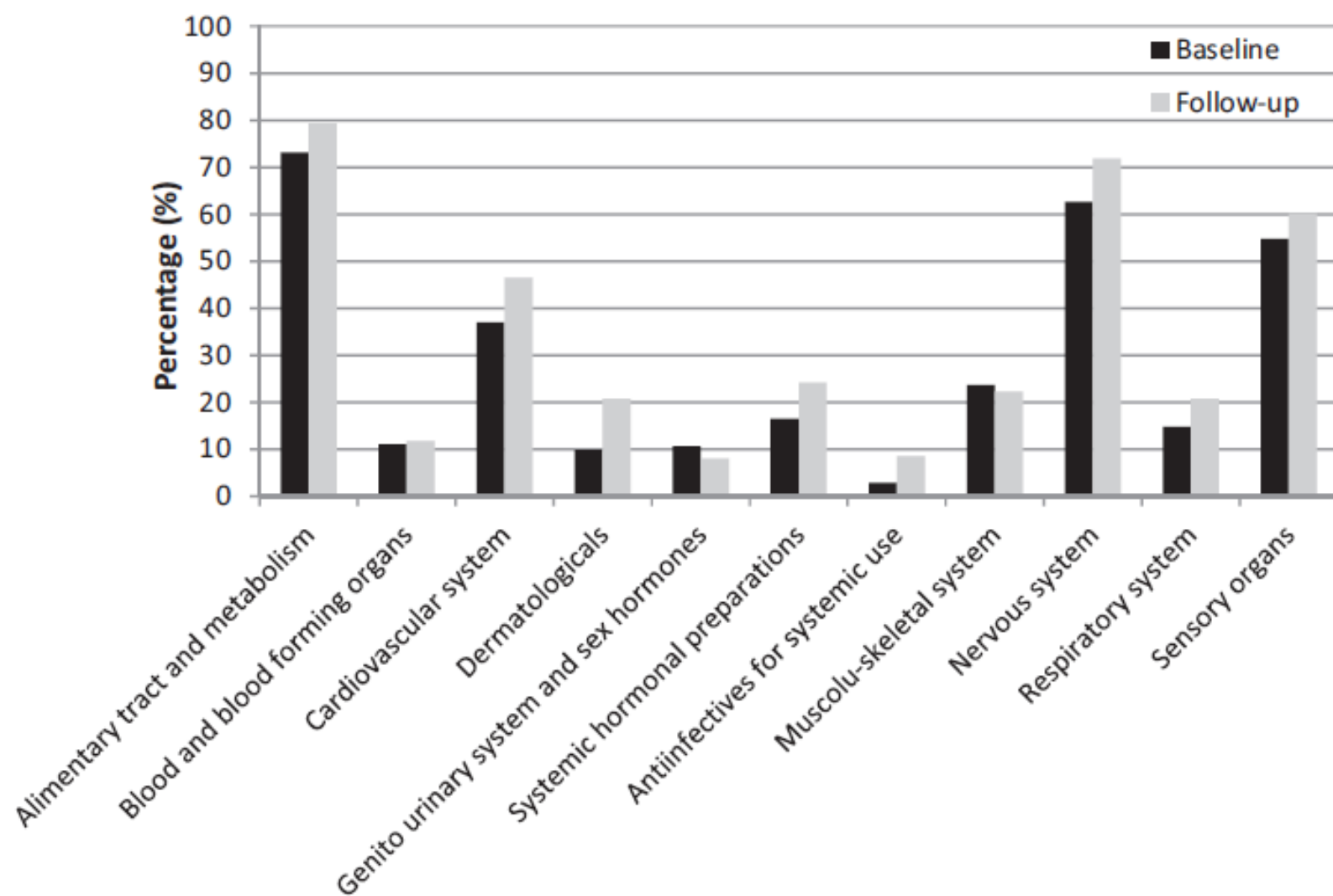
Three-year outcomes associated with the frailty index.

Outcome	n (events)	Model	OR/B (95%CI)	p-value	R ²
Falls	597 (148)	Unadjusted	1.01 (0.99–1.02)	.23	0.004
		Adjusted ^a	1.01 (0.98–1.03)	.54	0.15 ^{b,c,d}
Fractures	617 (97)	Unadjusted	1.00 (0.98–1.02)	.62	<0.01
		Adjusted ^a	0.99 (0.97–1.02)	.32	0.09 ^{a,c}
Hospitalization	540 (114)	Unadjusted	1.01 (0.99–1.03)	.38	<0.01
		Adjusted ^a	1.01 (0.99–1.03)	.49	0.03
Medication use	601 (NA)	Unadjusted	0.14 (0.12–0.16)	<.001	0.21
		Adjusted ^a	0.07 (0.04–0.09)	<.001	0.44^c

In conclusion, we demonstrated that frailty, defined as deficit accumulation, is related to negative health outcomes in people with ID, but to a lesser extent than found in the general population.

The frailty index is not suitable as a tool to predict admission to general hospitals and falls in this group.

The low explained variance of the models implies that specific (individual) problems may be more important risk factors than a measure of general health, such as the frailty index. The frailty index did predict an increase in medication use.



Doppia diagnosi

Dual diagnosis

Toward Impacting Medical and Psychiatric Comorbidities in Persons with Intellectual/ Developmental Disabilities: An Initial Prospective Analysis

by **JULIE P. GENTILE, MD; PAULETTE MARIE GILLIG, MD, PhD;
KELLY STINSON, MD; and JEREMY JENSEN, MD**

Dr. Gentile is Professor, Department of Psychiatry, Wright State University, Dayton, Ohio; Dr. Gillig is Professor, Department of Psychiatry, Wright State University, Dayton, Ohio; Dr. Stinson is Administrative Chief Resident, Department of Psychiatry, Wright State University, Dayton, Ohio; and Dr. Jensen is Staff Psychiatrist, Scott Air Force Base, 375 MDOS/SGOW.

Innov Clin Neurosci. 2014;11(11–12):22–26

ID groups combined, n (%)		Mild n (%)	Moderate n (%)	Severe/Profound n (%)	US Population Prevalence, % *
Dementia	15 (10.6%)	8 (53.3%)	2 (13.3%)	1 (6.7%)	13.9
Bipolar	21 (14.9%)	7 (35.0%)	5 (25.0%)	3 (15.0%)	2.6
Autism	23 (16.3%)	6 (30.0%)	7 (35.0%)	4 (20.0%)	1.1
Anxiety	73 (51.8%)	38 (54.3%)	16 (22.8%)	7 (10.0%)	18.1
Psychosis	39 (27.7%)	19 (50%)	8 (21.1%)	4 (10.5%)	1.1
Depression	31 (22.0%)	16 (53.3%)	7 (23.3%)	3 (10.0%)	8.0

NATIONAL ASSOCIATION FOR THE DUALY DIAGNOSED



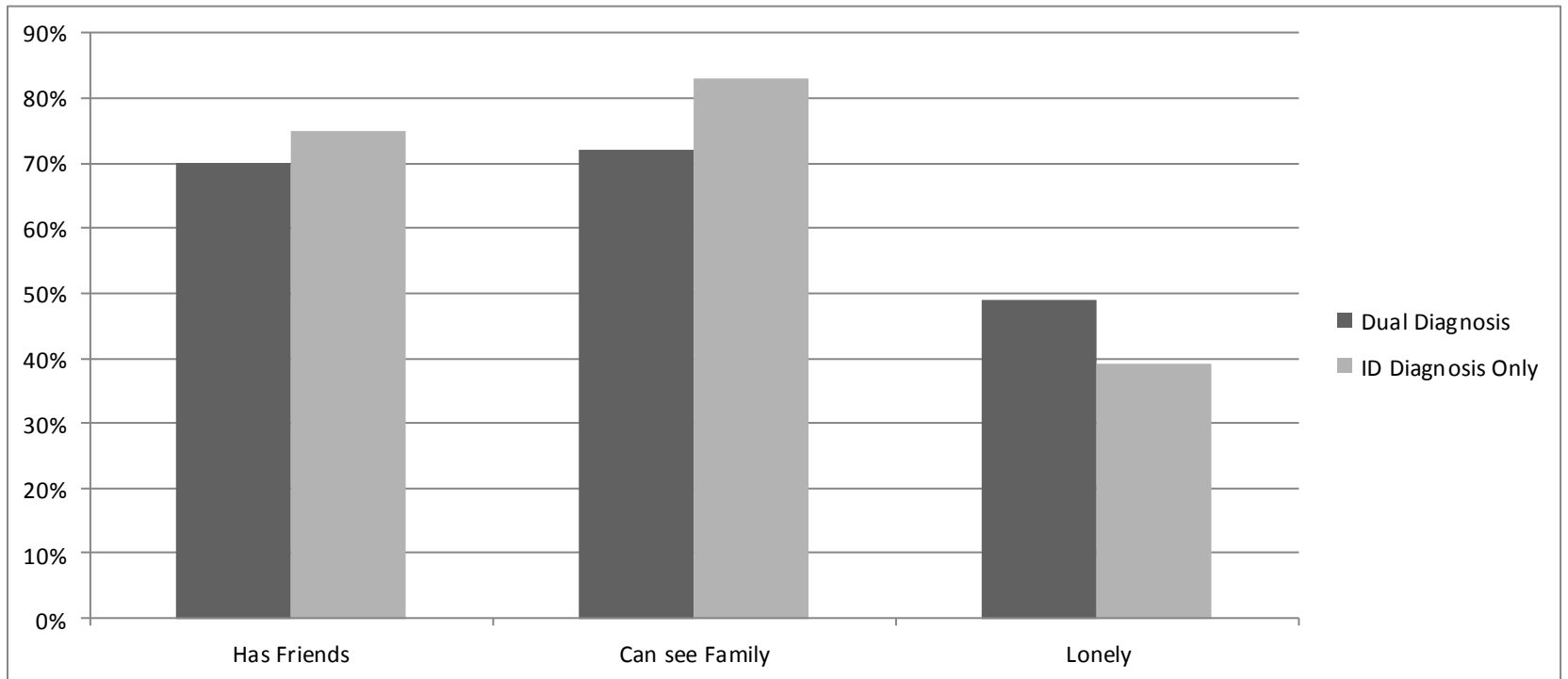
Characteristics of Persons with ID/MH

Employment (community job)

	Hours worked in 2 weeks	Amount earned in two weeks	Hourly Wage	Earning at or above minimum wage (%)	Length at current job
Dual Diagnosis	30.6	\$170	\$5.81	35%	56 months
ID Only	31.5	\$201	\$6.40	43%	66 months

Characteristics Of Persons With ID/MH

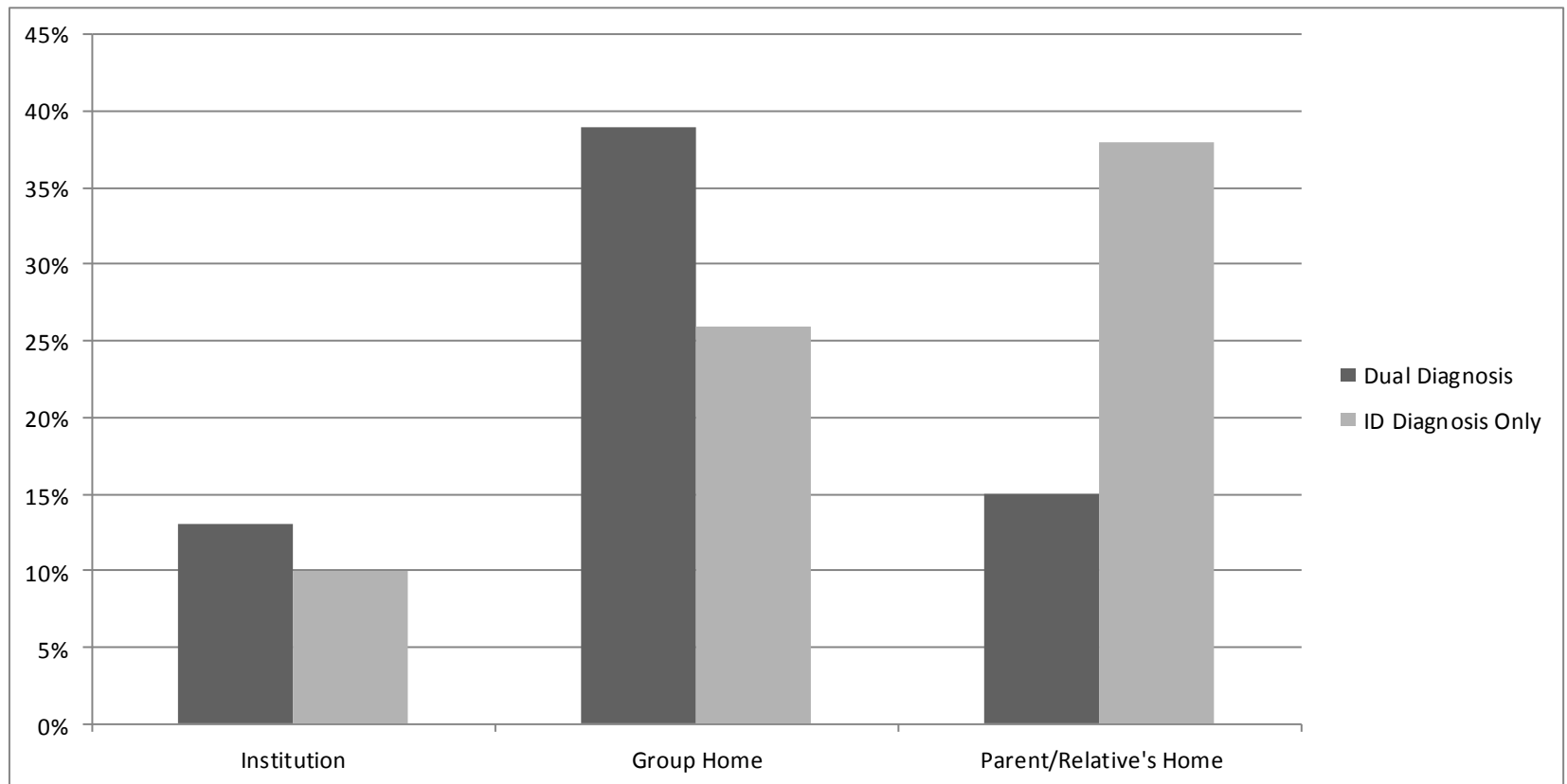
Relationships



NCI Survey Report, 2010

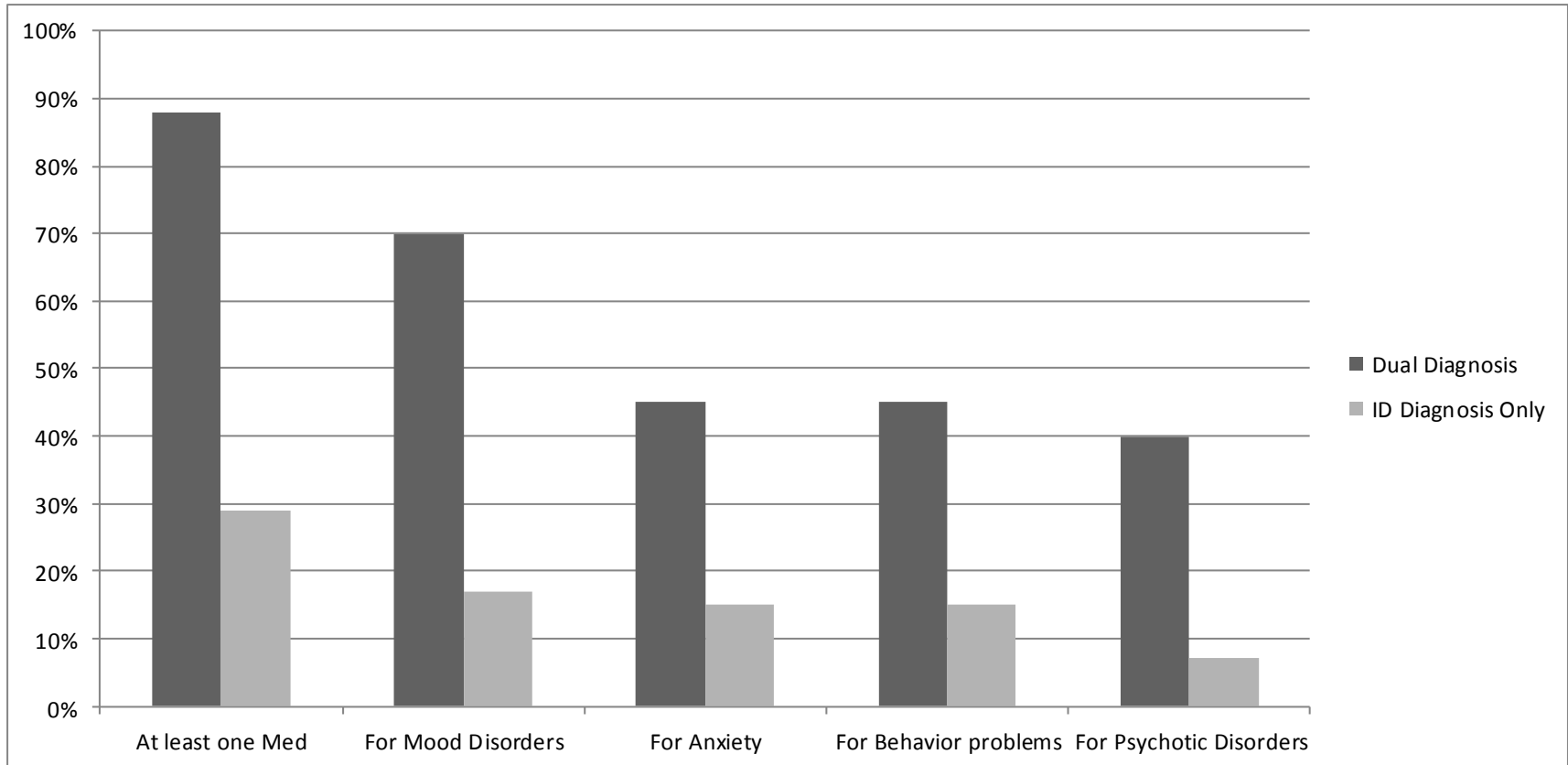
Characteristics of Persons with ID/MH

Type of Residence



Characteristics of Persons with ID/MH

Use of Psychotropic Medications



NCI Survey Report, 2010

Vulnerability Factors

Persons with ID are at increased risk of developing psychiatric disorders due to complex interaction of multiple factors:

- **Biological**
- **Psychological**
- **Social**
- **Family**

Royal College of Psychiatrists, 2001

Vulnerability Factors

Vulnerability factors for psychiatric disorders

Biological

- Brain damage/epilepsy
- Vision/hearing impairments
- Physical illnesses/disabilities
- Genetic/familial conditions
- Drugs/alcohol abuse
- Medication/physical treatments

Royal College of Psychiatrists, 2001

Vulnerability Factors

Vulnerability factors for psychiatric disorders

Psychological

- Rejection/deprivation/abuse
- Life events/separations/losses
- Poor problem solving/coping strategies
- Social/emotional/sexual vulnerabilities
- Poor self-acceptance/low self-esteem
- Devaluation/disempowerment

Vulnerability Factors

Vulnerability factors for psychiatric disorders

Social

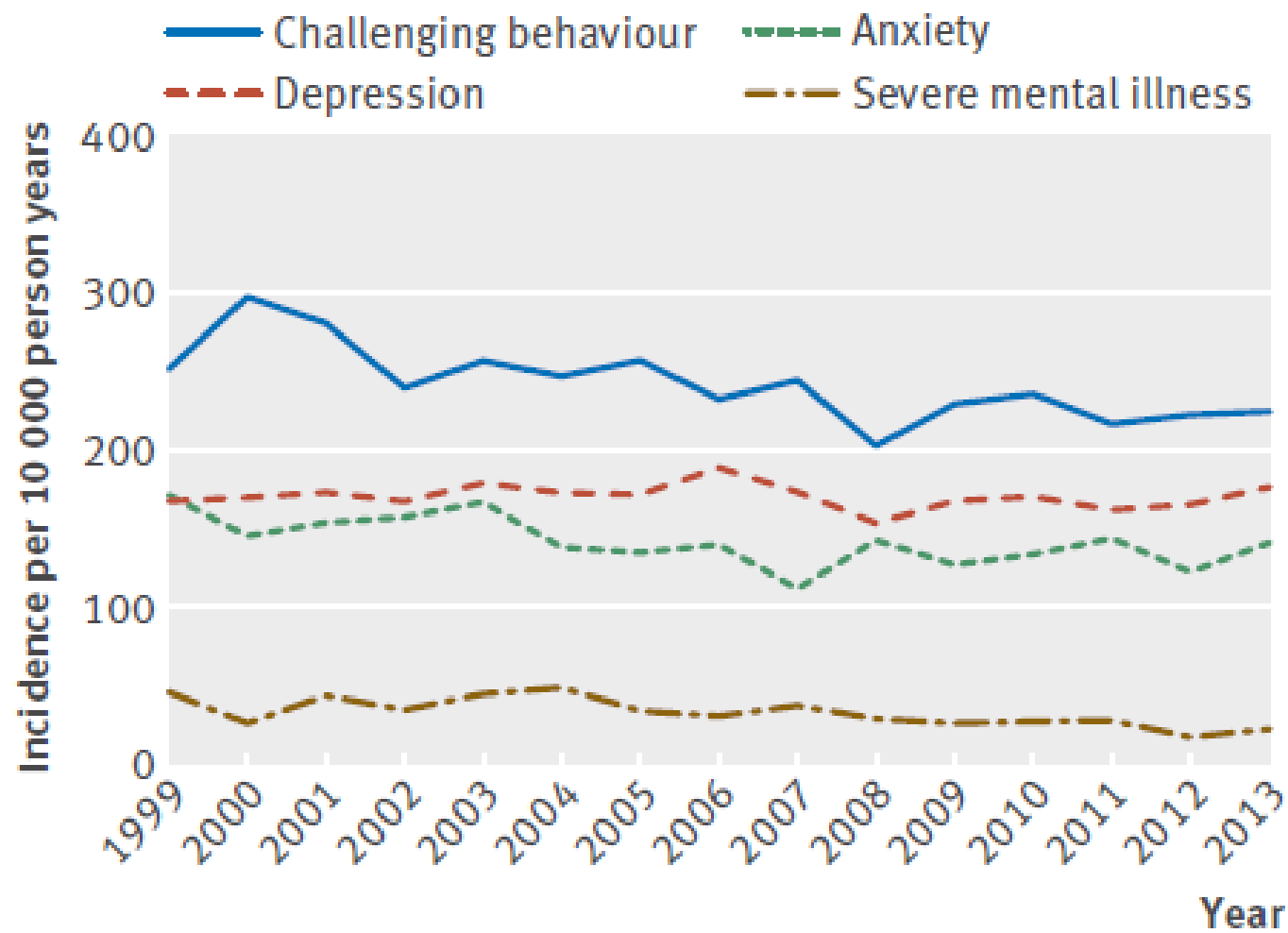
- Negative attitudes/expectations
- Stigmatization/prejudice/social exclusion
- Poor supports/relationships/networks
- Inappropriate environments/services
- Financial/legal disadvantages

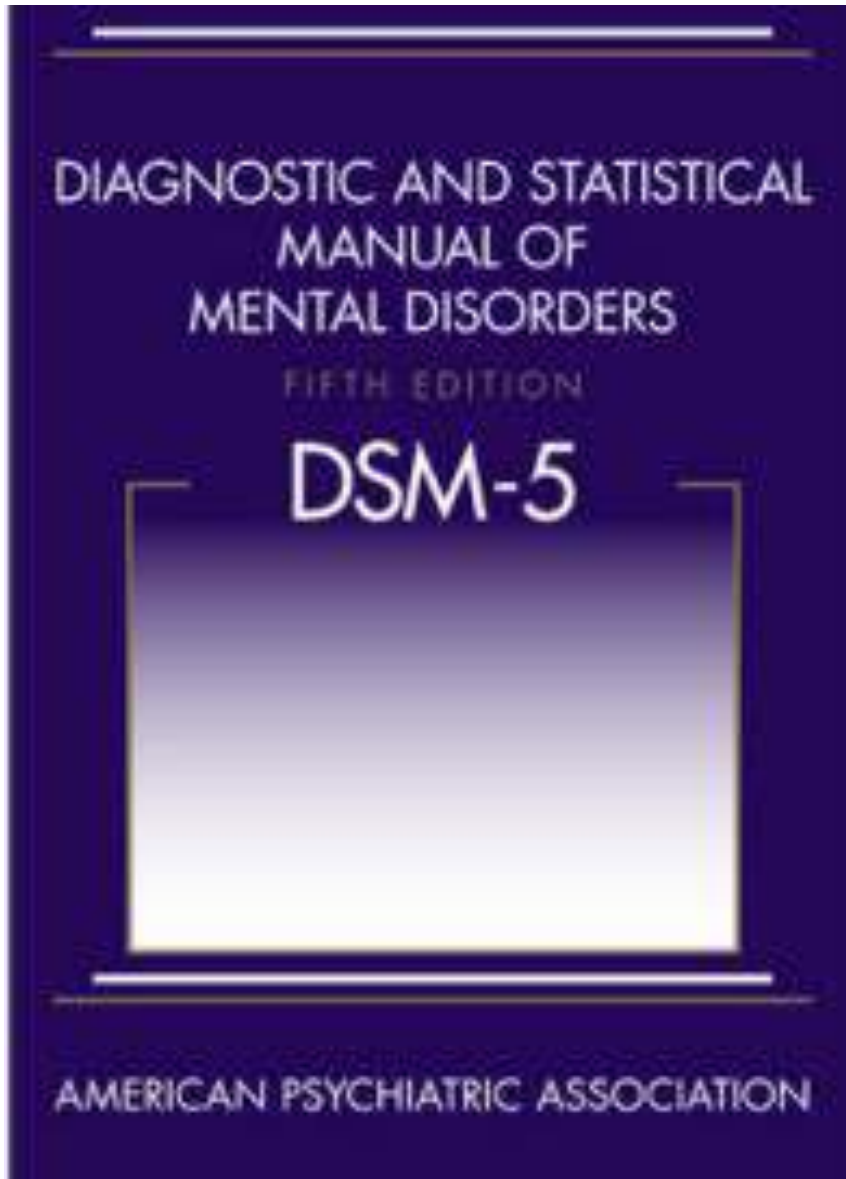
Vulnerability Factors

Vulnerability factors for psychiatric disorders

Family

- Diagnostic/bereavement issues
- Life-cycle transitions/crises
- Stress/adaptation to disability
- Limited social/community networks
- Difficulties "letting go"





Alcuni esempi...

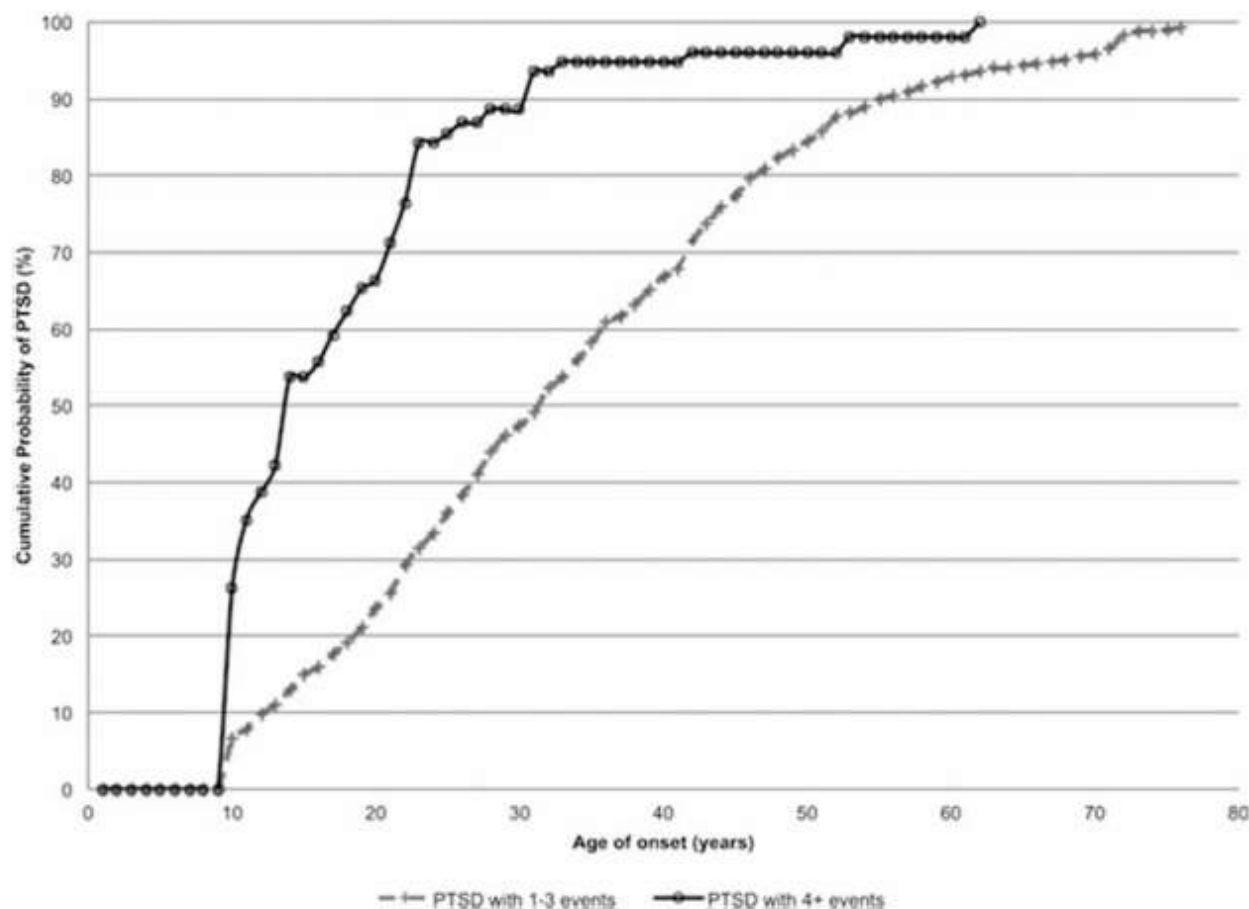
Disturbo delirante: le allucinazioni, se presenti, non sono preminenti e sono correlate al tema delirante (es. sensazione di essere infestato da insetti associata ai deliri di infestazione)

Disturbo psicotico breve:
durata < 1 mese

Disturbo schizofreniforme:
1 mese < durata < 6 mesi

Psicotraumatologia delle
figure genitoriali di
disabili

CUMULATIVE TRAUMAS AND RISK THRESHOLDS: 12-MONTH PTSD IN THE WORLD MENTAL HEALTH (WMH) SURVEYS



The impact of Prader–Willi syndrome on the family's quality of life and caregiving, and the unaffected siblings' psychosocial adjustment

M. M. Mazaheri,¹ R. D. Rae-Seebach,² H. E. Preston,³ M. Schmidt,³ S. Kountz-Edwards,³ N. Field,³ S. Cassidy⁴ & W. Packman³

1 San Diego Functional Restoration Program, San Jose, CA, USA

2 Olivia's Place Pediatric Therapy Center, Shanghai, China

3 Pacific Graduate School of Psychology, At Palo Alto University, Palo Alto, CA, USA

4 Department of Pediatrics, University of California, San Francisco, CA, USA

**92% dei fratelli evidenziava
sintomi post-traumatici**

Una caratteristica del potere dis-integrante dell'esperienza traumatica è la difficoltà o l'impossibilità di dare ad essa un **significato unitario e coerente.**

Ma cosa accade se chi dovrebbe sostenere vicendevolmente il riconoscimento e la condivisione delle sofferenze, delle fatiche e degli affetti permettendo lo sviluppo di un senso sufficiente di sicurezza è anche la persona che attiva il sistema motivazionale di difesa?

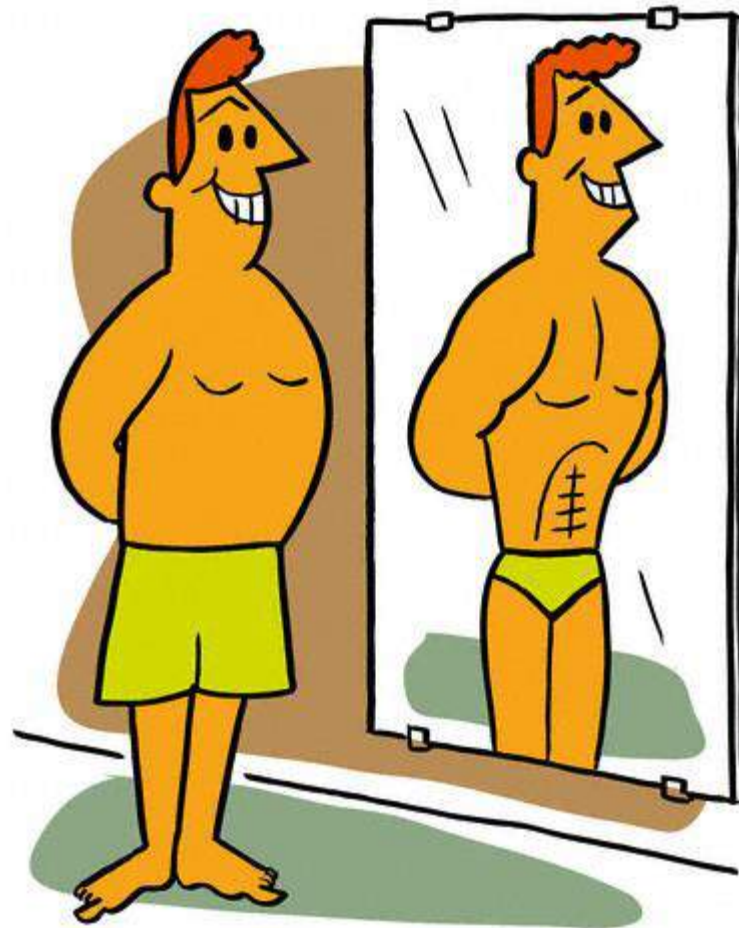
La vergogna è legata ad una mancata **"connessione emotiva"**, che deriva dal tentativo del genitore di raggiungere uno stato di **sintonizzazione affettiva** con il bambino che, però, non vi risponde.

Interazioni che inducono emozioni di vergogna e che non sono seguite da riparazioni nella comunicazione genitore-figlio, o che sono accompagnate da manifestazioni di rabbia da parte del bambino, portano all'instaurarsi di stati di umiliazione che impediscono una adeguata validazione emotiva.

Alcuni comportamenti dei bambini, come ascoltare il genitore, empatizzare con lui, mostrare piacere nello stare insieme o permettere di gratificarlo, permettono al genitore di **sentirsi amabile e accettabile**.

Attraverso l'approvazione e la condivisione di emozioni di gioia il comportamento del bambino permette al genitore di sviluppare un senso di **sicurezza interpersonale**, favorendo lo sviluppo di una percezione di sé come di una **persona valida e competente**.

Il senso di inferiorità può derivare dal sentirsi trattato come debole e incapace, messaggio che può derivare da segnali svalutanti che fanno sentire il genitore non attraente, e che, nel futuro, potrebbe influenzare le sue modalità di gestione dei conflitti.





Tema del salvatore

**Triangolo
drammatico**

Liotti (1999)

**Importanza di
sé e/o
dell'altro
(tema della
vittima)**

**Tema del
persecutore**

Cognitività e disabilità

Gli interventi di rimedio cognitivo possono essere classificati secondo due principali modelli:

✓ **compensatorio**



✓ **riparativo/restorativo.**



A computer-based interactive game to train persons with cognitive impairments to perform recycling tasks independently

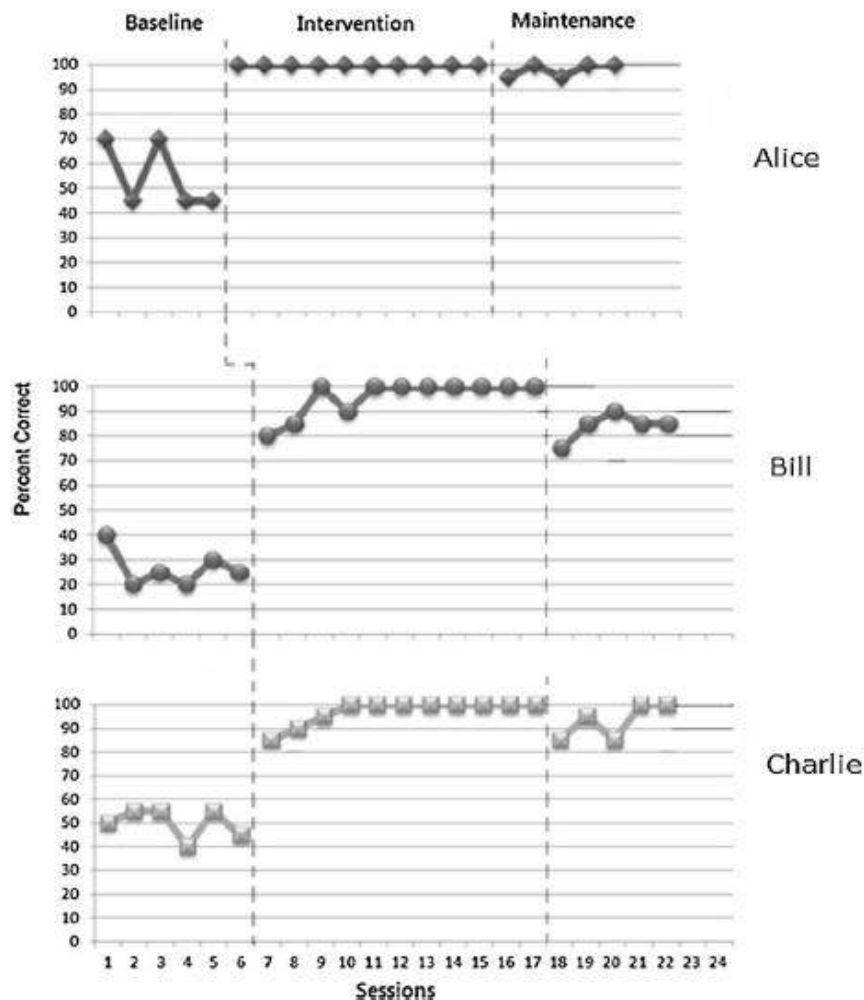
Yao-Jen Chang^{a,c,*}, Ya-Shu Kang^b, Fang-Lin Liu^a

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- ✓ Immersività
- ✓ Impersonalità

Using Virtual Reality to Provide Health Care Information to People With Intellectual Disabilities: Acceptability, Usability, and Potential Utility

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J Med Internet Res. 2011 Oct-Dec; 13(4): e91.

This study assessed the acceptability, usability, and potential utility of a virtual reality experience as a means of providing health care-related information to people with intellectual disabilities. We designed a prototype multimodal experience based on a hospital scenario and situated on an island in the Second Life 3D virtual world.

The effectiveness of working memory training with individuals with intellectual disabilities – a meta-analytic review

Henrik Danielsson^{1,2}, Valentina Zottarel³, Lisa Palmqvist^{1,2} and Silvia Lanfranchi^{3*}*

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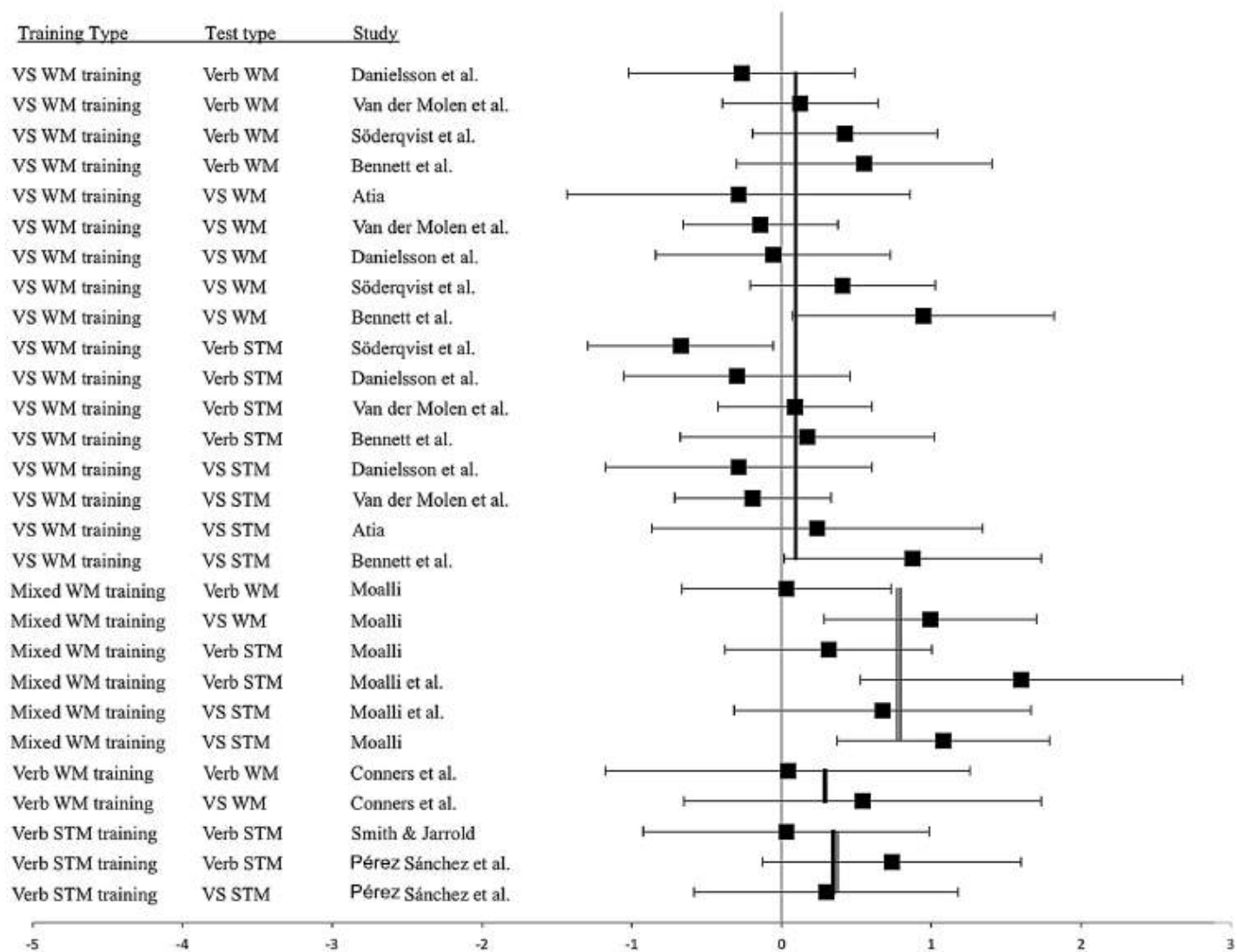


FIGURE 3 | Forrest plot for training group minus control group ESs sorted by type of training and test type. The overall ES for each training type is displayed by a line. Type of training and type of test are listed in the two left columns.

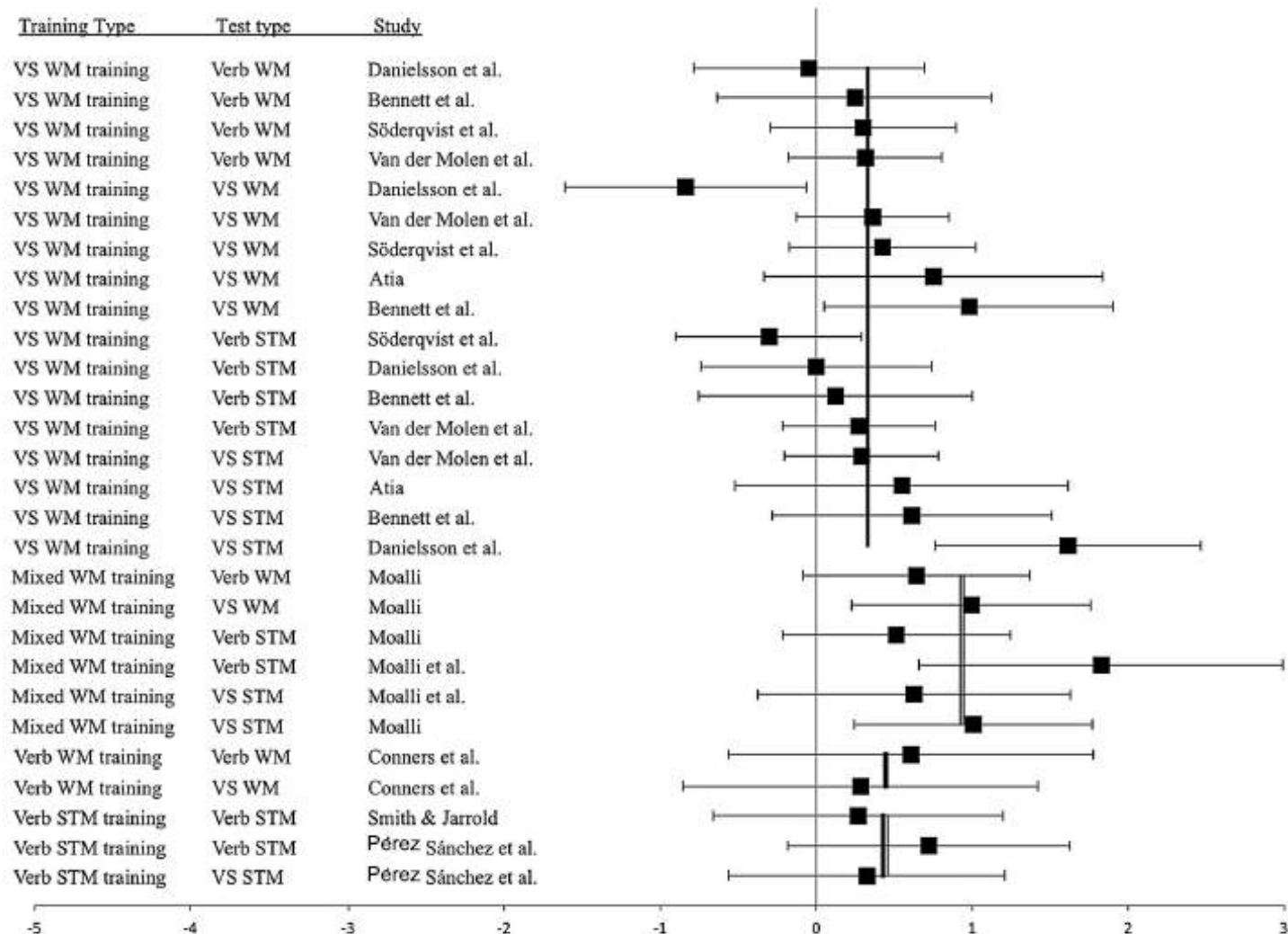


FIGURE 2 | Forrest plot for training group post-test minus pre-test effect sizes (ESs) sorted by type of training and test type. The overall ES for each training type is displayed by a line. Type of training and type of test are listed in the two left columns.

A Meta-Analysis of Cognitive Remediation in Schizophrenia

Susan R. McGurk, Ph.D., Elizabeth W. Twamley, Ph.D., David I. Sitzer, Ph.D., Gregory J. McHugo, Ph.D., and Kim T. Mueser, Ph.D.

Dartmouth Psychiatric Research Center, the Department of Community and Family Medicine, and the Department of Psychiatry, Dartmouth Medical School; the Department of Psychiatry, University of California, San Diego; and the School of Psychology, Argosy University, Santa Monica, Calif

Una recente metanalisi di McGurk et al. (2007) ha evidenziato come i programmi di rimedio cognitivo che includono tecniche di apprendimento basate sull'elaborazione di strategie (**ri-apprendimento**) e sulla ripetizione di compiti (**ri- allenamento**) e che insegnano abilità di **problem solving**, basate sull'apprendimento di strategie (**strategy coaching**) da applicare nella vita quotidiana, hanno effetti più marcati sul funzionamento di quelli focalizzati solo su esercizi di tipo istruzione ed esercitazione.

Computer aid training -> metodo di ascolto ed osservazione

- ✓ **Valutazione non corretta dei bisogni e delle potenzialità del paziente**
- ✓ **Errore di programmazione della terapia**
- ✓ **Scelta di una strategia non adeguata**
- ✓ **Modello terapeutico (anche e soprattutto farmacologico) incongruente**

Take home message 1.

- ✓ Adozione di criteri condivisi per deterioramento/declino cognitivo e programmi di screening
- ✓ la salute fisica è importante tanto quanto lo è per esempio, per i DCA (-> ne influenza il comportamento e non può limitarsi ad un solo problema di comunicazione)
- ✓ Sviluppare criteri di valutazione funzionale "operativi" (=daily life)
- ✓ Follow-up "ravvicinati" degli outcomes clinici per valutare il mantenimento a lungo termine delle strategie apprese ed intervenire preventivamente in caso di insorgenza di problematiche cognitive e/o comportamentali
- ✓ Acquisizione di informazioni cliniche ed ambientali sul life course del disabile.

Take home message 2.

- ✓ essere un familiare di un ragazzo con ID non vuol dire solo essere un genitore più stressato rispetto alla media dei genitori, ma significa sviluppare delle competenze emotive e comportamentali qualitativamente peculiari.
- ✓ il caregiving del ragazzo con ID deve comprendere anche la le modalità di relazione con la famiglia in senso biunivoco
 - ✓ rischio di sintomi post-traumatici del genitore/ragazzo che si manifestano quando quest'ultimo diventa adolescente/adulto.

***Non è mai troppo
tardi per un
intervento precoce
nell'adulto***



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*Grazie per
l'attenzione*