

AFFECTIVE DISORDERS IN COMPLEX DISABILITIES: STRATEGIES EMPOWERMENT FOR IMPROVING THE LIFESTYLE OF THE DISABLED PERSON

Chiara Tinarelli¹, Alessandro Lepri^{1,2}, Guido Camanni¹, Antonella Baglioni¹, Marina Menna¹,
Silvia Ilicini¹, Gianni Lanfaloni¹, Maria Grazia Rossi¹ & Sandro Elisei^{1,2}

¹Serafico Institute, Viale Guglielmo Marconi, Assisi, Italy

²Department of Philosophy, Social and Human Sciences and Education, University of Perugia, Perugia, Italy

SUMMARY

The concept of physical and intellectual disability has experienced a series of changes and evolutions over time with regard to approach, classification and rehabilitation-therapeutic programs, since it contemplates a heterogeneous clinical phenomenology in terms of severity, complexity, pervasiveness and severity of the diagnosis. The significant repercussions on the quality of life mean that a comprehensive approach is required with attention to the physical, social, emotional, sensory and cognitive profile, and that there is a need for the adoption of classification systems and assessment tools that are different and in some ways pioneering, so as to guarantee the surpassing of the concept of disability as a "mere defect" physical and/or impairment and/or loss of psychological, physiological or anatomical function (Holden & Gitlesen 2003, Linden 2017, WHO 2001). It is exactly in contemplation of a bio-psycho-social model, that the International Classification of Functioning, Disability and Health (ICF) arises, which possesses a neutral position with respect to etiology and a complementarity with the ICD-10 classification (WHO 2001), since it allows the functional diagnosis (i.e. a specialized analytical description of the potential and deficits in relation to the pathology) proposing a detailed analysis of the possible social consequences of disability by evaluating the residual capacities and measuring the "social skills" (WHO 2001).

Key words: disability - complex disability - intellectual disability – affective disorders -empowerment strategies

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The concept of disability, particularly intellectual disability has been subject to numerous revisions over

time. The AAMR (American Association on Mental Retardation) defines mental retardation as a disability characterized by significant limitations in both intellectual functioning and adaptive behavior with onset in childhood with impairment of the global level of intelligence, in terms of cognitive, language, motor and social skills in association or not with other mental or somatic disorders (Blacher & Baker 2002). In the transition between DSM-IV and DSM-5, the term "mental retardation" was officially replaced by "intellectual disability" and three criteria must be achieved for its proper diagnosis: a deficit in intellectual function, a deficit in adaptive behavior such that it results in failure to meet sociocultural developmental standards, and an onset of the deficit in intellectual function and adaptive behavior during the childhood (APA 2013).

Intellectual disability does not seem to be simply attributable to a disorder or a disease, nor to a unique condition of disability but rather to a meta-syndromic cluster (Bertelli et al. 2011, 2010) in turn included in neurodevelopmental disorders, whose prevalence worldwide is between 1% and 4% (Durkin 2002). The high psychopathological vulnerability of these individuals (Bertelli et al. 2011, Clarke et al. 2002) contributes to the high prevalence of psychiatric disorders, in intellectual disability is far higher than in the normal patient (Mevissen & De Jongh 2010), with rates up to four times higher and with earlier onset (Bertelli 2019, Bertelli et al. 2010, Clarke et al. 2002, Cooper et al.

2007). Some studies indeed show that 25-44% of individuals with intellectual disabilities have at least one psychiatric disorder (Bertelli 2019, Clarke et al. 2002, Cooper et al. 2007, Holden & Gitlesen 2003). The prevalence of psychopathology increases further in cases where criteria for an autism spectrum disorder are satisfied in conjunction with criteria for intellectual disability (Bertelli 2019, Clarke et al. 2002), although there is actually no univocity on prevalence data (Bertelli 2019, Borthwick-Duffy & Eyman 1990) due to the difficult interpretation of the atypical presentation of psychiatric signs and symptoms of the intellectually disabled and the discordance of diagnostic criteria, as well as communication deficits, resulting in the risk of underestimation (Bertelli 2019, 2010). Indeed, there is a high risk of confusing the psychiatric symptom (diagnostic adumbration) with the characteristic manifestations of the diagnosis of intellectual disability (Bertelli 2019, Borthwick-Duffy & Eyman 1990, Holden & Gitlesen 2003), such that making the diagnosis of psychiatric illness in patients with intellectual disability continues to be a real challenge for clinicians (Hurley 2008).

That is because cognitive impairment can somewhat mask some psychiatric signs and exacerbate others (Bertelli 2019, Bertelli et al. 2011), making it difficult to discriminate the psychiatric symptom from that characteristic of intellectual disability (Bertelli 2019, Bertelli et al. 2011, Holden & Gitlesen 2003). It is inferred, for example, that the rate of unipolar depression in intellectual disability is about 3.8%, that of bipolar disorder around 1.9%, manic episodes at 0.6%, while the rate of anxiety disorders is 3.5% (Alexander & Cooray 2003, Clarke et al. 2002, Cooper et al. 2007, Durkin 2002, Hurley 2008, Mevissen & De Jongh 2010). Notably, the incidence of bipolar disorder would appear to be as much as double that of the normotyped individual (Cain et al. 2003, Campbell et al. 2014) and psychotic disorders from 2.6% to 4.4% (Clarke et al. 2002, Cooper et al. 2007, Durkin 2002, Morgan et al. 2008).

The extreme underlying psychopathological vulnerability of these individuals, which leads to an increased risk of mood disorders, actually recognizes either biological causes (Clarke et al. 2002) (e.g., some genetic syndromes implicate the risk of developing psychiatric symptoms), socio-environmental factors such as social exclusion (Bertelli et al. 2011), or psychological factors, such as poor coping strategies and awareness of reduced opportunities for achievement (Bertelli et al. 2011). Given the atypical symptomatology (Bertelli et al. 2011) and the difficulty in making a diagnosis (for example, due to the inapplicability of scales for the assessment of the normally impaired) there is an increasing need for other clinical supports for the semeiological assessment, such as the interpretation of sudden changes from previous levels of functioning or the interpretation of

the loss of linearity in problem behaviors (Rojahn & Meier 2009, WHO 2001, Wieseler & Hanson 2005), through the study of functional analysis of behavior (Rojahn & Meier 2009, Wieseler & Hanson 2005). Indeed, problem behaviors (i.e., those behaviors defined as destructive, damaging to social interaction, dangerous and inappropriate) in the intellectually disabled generally have a precise function (both self-regulatory and communicative) which can be investigated and studied through the functional analysis of behavior (Rojahn & Meier 2009, WHO 2001, Wieseler & Hanson 2005) to acquire data in order to describe the variables that preserve the behavior (Rojahn & Meier 2009, Wieseler & Hanson 2005) and thus be able to set a proactive intervention (Rojahn & Meier 2009). Some of the literature argues that the individual with an intellectual disability has prevalence rates of problem behaviors ranging from 9.9% to 16.7% (Lowe et al. 2007). Occasionally, some correlation between exacerbation of problem behavior and the onset of a mood disorder would seem probable, although the literature is discordant (Lowe et al. 2007, Melville et al. 2016, Rojahn & Meier 2009). Some authors argue that problem behavior should be interpreted only as a nonspecific indicator of emotional distress and not as a frank symptom of a depressive and/or manic episode (Rojahn & Meier 2009) and that ultimately problem behaviors should not be considered "equivalents of psychiatric symptoms" but only an expression of general emotional dysregulation (Melville et al. 2016, Rojahn & Meier 2009).

Regarding treatment approaches, the literature suggests that the use of psychotropic drugs has steadily increased in recent years (Flood & Henman 2021, Sheehan et al. 2015, Stephenson et al. 2013). Obviously, in the context of intellectual disability, the use of psychopharmaceuticals is more complex due to the frequent concomitant assumption of medications for organic conditions as well.

In addition, individuals with this diagnosis, are unable to verbalize the unwanted and adverse effects of the drugs taken and neither the effectiveness and often respond in atypical and unpredictable motion to drug therapies (Stephenson et al. 2013, Sullivan et al. 2011). The literature also shows that many individuals are treated with antipsychotics not so much for an underlying diagnosis of psychiatric pathology but for containment of hetero and autoaggressive acts (Sheehan et al. 2015, Wieseler & Hanson 2005).

Regarding nonpharmacological strategies, there are effective techniques and methods for both mild and severe disabilities. Regarding mild disabilities, efficacy has been unequivocally demonstrated on psychosocial interventions and communication support (Campbell et al. 2014, Taylor et al. 2008), while the efficacy of the psychotherapeutic approach is compromised due to

deficits in communication and conceptualization (Campbell et al. 2014, Taylor et al. 2008). With regard to mild and severe, multicomponent intervention procedures (which used educational negotiation as the psychoeducational strategy of choice) resulted in a drastic decrease in problematic behavior over time in all study participants (Fioriti et al. 2020). These strategies promote specifically, an increase in daily life commitments, an increase in the skills of participation in activities and in people with "higher functioning", even to a strong increase in the frequency of the request for help in the face of environmental stressors thus facilitating the implementation of the strategy of cognitive restructuring (Fioriti et al. 2020). Thus, it is certainly desirable to achieve synergy of various interventions, contemplating the optimization and rationalization of pharmacological strategies (Fioriti et al. 2020, Sheehan et al. 2015, Wieseler & Hanson 2005) together with other non-pharmacological approaches, such as occupational therapy (Redaelli & Valsecchi 1996) and all those that relate to the multicomponential strategies mentioned above, with consequent positive reverberations both on thymic tone disorders and on the improvement of empowerment (Dan 2020), i.e., that feeling of self-awareness that can be particularly disempowered in intellectual disability.

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Chiara Tinarelli: conception of the manuscript;
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Sandro Elisei: revision of the manuscript.

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Correspondence:

Chiara Tinarelli, MD
Serafico Institute
Viale Guglielmo Marconi, 6, 06081, Assisi, Italy
E-mail: chiaratinarelli@serafico.it