Dal “Coping Power Program”

a

“In ACTion!”

UN NUOVO MODELLO DI CHILD TRAINING PER L’ADHD

Laura Vanzin, Angela Valli, Valentina Mauri,

Massimo Molteni

"Eugenio Medea"
Istituto di Ricovero e Cura
a Carattere Scientifico
Scientific Institute

ASSOCIAZIONE
la Nostra Famiglia
ONLUS

CPP

N= 30

	media	SD
Età	10,3	1,8
QI	97,9	13,1
S.E.S.	54,3	21,6

farmaco	n=3

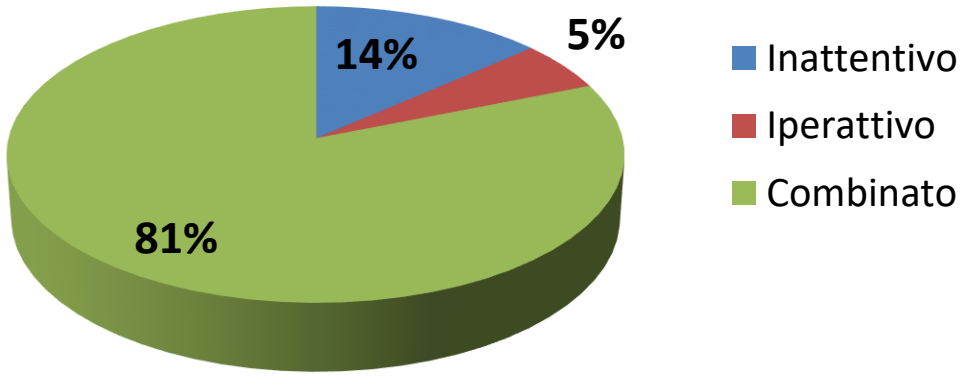
In ACTion!

N= 37

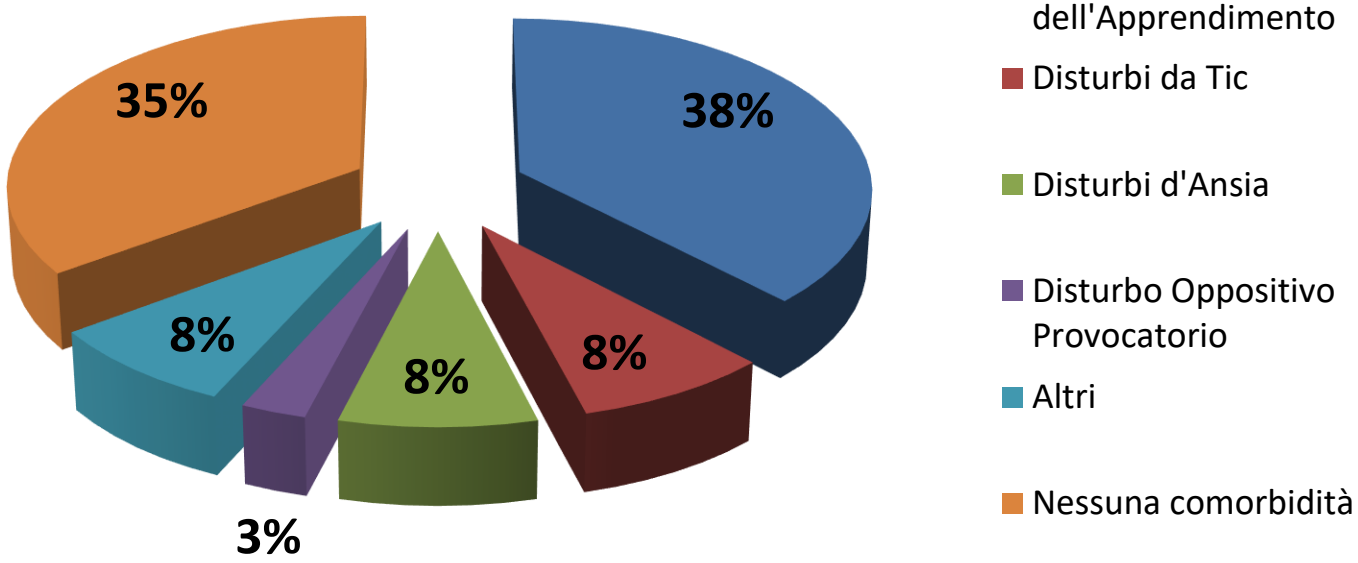
	media	SD
Età	10,6	1,3
QI	98,6	11,2
S.E.S.	58,2	18,3

farmaco	n=3

SOTTOTIPO ADHD



COMORBIDITA’



Disturbo da Deficit dell'Attenzione con Iperattività

- Deficit di autoregolazione
- Peculiarità sistema rinforzo/punizione

AREA MESOLIMBICA e MESOCORTICALE

Ridotto livello di DOPAMINA a livello INTERSINAPTICO

→

Tempi di RISPOSTA NEURONALE accorciati

Il RUMORE DI FONDO non viene filtrato

↓

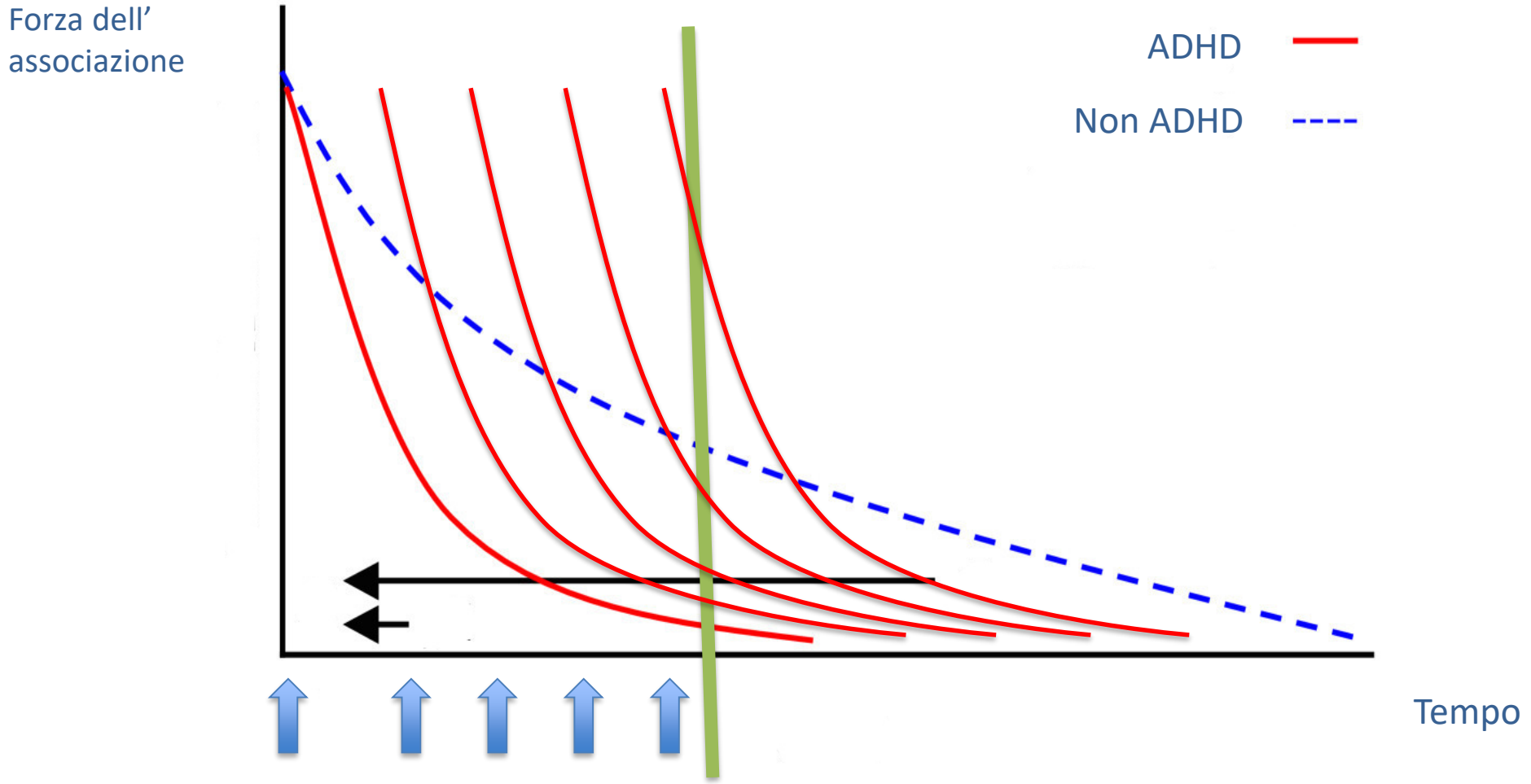
COMPORTAMENTO OSSERVABILE

E' più probabile che il bambino reagisca — RIDUZIONE DEI FILTRI

Lo farà in tempi brevi — RIDUZIONE DEI TEMPI DI RISPOSTA

T.Sagvolden et al., 2005

Alterazione nel sistema di rinforzi/punizioni



T.Sagvolden et al., 2005

…Da **RULE-GOVERNED BEHAVIOR**

- Uno specifico comportamento viene compreso ed influenzato attraverso i fattori che lo precedono (ANTECEDENTI) o lo seguono (CONSEGUENZE)
- Alcuni antecedenti funzionano da regole o istruzioni specificando il comportamento e le sue conseguenze.
- Le regole provengono inizialmente dal contesto, ma gradatamente noi siamo in grado di generare regole personali che influenzano il nostro comportamento (“Ritenta e farai meglio!”) derivandole da esperienze passate.
- I comportamenti controllati da regole sono poco sensibili ai dati di realtà (contingenze dirette) e spesso “resistenti” al cambiamento

…A **COMPORTAMENTO MODELLATO DALLE CONTINGENZE**

- Il comportamento viene controllato dalla relazione tra comportamento e conseguenze dirette

(Catania, 1984; Hayes, 1989; Skinner, 19661974)

ADHD:
SISTEMA DI RINFORZO ALTERATO E
DEFICIT DI ESTINZIONE DEI COMPORTAMENTI PRECEDENTEMENTE RINFORZATI
(Salgvolden et al., 2005)

NECESSITÀ DI TRATTAMENTI BASATI SU CONTINGENCY-GOVERNED BEHAVIOR

TRATTAMENTI BASATI SU RULE-GOVERNED BEHAVIOR

CONTESTO INTERNO ED ESTERNO COME GUIDA PER LE SCELTE

Available online at www.sciencedirect.com
ScienceDirect
Cognitive and Behavioral Practice xx (2014) xxx-xxx
Cognitive and Behavioral Practice
www.elsevier.com/locate/cabp

Mindfulness Meditation Training for Attention-Deficit/Hyperactivity Disorder in Adulthood: Current Empirical Support, Treatment Overview, and Future Directions

John T. Mitchell, *Duke University Medical Center*
Lidia Zylowska, *University of California, Santa Cruz, and University of California, Los Angeles*
Scott H. Kollins, *Duke University Medical Center*

Mindfulness Training: General Overview

Mindfulness-based interventions are part of a "third wave" or "third generation" of behavior therapy (Hayes, Follette, & Linehan, 2004; Hayes, Luoma, Bond, Masuda, & Lillis, 2006). Mindfulness meditation training is derived

Neuroimaging studies suggest that mindfulness meditation engenders neuroplastic changes in brain areas associated with attentional functioning typically impaired in ADHD. For instance, Hölzel and colleagues (2011) discuss the role of the anterior cingulate cortex, which is involved with executive/attentional processes via detection of conflicting incompatible incoming information. Given that this region is also involved with attentional processing in ADHD (e.g., Cubillo, Halari, Smith, Taylor, & Rubia, 2012; Passarotti, Sweeney, & Pavuluri, 2010), it represents a potential target for mindfulness training in ADHD samples.

Values

Incorporation of individualized values, similar to values work in Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 2012), can be helpful in adult ADHD, especially as patients often express concerns of being overcommitted and having trouble prioritizing.

Wednesdays"). In MAPs, values can be used to encourage mindful observation of one's behavior and guide prioritization of actions. Using values, patients can assess how

Acceptance-Change Strategies

An additional adaptation to MAPs, primarily a training in self-awareness and experiential acceptance, involves adding selected mind-body change strategies to encourage patients to further explore redirection (or self-regulation) should they recognize they are distracted or engaged in a maladaptive behavior. This greater emphasis on combining acceptance and change perspectives is consistent with third-wave behavior therapies such as DBT (Linehan, 1993) and ACT (Hayes et al., 2012). These strategies involve

J Child Fam Stud (2015) 24:2174–2181
DOI 10.1007/s10826-014-0020-7

ORIGINAL PAPER

Acting Out to ACTing On: A Preliminary Investigation in Youth with ADHD and Co-morbid Disorders

Amy R. Murrell · Daniel S. Steinberg · Melissa L. Connally · Teresa Hulsey · Erin Hogan

Published online: 15 July 2014

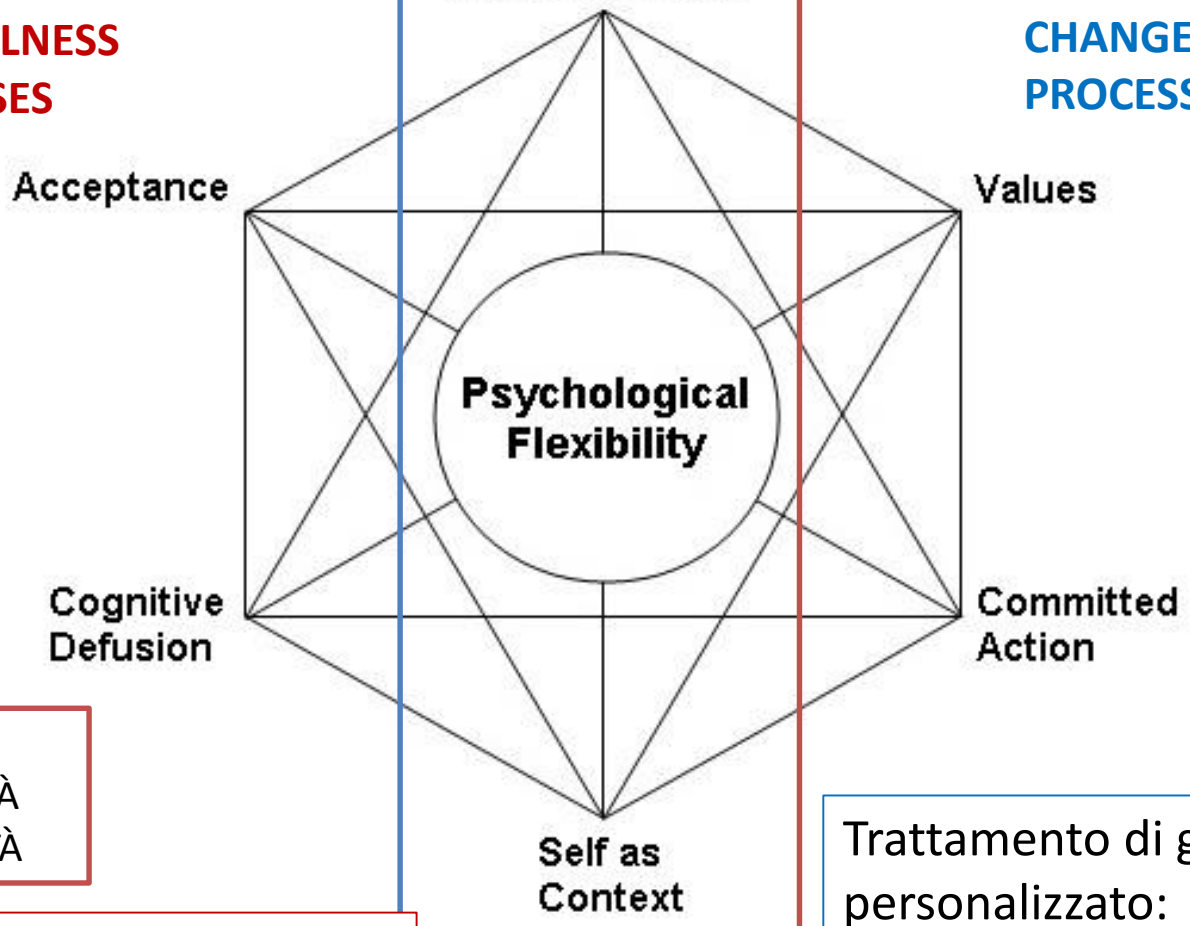
Published online: 15 July 2014
© Springer Science+Business Media New York 2014

Abstract The feasibility of using acceptance and commitment therapy (ACT) to foster increases in congruence between values and behaviors pertinent to those values was evaluated with adolescents. Participants were nine, primarily African American, school aged children (11–15 years) with comorbid attention-deficit/hyperactivity disorder, learning disorders, and behavior problems who were enrolled at a charter school in an urban, South-central area of the United States. Despite some feasibility obstacles, several significant Reliable Change Index scores on the Behavior Assessment Scale for Children—second edition and the Bull's-Eye Values Assessment were found and other results approached statistical significance in the desirable direction. These findings suggest that ACT may be feasible for increasing congruence between values and behavior, and may have potential clinical utility with acceptance and mindfulness based treatments in youth with comorbid psychological and behavioral problems.

Keywords ACT · ADHD · Learning disability · Values · Externalizing

ACCEPTANCE AND MINDFULNESS PROCESSES

COMMITMENT AND BEHAVIOR CHANGE PROCESSES



ATTENZIONE
↓ IPERATTIVITÀ
↓ IMPULSIVITÀ

AUTO-REGOLAZIONE EMOTIVA

Trattamento di gruppo personalizzato:
“Gli interessi ci accomunano”
“Chi sono io”

Eur Child Adolesc Psychiatry
DOI 10.1007/s00787-017-1008-9

REVIEW

Systematic review of meditation-based interventions for children with ADHD

Subhadra Evans[1] · Mathew Ling[1] · Briony Hill[1] · Nicole Rinehart[1] · David Austin[1] · Emma Sciberras[1]

health [28]. A variety of working definitions of meditation exist, some describing a method and others a state [29]. For the purposes of this review, we understand the core, shared features of MI's to involve the cultivation of attention processes that lead to strengthened awareness, presence and a more integrated sense of self [30]. In addition to attention regulation strategies, MI's also typically tend to develop emotion regulation skills, with calmness and contentment commonly co-occurring. This broad definition subsumes a number of Eastern traditions, including physical practices (such as Tai chi and yoga taught in its many lineages), concentrative practices (such as transcendental meditation and mantra meditation), vipassana (mindfulness), metta (loving kindness), and a range of modern day descendants, including acceptance and commitment therapy (ACT), and mindfulness-based stress reduction (MBSR). Inclusion of various meditation styles allows for investigation of common and overlapping elements of MI's, with a broader range of potentially therapeutic practices available for analysis.

Meditation-based activities seem particularly suited to addressing the deficits associated with ADHD. For example, mindfulness involves attention and emotion regulation through focusing one's awareness on the present moment, while calmly acknowledging and accepting one's feelings, thoughts, and bodily sensations; the very regulatory capacities that are impaired in ADHD [31]. Two primary symptom groups exist for ADHD: inattention and poor behavioural control, expressed as hyperactivity and impulsivity. The difficulty sustaining attention is typically due to an inability to inhibit and control external and internal stimuli that interfere with the executive functions that assist in self-regulated persistence [32]. While hyperactivity may diminish over time, impulsivity/inattention is often stable across development and has associated problems with a range of wellbeing outcomes, including physical and mental health [33]. ADHD and mindfulness clearly appear to involve the same processes, with ADHD compromising sustained attention and impulse control, and mindfulness building upon the capacity to observe impulses without acting upon them [34]. The emotion and attention regulation benefits of

Table 1 Meditation-based interventions for children with ADHD

References; Country of research	Research design	Participant characteristics	Intervention	Therapist characteristics	Child outcomes	Parent outcomes	Findings	Post-study follow-up	Effect size (Hedges' g) [95% CI]
Abadi et al. [53] Iran	Controlled trial	9–12 yo 40 children (% male not specified) Yoga $n = 20$ Control $n = 20$	Yoga group 45 min twice/week for 8 weeks No-intervention controls	No description	ADHD subscale of the CSI-4 (unclear, but appears to be a combined parent/teacher score)	N/A	Relative decrease in mean CSI-4, including hyperactivity/impulsivity in the yoga group compared to the control group	No FU	CSI-4 (ADHD) 1.43
Carboni et al. [60] USA	Single-arm Single-case multiple baseline	8 yo 4 children 100% male	Individual MF adapted from MBSR 30-45 min twice/week for 8 sessions	Interventionist with MF training and experience working with children	P/T BASC-2	N/A	Graphic analysis of observation: increased % of intervals of on-task behaviour; general decrease in hyperactive behaviours (parent and teacher ratings), no change in attention problems	No FU	P BASC-2 (hyperactivity) 1.12 [−2.25, 0.02] P BASC-2 (inattention) 0.39 [−1.39, 0.61] T BASC-2 (hyperactivity) 0.53 [−1.54, 0.49] T BASC-2 (inattention) 1.04 [−2.15, 0.07]
Haydicky et al. [59] Canada	Controlled trial (waitlist)	12–18 yo 28 children 100% male MMA = 14 Control = 14	Mindfulness Martial Arts (MMA) 90 min/week for 20 weeks Waitlist control	Child/family therapists with black belts and MF practitioners	P BRIEF P CBCL YSR	N/A	ANCOVA: significantly reduced parent-reported CBCL conduct and social problems and self-reported social and externalizing problems in the MMA group compared to controls	No FU	BRIEF (total) 0.46 [0.18, 0.75] CBCL (ADHD) −0.39 [0.1, 0.67] (Social) 0.44 [−0.73, −0.16] (Externalizing) 0.63 [0.34, 0.92] YSR (ADHD) 0.1 [−0.18, 0.38] (Social) 0 [−0.28, 0.28] (Externalizing) −0.43 [0.15, 0.72]

Table 1 continued

References; Country of research	Research design	Participant characteristics	Intervention	Therapist characteristics	Child outcomes	Parent outcomes	Findings	Post-study follow-up	Effect size (Hedges' g) [95% CI]
Jensen and Kenny [54] Australia	RCT	8–13 yo 19 children 100% male Yoga $n = 11$ Control $n = 8$	Yoga: 60 min/week for 20 weeks Control: 60 min/month of cooperative activities	No description	P CPRS T CTRS TOVA; Actigraph	N/A	Yoga improved Oppositional and ADHD Index. Controls improved Anxious and Social Problems. Both groups improved on DSM–IV Hyperactive/Impulsive, DSM–IV total	No FU	CPRS (ADHD) 0.71 [−1.16, −0.26] (Anxious) −0.29 [−0.72, 0.14] (Social) −0.24 [−0.67, 0.19] (oppositional) 0.55 [−0.99, −0.11] CTRS (ADHD) −0.38 [−0.05, 0.81] (Anxious) 0.32 [−0.11, 0.74] (Social) 0.15 [−0.58, 0.27] (Oppositional) 0.41 [−0.02, 0.84]
Mehta et al. [55] India	Single-arm	6–11 yo 76 children 63% male	Climb Up (yoga, meditation BT) 60 min/twice week for 6 weeks	Trained high school volunteers	T/P Vanderbilt:	N/A	91% of children improvement in school performance (no threshold set); 40% of children improved into a normative range	FU below	Vanderbilt (ADHD)− 2.2 [−2.29, −2.11]]
Mehta et al. [56] India	(one year follow-up)	69 children	As above once/week for one year	As above	As above	As above	Above improvements were sustained through 12 months	Study is FU to above	N/A (data not presented in a manner to calculated ESs)
Murrell et al. [57] USA	Single-arm	11–15 yo 9 children 44% male	ACT for Kids Group format 60 min/week for 8 weeks	Recognized ACT trainer	C BASC-2 (Emotional Symptoms) Bulls-Eye Values	N/A	Single-case analysis: 2 BASC-2 scores changed in unexpected direction; Interview data noted positive experiences of children	No FU	C BASC-2 (Emotional Symptoms) −0.44 [0, 0.89]
Singh et al. [58] USA	Single-arm Single-case Multiple baseline	10–12 yo 4 children 100% male	Samatha meditation Individual (during school) 10-30 min daily for 8 weeks	Meditation instructor with 40 years personal experience meditating	Observational data during maths instruction; maths quiz	N/A	Significant increase in maths engagement and significant increase in correct answers to maths problems	No FU	Engagement 4.38 [1.05, 7.71] Problem solving 9.11 [−2.04, 20.26]

yo years old, *MF* Mindfulness, *FU* Follow-up, *T* Teacher report, *P* Parent report, *C* Child report, *ACT* Acceptance and Commitment Therapy, *BASC-2* Behaviour Assessment System for Children-Second edition, *BRIEF* Behaviour Rating Inventory of Executive Functioning (consists of behaviour regulation and monitoring), *CBCL* Child Behaviour Checklist, *CPRS* Conners' Parent Rating Scale—Revised: Long, *CTRS* Conners' Teacher Rating Scale–Revised: Long, *CSI-4* Child Symptom Inventory—4th edition, *MBSR* Mindfulness-Based Stress Reduction, *TOVA* Test Of Variables Of Attention, *YSR* Youth Self Report

Table 2 Combined meditation-based interventions for children with ADHD and their parents

References; Country of research	Research design	Participant characteristics	Intervention	Therapist characteristics	Child outcomes	Parent outcomes	Findings	Follow-up	Effect size (Hedges' g) [95% CI]
Bogels et al. [31] Netherlands	Clinical case study	10- yo 1 child 100% male 1 mother	MYMind MF for children and parents 90 min/week for 8 weeks	Experienced MF teacher who is also a child therapist (second support teacher)	Quantitative: not specified Qualitative Interview	Quant: not specified Qualitative Interviews	Quant: less inattention, stress and OR in mother; less inattention and opposition in child. Qual: C: sleep, coping, relationship with mother. M: less stress, better structure	No FU	N/A
Hariprasad et al. [47] India	Single-arm	5–16 yo 9 children 90% male Parent data not reported (*n*, % mothers)	Daily 60 min yoga inpatient stay (8 sessions) Child-parent	Certified yoga instructor with > 2 years yoga teaching experience	Research staff: ADHD-RS; CARS; CGI Severity	None provided	Significant improvement on all outcomes	Effects not maintained at 1st, 2nd or 3rd month post-study FU	ADHD-RS 1.02 [−1.52, −0.53] CARS 1.27 [−1.8, −0.75] CGI 1.44 [−1.99, −0.89]
Harrison et al. [48] Australia	Single-arm Mixed-methods Quasi control using waitlist	4–12 yo 26 children 85% male Parent data not reported (*n*, % mothers)	Sahaja Yoga Meditation 90 min twice/week for 6 weeks Parallel/joint parent group	No description	P Conners'; P/C Indicators of Self-Esteem; CPRS	CPRS; interview	Quant benefits: ADHD symptoms, self-esteem, relationship quality. Qual benefits: sleep, less anxiety, concentration, less conflict. PR: happier, less stressed, manage child's behaviour	No FU	*Child Outcomes* P ADHD 1.3 [−1.48, −1.12] P Self-esteem 0.75 [0.58, 0.91] C Self-esteem 0.07 [−0.22, 0.08] Parent/child relationship 0.66 [0.5, 0.82]

Table 2 continued

References; Country of research	Research design	Participant characteristics	Intervention	Therapist characteristics	Child outcomes	Parent outcomes	Findings	Follow-up	Effect size (Hedges' g) [95% CI]
Haydicky et al. [49] Canada	Single-arm	13–18 yo 18 teens, 72% male 17 mothers and 4 fathers (data used from 16 mothers and 1 father)	MYmind groups based on MBCT 1.5 h/week for 8 weeks Parallel parent group	Clinical psych students attended 12 week MF course and meditate regularly	P/C Conners-3P; RCADS; FAD AAQ	SIPA; IM-P	Reduced child inattention, conduct problems, peer problems and parent stress, increased parent mindfulness; no child SR changes	6 weeks: improvement maintained; child SR reductions in internalizing problems	*Child Outcomes* P Inattentive 0.78 [−1.03, −0.53] P H/I 0.42 [−0.66, −0.18] C Inattentive −0.15 [−0.07, 0.37] C H/I 0.11 [−0.33, 0.1] P CD 0.68 [−0.93, −0.44] C CD −0.07 [−0.15, 0.29] P Internalizing 0.11 [−0.34, 0.13] C Internalizing 0.11 [−0.33, 0.11] Impairment in: P Learning 0.54 [−0.78, −0.3] P EF 0.34 [−0.58, −0.11] Peer relations 0.48 [−0.71, −0.26] C family −0.15 [−0.07, 0.37] Parent stress 0.33 [−0.56, −0.1]
Singh et al. [58] USA	Single-arm Single-case Multiple Baseline	10–12 yo 2 children 100% male 2 mothers	12 MF sessions with mothers; followed by 12 MF with child (unspecified duration)	Experienced MF trainer	Mother-reported child compliance	SSIMC; SUHMC; interviews	Child compliance increased after MF in mothers; increased further after child MF; Mothers' satisfaction with self and happiness with child increased	Mothers' satisfaction continued to increase across 24 weeks FU	*Child Compliance* Mother MF 0.49 [−1.53, 2.5] Child MF 1.65 [−0.98, 4.28] *M satisfaction* Mother MF 0.92 [−1.25, 3.09] Child MF 1.59 [−0.99, 4.17] *M Happiness* Mother MF 1.18 [−1.12, 3.48] Child MF 8.77 [−12.02, 29.55]

Table 2 continued

References; Country of research	Research design	Participant characteristics	Intervention	Therapist characteristics	Child outcomes	Parent outcomes	Findings	Follow-up	Effect size (Hedges' g) [95% CI]
Van de Weijer-Bergma et al. [50] Netherlands	Single-arm	11–15 yo 10 teens 67% male 11 parents (6 mothers; 5 fathers:- one child had both parents undertake MF)	MF groups with homework 1.5 h/week for 8 weeks Parallel parent group Homework	Cognitive-behaviour therapists who were MF practitioners	YSR, CBCL, TRF, BRIEF, MAAS, FFS, SHS, ANT	MAAS, PSI, PS	Paired t-tests: less teen attention and behaviour problems, improved executive functioning (SR, father and teacher report); attention test improvement; Fathers, not mothers reported reduced parenting stress; reduced mother over-reactive parenting while fathers' increased	8-week FU: stronger effects 16-week FU: effects waned	*Child Outcomes* C Attention 0.46 [−0.86, −0.06] M Attention 0.08 [−0.74, 0.57] F Attention 0.55 [−1.36, 0.26] C Internalizing 0.09 [−0.48, 0.3] M Internalizing 0.1 [−0.75, 0.56] F Internalizing 0.4 [−1.2, 0.4] C Externalizing −0.11 [−0.29, 0.5] M Externalizing −0.17 [−0.49, 0.82] F Externalizing 0.18 [−0.97, 0.6] C Happiness −0.43 [−0.83, −0.03] M BRIEF 0.23 [−0.42, 0.89] F BRIEF 0.86 [−1.72, −0.01] M Par Stress −0.44 [−0.23, 1.1] F Par Stress 0.63 [−1.45, 0.19] M Overreact 0.96 [−1.69, −0.23] F Overreact −0.78 [−0.07, 1.62]
Van der Oord et al. [51] Belgium	Single-arm	8–12 yo 22 children 72% male 22 parents (21 mothers)	MF based on MBSR and MBCT 1.5 h/week for 8 weeks Parallel parent group Homework	Cognitive behaviour therapists with MF experience	P/T DBDRS	PSI, PS, ARS-D, MAAS	Paired t-tests: reduced parent-rated ADHD behaviour (self and child); increase parent mindful awareness and reduced parental stress and over-reactivity	8 week FU: child/parent ADHD improved, parent stress and OR maintained	*Child outcomes* P Inattention 0.80[a] P H/I 0.56[a] *Parent outcomes* Inattention 0.36[a] H/I 0.48[a] Parent stress 0.57[a] OR 0.85[a]

Table 2 continued

References; Country of research	Research design	Participant characteristics	Intervention	Therapist characteristics	Child outcomes	Parent outcomes	Findings	Follow-up	Effect size (Hedges' g) [95% CI]
Zhang et al. [52] China	Single-arm	8–12 yo 11 children 72% male 11 parents (7 mothers)	MYmind MF groups 1.5 h/week for 8 weeks Parallel parent group Homework	Therapists with MF training	Conners, reaction time, TEA-Ch, ECBI	PSI, PS, IM-P	Piared t-tests: improved Conners (detectability), omissions), TEA-Ch, Sky Search, ECBI Worse PSI	No FU	*Child outcomes* Conners-d 0.73[a] Conners-o 2.29[a] Reaction time 0.05[a] TEA-ch-sky 0.76 TEA-ch-creature 0.81 TEA-ch-Walk −1.35 TEA-opp world −0.16 ECBI intensity 0.36 *Parent outcomes* PSI −0.18 PS lax 0.28 PS overreact −0.12 PS verbose 0.07

[a] Effect sizes as reported in text

yo years old, *MF* Mindfulness, *FU* Follow-up, *T* Teacher report, *P* Parent Report, *C* Child report, *AAQ* Acceptance and Action Questionnaire, *ACT* Acceptance and Commitment Therapy, *ADHD-RS* ADHD Rating Scale IV, *ANT* Amsterdam Neuropsychological Tasks, *ARS-D* ADHD Rating Scale-Dutch, *BRIEF* Behaviour Rating Inventory of Executive Functioning (consists of behaviour regulation and monitoring), *CARS* Conners' Abbreviated Rating Scale, *CBCL* Child Behaviour Checklist, *Conners'* Conners Parent-Teacher Questionnaire; *Conners 3P* Conners 3rd edition, *CGI* Clinical Global Impression, *CPRS* Child-Parent Relationship Scale, *DBDRS* Disruptive behaviour Disorder Rating Scale, *ECBI* Eyberg Child Behaviour Inventory, *FAD* Family Assessment Device, *FFS* Flinders Fatigue Scale, *IM-P* Interpersonal Mindfulness in Parenting Scale, *MAAS* Mindful Awareness Attention Scale, *MBCT* Mindfulness-Based Cognitive Therapy, *MBSR* Mindfulness-Based Stress Reductuion, *OR* Over reactivity, *PS* Parenting Scale, *PSI* Parenting Stress Index, *RCADS* Revised Manifest Child Anxiety and Depression Scale, *SIPA* Stress index for Parents of Adolescents, *SHS* Subjective Happiness Scale, *SR* self report, *SSIMC* Satisfaction with Self in Interactions with My Child, *SUHMC* Subjective Units of Happiness with My Child, *TEA-ch* Test of Everyday Attention for Children, *TOVA* Test of Variables of Attention, *TRF* Teacher Report Form, *YSR* Youth Self Report

Article types
Clinical Trial
Review
Customize ...

Text availability
Abstract

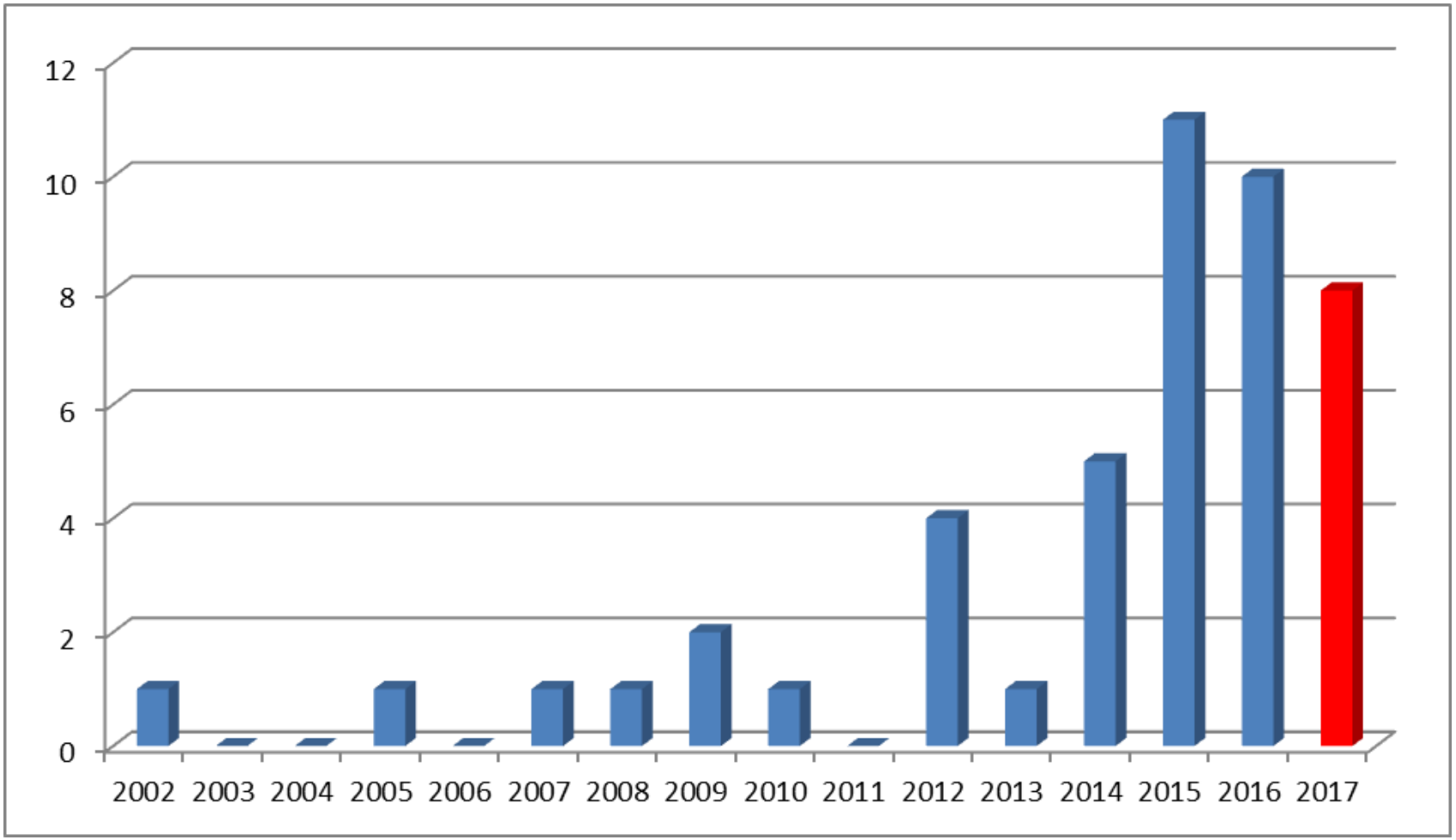
Format: Summary Sort by: Most Recent Per page: 20 Send to Filters: Manage Filters

Search results

Items: 1 to 20 of 46

<< First < Prev Page 1 of 3 Next > Last >>

Find related data
Database: Select
Find items



CPP	In ACTion!
SISTEMA DI RINFORZI E PUNIZIONI	
Contingenze di rinforzo indirette	Contingenze di rinforzo dirette
Contingenze di punizione dirette	-
CONTESTO MOTIVAZIONALE	
L'aggressività è il focus terapeutico e ciò che accomuna il gruppo	Ambiente metaforico e linguaggio coerente con il livello del gruppo: "è un interesse che ci accomuna"
Rinforzatori alla fine dell'incontro	Rinforzatori legati alla contingenza del comportamento
PRINCIPALI PROCEDURE	
Problem Solving	Consapevolezza delle contingenze e del momento presente (MINDFULNESS) INDIVIDUARE LE DIREZIONI VALORIALI (rinforzatori naturali)= "chi vogliono essere, cosa mi sta a cuore, a cosa miro, a cosa aspiro" e comportamenti in linea con quei valori

CPP	In ACTion!
TRAINING ABILITÀ EMOTIVE	
Riconoscimento	Riconoscimento
Modificare o eliminare i pensieri alla base di emozioni negative	I pensieri rappresentano la nostra storia di apprendimento, non è possibile eliminarli. Già la “lotta” contro i propri pensieri ne aumenta l’importanza della funzione.
MODIFICARE LA **TOPOGRAFIA**: Utilizzo di tecniche di rilassamento, confutazione, auto-istruzioni e del ragionamento logico (=*REGOLE VERBALI e MIGLIORI STRATEGIE DI EVITAMENTO ESPERIENZIALE*)	MODIFICARE LA **FUNZIONE**: Possiamo modificare il contesto (esterno ed interno) in cui questi pensieri si presentano in modo che la loro funzione cambi. Utilizzo di metafore, storie e esercizi esperienziali
CONTROLLO	ACCETTAZIONE

CPP	In ACTion!
Psico- educazione: comprendere le emozioni (ad es. rabbia) e descriverne le componenti fisiologiche	Notare ed essere consapevoli dei sentimenti
Training sulla gestione delle emozioni	Accettazione
Affrontare le emozioni grazie a rilassamento e auto istruzioni	Mindfulness and Accettazione
Perspective taking per agevolare la risoluzione dei problemi	Perspective taking per promuovere la flessibilità psicologica e le azioni impegnate
Applicazione di problem solving sociale ai diversi contsti	Valori e Azioni Impegnate

COSA?

Struttura del trattamento

- 25 sedute di gruppo
- Colloquio pre e post con genitori e ragazzo
- Test and re-test con CPRS, CBCL, CGI, prove della Batteria ANT
- Durata di ogni incontro: 1 ora e mezza
- 2 conduttori e 1 osservatore

QUANDO?

frequenza

Settimanale

CHI?

Partecipanti

Criteri di Inclusione

- ADHD
- età: 8 -13
- Genitori hanno frequentato o frequentano percorso di PT

Criteri di Esclusione

- QI<75
- Disturbi dello spettro autistico
- D. della comprensione del linguaggio

DOVE?

Il nostro setting

Unita di psicolpatologia dell'età evolutiva; Istituto Scientifico IRCCS Eugenio Medea, Bosisio Parini, Lecco

PERCHÈ?

Scopo del trattamento

Migliorare la flessibilità psicologica

Struttura della Seduta

- **Esercizi di Mindfulness**
- **Revisione della seduta precendente attraverso compiti**
- **Attività di gruppo**
- **Assegnazione dei compiti**
- **Attività piacevoli**

Principi e Procedure (1)

- ❑ Rinforzo
- ❑ Estinzione
- ❑ Generalizzazione
- ❑ Discriminazione
- ❑ Pairing
- ❑ Modeling
- ❑ Shaping delle risposte
- ❑ Manipolazione delle operazioni motivazionali
- ❑ Contingenze di rinforzo positivo

Principi e Procedure (2)

Rinforzo condizionale generalizzato = token economy

1. ATTIVITÀ	2. GONG
	
COMPORTAMANTO TARGET Essere consapevole: apertura e impegno nelle attività proposte.	TARGET BEHAVIOR Silenzio Respiri Prestare Attenzione

Target behavior activity

Target behavior activity + target behavior GONG

No target behavior

EXT

IL NOSTRO GRUPPO DI CHILD TRAINING