FACULTAD PADRE OSSÓ

Universidad de Oviedo

Salud mental y calidad de vida en población adulta con trastorno del desarrollo de la coordinación.

Una revisión sistemática.

Pablo Alconada García

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Tutora: Laura Delgado Lobete

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INTRODUCCIÓN

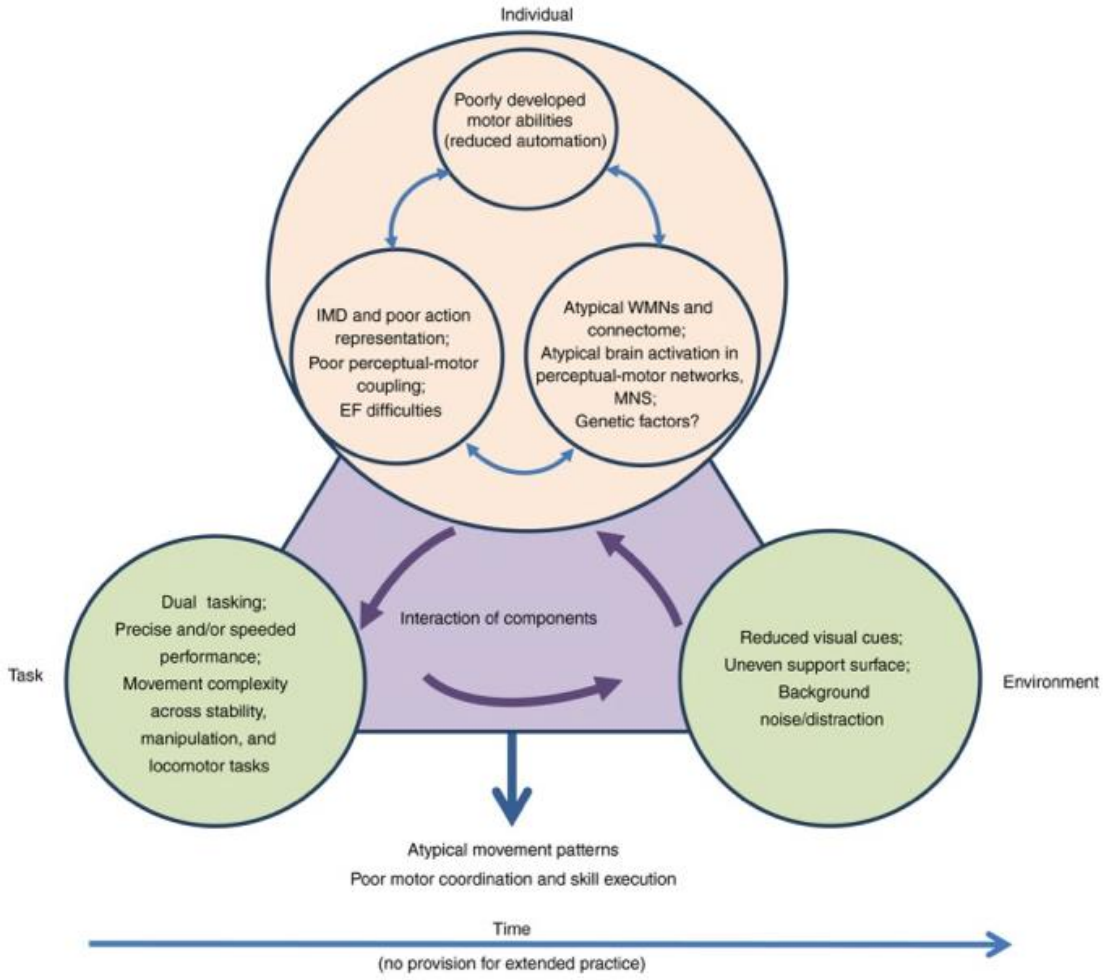
El Trastorno del Desarrollo de la Coordinación (TDC) es un trastorno del neurodesarrollo que se caracteriza por un déficit en las habilidades de coordinación motora en las etapas temparanas de desarrollo, que influye en el desempeño diario (Barnhart et al., 2003).

El término TDC fue aceptado en el Consenso de Londres en el año 1994 para facilitar la comunicación y el conocimiento entre investigadores y personal sanitario que trataban con niños con déficits en las habilidades motoras, y los criterios diagnósticos unificados del TDC fueron incluidos en la tercera edición del DSM (Zwicker et al., 2012).

La etiología del TDC es poco conocida, pero puede estar relacionada con una afectación del sistema nervioso central y déficits tanto en la función como en la estructura cerebral. Existen dos posibles hipótesis acerca de la causa del TDC. La primera es "la hipótesis del déficit de automatización" que explica que la población en edad escolar puede tener dificultades realizando habilidades motoras de forma automática. Esto hace especular que el cerebelo puede estar involucrado en el desarrollo del TDC. La segunda recibe el nombre de "la hipótesis del déficit de modelado interno". La realización de un movimiento de manera satisfactoria se debe a un modelado interno que predice de manera precisa las consecuencias sensoriales de la orden de movimiento. El cerebelo recibe una copia de la orden del movimiento y la compara con el movimiento que se predice, si hay un fallo el cerebelo mando una señal para crear más precisión en el movimiento. Tanto en la primera hipótesis del déficit de automatización, como en el déficit del modelado interno, el cerebelo está involucrado en el desarrollo el TDC (Zwicker et al., 2012). Algunos de los factores etiológicos del TDC son neurológicos, conductuales y déficits funcionales y estructurales, en estos últimos se observa una reducción del grosor cortical y una hipoactivación de las conexiones que envuelven el prefrontal, parietal y la región cerebelosa, y también una alteración de la organización interna de la materia blanca, especialmente en los tractos sensoriomotores, como eltracto corticoespinal, la radiación talamica posterior y la región del tronco del cuerpo calloso correspondiente con los lóbulos parietales. Finalmente, también influyen factores externos a la persona, como la naturaleza de la tarea a realizar y factores del entorno. Tanto los factores de la tarea como los del entorno estarían interaccionando con los individuales (Figura 1) (Blank et al., 2019).

Figura 1

Correlación de factores individuales, de la tarea y el entorno (Blank et al., 2019)



Nota. Adaptado de "International clinical practice recommendations on the definition, diagnosis, assessment, intervention, and psychosocial aspects of developmental coordination disorder" (p.14), por R. Blank et al., 2019, *Developmental Medicine & Child Neurology*, *61*(3).

La prevalencia de TDC se encuentra aproximadamente entre un 5-6% en población en edad escolar, aunque se estima que puede alcanzar el 1,4-19% . El TDC aparece en varones con mas frecuencia que en mujeres (2:1), y también aparece con frecuencia en recién nacidos pretérminos o que presenta un bajo peso al nacer en comparación a los nacidos a término (Bolk et al., 2018).

Sin embargo, aunque el TDC tenga una alta prevalencia, existe poco conocimiento en el diagnóstico del TDC por parte de profesionales de la salud. Según un estudio desarrollo en el que se preguntaba acerca del TDC a padres, profesores y médicos de Canadá, Estados Unidos y Reino Unido, solo un 41% de los pediatras tenían conocimientos acerca del TDC, y solo un 23% lo había diagnosticado en alguna ocasión (Harris et al., 2015).

En España, durante el año 2005, en el País Vasco no se detectó ningún caso de TDC. Sin embargo, siguiendo la prevelencia descrita en el momento, debería haber, al menos, 1.001,9 casos sólo en esa región. Por lo tanto, la detección temprana en el País Vasco y en otras regiones, como Galicia, es relativamente inexistente en la población con TDC. No obstante, aproximadamente un 12% de la población española en etapa escolar, es decir, entre 6 y 12 años, presenta sospecha de TDC (Delgado-Lobete et al., 2019). Por lo anterior, se puede considerar que el TDC es un trastorno poco conocido en España pese a su prevalencia, y, además, es difícil encontrar literatura científica al respecto en castellano (Garbiñe Guerra & Raquel Plata, 2009).

El TDC presenta comorbilidades con otros trastornos del desarrollo, especialmente con el trastorno por déficit de atención e hiperactividad (TDAH). El 50% de población con TDC en edad escolar también cumple los criterios diagnósticos de TDAH (Cairney et al., 2009). También se ha asociado el TDC con el deterioro del lenguaje y las dificultades de aprendizaje (Zwicker et al. 2012). Finalmente, existen estudios que reportan que la población infantil con trastorno del espectro autista (TEA) presentan una alta comorbilidad con el riesgo de TDC (Caçola & Lage, 2019).

Los criterios diagnósticos para el TDC según la quinta edición del *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) de la Asociación Americana de Psiquiatría (American Psychiatry Association, 2013), son los siguientes:

- Criterio A: la adquisición y ejecución de habilidades motoras coordinadas es inferior a la esperada para la población con su misma edad y para la oportunidad de aprendizaje y uso de habilidades de la persona.
- Criterio B: el déficit de coordinación motora debe afectar de manera significativa y persistente a la funcionalidad de las actividades diarias.
- Criterio C: los síntomas deben comenzar en el periodo de desarrollo temprano.

- Criterio D: el déficit de coordinación motora no puede ser explicado debido a un déficit intelectual o visual ni puede ser atribuido a una condición neurológica que afecte al movimiento.

La Academia Europea de Discapacidad Infantil recomienda utilizar la *Movement Assessment Battery for Chidren-Second Edition* (MABC-2) y el *Developmental Coordination Disorder Questionnaire* (DCDQ) como herramientas para evaluar los criterios A y B en población escolar, respectivamente. En el caso del criterio B para población adulta, se utilizan dos herramientas de evaluación como son el *Adult Dyspraxia/DCD Checklist* (ADC) y el *Adolescents and Adults Coordination Questionnaire* (AAC-Q). Sin embargo, no existe ninguna herramienta recomendada para evaluar el criterio A en adultos (Blank et al., 2019).

El TDC afecta al rendimiento académico, a las actividades de la vida diaria, ocio y juego (Engel-Yeger, 2020). Debido a los déficits funcionales y la frustración que produce realizar actividades motoras diarias, la población con TDC evita las actividades físicas y sociales y presentan baja autoestima. Además, el TDC aumenta el riesgo de desarrollar problemas de salud mental como depresión, ansiedad y baja satisfacción con la vida, lo que reduce su calidad de vida y restringe su participación (Engel-Yeger, 2020).

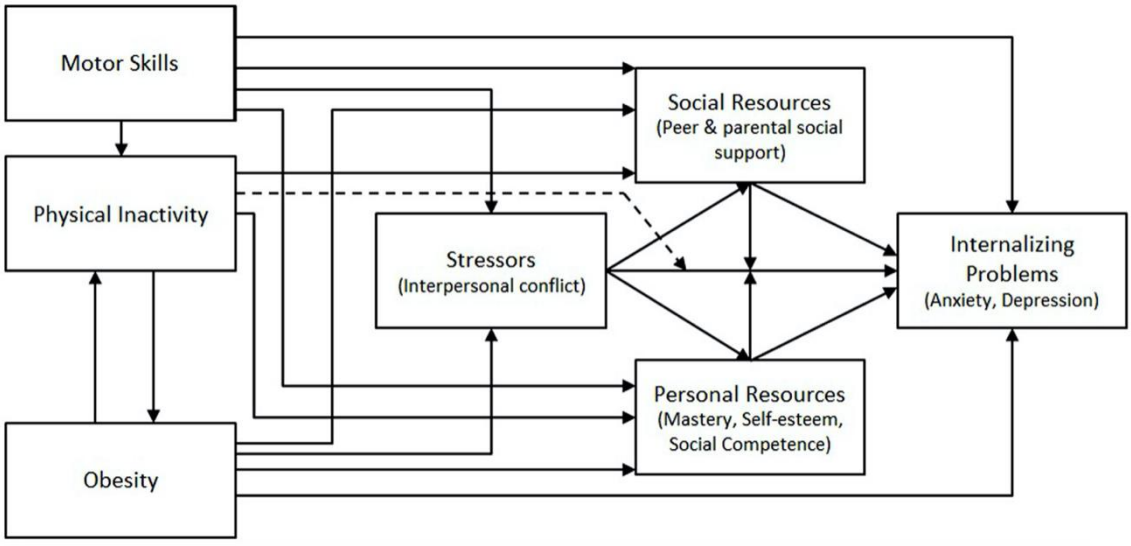
La influencia del TDC se mantiene en la adultez, afectando el desempeño ocupacional, la salud física, mental y el bienestar de la persona, y hace que se relacione la baja coordinación motora con la disminución de calidad de vida (Engel-Yeger, 2020). Por ejemplo, la baja coordinación motora unida a la afectación de las funciones ejecutivas provoca un impacto negativo en la habilidad para completar tareas académicas (Tal-Saban et al., 2018). También ha aumentado la evidencia de la relación de dichos déficits motores con la disminución de la autoestima y la aparición de depresión y ansiedad durante la adolescencia y etapa adulta. Esta relación se suele explicar con la Hipótesis de Estrés Ambiental (Rigoli et al., 2016).

La Hipótesis de Estrés Ambiental (*Environmental Stress Hypothesis*, Cairney et al., 2013) explica la asociación entre el déficit en las habilidades motoras y los problemas internalizantes (ansiedad y depresión) especialmente en población infantil, adolescente y adulta con TDC. Esta hipótesis postula que el déficit en las habilidades motoras predispone el desarrollo de los problemas internalizantes, debido a la interacción con factores estresores del ambiente. Se crea un modelo conceptual (Figura 2) que muestra

distintas vías que causan los problemas internalizantes debido al déficit en las habilidades motoras. El principal factor estresor de esta hipótesis es el déficit en habilidades de coordinación motora, que expone a la persona a un abanico de estresores secundarios, como por ejemplo, baja relación con compañeros, baja autoestima, obesidad o baja actividad física, lo que en conclusión deriva a problemas internalizantes de salud mental (Mancini et al., 2016).

Figura 2

Hipótesis de estrés ambiental (Mancini et al., 2016)



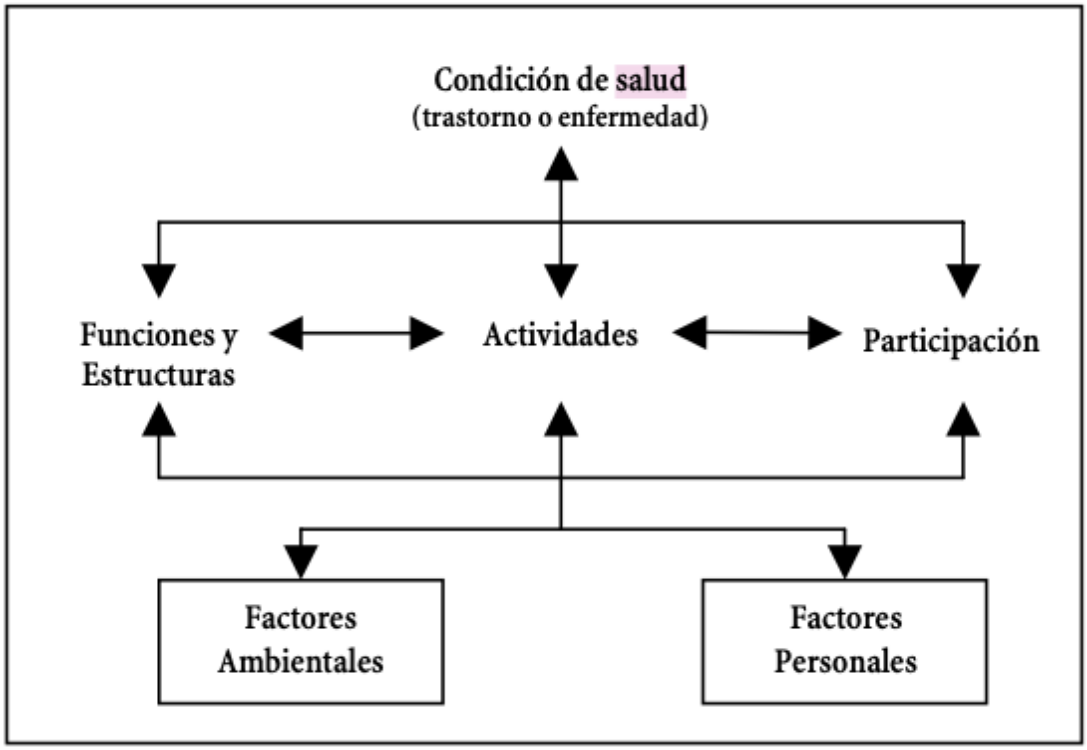
Nota. Adaptado de "The Elaborated Environmental Stress Hypothesis as a Framework for Understanding the Association Between Motor Skills and Internalizing Problems: A Mini-Review" (p.4), por V. Mancini et al., 2016, *Frontiers in Psychology*, *7*.

En conjunto, el TDC afecta a la salud de las personas, que es definida por la Organización Mundial de la Salud (OMS) dentro de la la Clasificación Internacional del Funcionamiento de la Discapacidad y de la Salud (CIF) como "un estado completo de bienestar físico, mental y social, y no solamente la ausencia de afecciones o enfermedades". Unos de los ámbitos de la CIF son los componentes de funcionamiento y discapacidad, incluyendo el componente cuerpo (sistemas corporales y estructuras corporales) y el componente de actividad y participación. Además, también existen otros componentes, como los factores personales y ambientales, y la condición de salud.

Todos estos componentes interaccionan entre ellos (Figura 3), de forma que la intervención en uno de esos componentes puede modificar uno o más componentes (Organización mundial de la salud, 2001).

Figura 3

Interacciones entre los componentes de la CIF (Organización mundial de la salud, 2001).



Nota. Adaptado de *Clasificación Internacional del Funcionamiento, de la Discapacidad y de la Salud* (p. 21), por Organización Mundial de la Salud , 2001, OMS.

Dichos componentes de la CIF se ven relacionados con la Terapia Ocupacional, que es una rama sanitaria que hace un uso terapéutico de las ocupaciones de la vida diaria con personas, grupos o poblaciones con el fin de mejorar su participación y su calidad de vida (AOTA, 2020). Por lo tanto, esta rama sanitaria tiene en cuenta tanto la participación como las actividades, además de las funciones y extructutas, factores ambientales y factores personales. Para conseguir llegar a dicha participación en ocupaciones o actividades, la Terapia Ocupacional intenta mejorar las habilidades y patrones de desempeño ocupacional, que se entiende como la realización una acción, actividad u ocupación resultado de la interacción dinámica entre el cliente, sus contextos y la ocupación (AOTA, 2020).

Además de tener como fin mejorar la participación, la Terapia Ocupacional también tiene como fin mejorar la calidad de vida, que abarca la manera en la que un individuo valora la satisfacción de muchos aspectos de su vida, como son sus ocurrencias, su sentimiento de vida plena, su humor, autoconcepto y satisfacción con el trabajo y sus relaciones sociales (Theofilou, 2013).

Como se ha mencionado anteriormente, la salud según la OMS es "un estado completo de bienestar físico, mental y social, y no solamente la ausencia de afecciones o enfermedades". La salud mental es uno de los componentes de la salud, y mantener una buena salud mental permite superar el estrés, trabajar de manera productiva y contribuir de manera activa en la sociedad (Etienne, 2018). El TDC afecta al desempeño diario de la población con TDC, y, por lo tanto, esta afectación del desempeño impide el desarrollo de la participación en sus ocupaciones de manera independiente.

Con respecto al abordaje terapéutico del TDC, algunos abordajes que se utilizan para intervenir en población infatil son los conocidos como abordajes Top-Down y abordajes Bottom-Up (Blank et al., 2019). El abordaje Bottom-Up se enfoca en remediar los déficits subyacentes al TDC y facilitar el desarrollo neuromadurativo basándose en la asunción de que existe una relación entre los procesos subyacentes y el movimiento funcional, es decir, está orientado a los déficits en las funciones y estructuras corporales. En cambio, el abordaje Top-Down busca intervenir directamente en la adquisición de habilidades y mejorar el desempeño, es decir, está orientado a la participación y la actividad (Chan, 2007).

Finalmente, hay que mencionar que existe un aumento del uso del abordaje Top-Down, frente al Bottom-Up, debido a que este ha sido cuestionado según algunas perspectivas teóricas (Cheryl Missiuna, 2014; Chan, 2007), y los abordajes Top-Down son más efectivos (Blank et al., 2019). Uno de los abordajes Top-Down con mayor evidencia es el enfoque Cognitive Orientation to daily Occupational Performance (CO-OP), desarrollado por terapeutas ocupacionales, que utiliza estretegias basadas en teorías de modificación de la conducta, especialmente la técnico de autoinstrucción verbal. En resumen, este enfoque busca que el terapeuta guíe al cliente para que este se dé cuenta de las partes erróneas en su desempeño y que él mismo cree soluciones para corregir dichos fallos mediante la estrategia "Goal-Plan-Do-Check" (Saeidi et al., 2019).

La mayoría de los estudios sobre TDC se centran en población infantil, pero actualmente están aumentando las investigaciones en población adulta y adolescente. Algunos estudios longitudinales exponen que la población infantil que había sido diagnosticada con TDC, sigue presentándolo en la adultez (Tal-Saban et al., 2012).

Con relación a lo anterior, entre el 30 y el 70% de la población infantil diagnosticada con TDC mantiene las dificultades en el desempeño ocupacional al crecer y convertirse en población adolescente y adulta. En consecuencia, la población adulta con TDC socializan menos con sus pares, lo cual aumenta el riesgo de padecer ansiedad y depresión. No obstante, la población adulta con TDC tiene la capacidad para controlar su entorno y evitar las situaciones donde sus dificultades puedan ser acentuadas: por ejemplo intentan no participar en deportes y, de hacerlo, lo hacen en deportes individuales evitando los grupales. Además, los síntomas de TDC en población adulta pueden variar si se ha realizado una intervención en el pasado (Tal-Saban & Kirby, 2018).

Al mismo tiempo, la población adulta con TDC o probable TDC tienen un riesgo mayor de presentar problemas psiquiátricos, emocionales, sociales, académicos y profesionales (Tal-Saban et al., 2012). Cuando la población infantil con TDC se convierte en adultos y comienzan nuevos periodos de su vida en la que necesitan mayores niveles de organización y responsabilidad, como puede ser conseguir un trabajo y adaptarse a sus nuevos compañeros, pueden incrementarse sus dificultades, ya que estos nuevos periodos se presentan como desafíos desconocidos y difíciles para ellos (Tal-Saban & Kirby, 2018).

Por lo anterior, se propone esta revisión sistemática debido a que no existe ninguna revisión acerca de la salud mental y la calidad de vida en población adulta con TDC, a pesar de su alta prevalencia. Por lo tanto, se plantea reunir y analizar la información que exista acerca de dos de las mayores afectaciones en población adulta con TDC, como son salud mental y calidad de vida.

OBJETIVOS

Se utilizó la siguiente pregunta en formato PICO: ¿cómo es la salud mental y la calidad de vida (resultado) de población adulta (población) con TDC (factor de interés)?

Por tanto, el objetivo que se planteó en esta revisión sistemática fue explorar la salud mental y la calidad de vida en población adulta con TDC.

MATERIAL Y MÉTODOS

Criterios de selección

Para llevar a cabo la selección de los estudios que se utilizaron, se plantearon los siguientes criterios de selección:

- Se incluyeron los estudios que incluían población bien con diagnóstico clínico de TDC o bien identificada como riesgo o probable TDC.
- Se incluyeron los estudios que incluían población adulta (18 años o más).
- Se incluyeron estudios que evaluaban, como variables respuesta, la salud mental o la calidad de vida.
- Se incluyeron estudios cuantitativos de estudios observacionales tipo transversal, de prevalencia, de cohortes, de asociación cruzada y de casos y controles.
- Se incluyeron estudios publicados desde 1995 hasta 31 de enero de 2022.
- Se incluyeron estudios publicados en español e inglés.

Además, se excluyeron las publicaciones que, cumpliendo lo anterior:

- Incluían participantes con una condición comórbida que pueda afectar a los resultados, excepto TDAH.
- Provenían de fuentes secundarias, terciarias o literatura gris.

Estrategia de búsqueda

La búsqueda tuvo lugar el día 31 de enero de 2022 en tres diferentes herramientas de búsqueda como son Scopus, PubMed y Web of Science, buscando artículos posteriores al año 1995, año después del consenso de Londres en el que se acepto el término TDC.

La estrategia de búsqueda que se utilizó para llevar a cabo la recolecta de información, en este caso en la herramienta de búsqueda PubMed, fue la siguiente: ("Quality of Life"[Mesh] OR "quality of life" OR "satisfaction with life" OR "life satisfaction" OR "mental health"[Mesh] OR "mental health" OR “Well-being” OR “depression”[Mesh] OR depression OR “anxiety”[Mesh] OR anxiety OR “internalizing problems”) AND ("Motor Skills Disorders"[Mesh] OR "motor skills disorder*" OR "motor skills" OR dyspraxia OR "developmental coordination disorder") AND (“Adult”[Mesh] OR adult* OR "college student*" OR "university student*").

Para consultar la estrategia utilizada en Scopus y Web of Science, se puede examinar el Anexo 1.

Proceso de gestión y selección

Se introdujeron los registros de las tres herramientas de búsqueda en el gestor bibliográfico Mendeley y se eliminaron los registros duplicados. A continuación, se trasladaron las referencias a un archivo Excel para favorecer el cribado mediante su título y abstract, aplicando los criterios de selección mencionados anteriormente.

Dicho Excel se dividia en 4 columnas: una columna de referencias, otra de cribado de título y abstract, otra de evaluación a texto completo y finalmente una columna en la que se escribía la razón por la que no se seleccionó el artículo. Si la publicación cumplía los criterios de selección se colocaba un "SÍ" en la columna de cribado y pasaba a la siguiente columna, si no cumplía los criterios se colocaba un "NO" y no pasaba a la siguiente columna. Tras leer a texto completo, se colocaba un "SÍ" al cumplir los criterior de selección y un "NO" si no los cumplía. ccando la publicación presentaba dos "SÍ" en el Excel, significaba que cumplía criterios de selección y se incluía en la revisión. En la columna de "Razón" se explicó brevemente por qué razón esa publicación no había sido elegida para ser añadida a la revisión sistemática.

Extracción de datos y evaluación de la calidad metodológica

Una vez seleccionados los artículos que se utilizarían para la revisión, se rellenó para cada uno de ellos una hoja de extracción de datos ad-hoc. En la hoja de extracción se incluyeron variables bibliométricas, como la revista y su factor de impacto y posición en su categoría, variables como la edad del grupo TDC, el país, la edad media y rango de edad, y los objetivos y resultados de cada publicación. Para consultar todas las variables que se incluyeron en la hoja de extracción, véase el Anexo 2.

A continuación, se evaluó el riesgo de sesgos de los artículos incluidos en la revisión mediante la herramienta *Mixed Methods Appraisal Tool* (MMAT) (Hong et al., 2018). Esta herramienta cuenta con dos preguntas de cribado general y cinco preguntas específicas en función del tipo de estudio (cualitativo, cuantitativo randomizado, no randomizado, descripitivo o métodos mixtos). Tanto las preguntas de cribado general como las específicas tienen tres opciones de respuesta (sí, no y no sé [can´t tell]), además de un cuadro para realizar comentarios al respecto sobre la respuesta. En cuanto a la tabla, siguiendo las recomendaciones de la propia herramienta, se ha decidio codificar las

respuestas por colores para que resulte más fácil su entendimiento (sí=verde, no=rojo, no sé=amarillo). Responder “no” o “no sé” en las preguntas de cribado general puede indicar que no se trata de estudio empírico y, por lo tanto, no puede ser evaluado utilizando MMAT. Esta herramienta desaconseja calcular una puntuación, y se utiliza para aportar más detalles acerca de la calidad de los estudios. En el caso de esta revisión sistemática, se respondieron a las preguntas de cribado general y a las preguntas específicas de la categoría de estudios cuantitativos no randomizados (Hong et al., 2018).

La jerarquía de evidencia de los artículos se midió utilizando la propuesta del *Centre for Evidence-Based Medicine de Oxford* (CEBM). Esta propuesta evalúa el grado de recomendación en 4 niveles (A, B, C y D), y dentro de cada uno de estos niveles se plantean unos niveles de evidencia (A [1a, 1b y 1c], B [2a, 2b, 2c, 3a, y 3b], C [4] y D [5]) en función de la pregunta que se aplica para realizar la jerarquización. En el caso de esta revisión sistemática se aplicó la pregunta de pronóstico (Manterola et al., 2014).

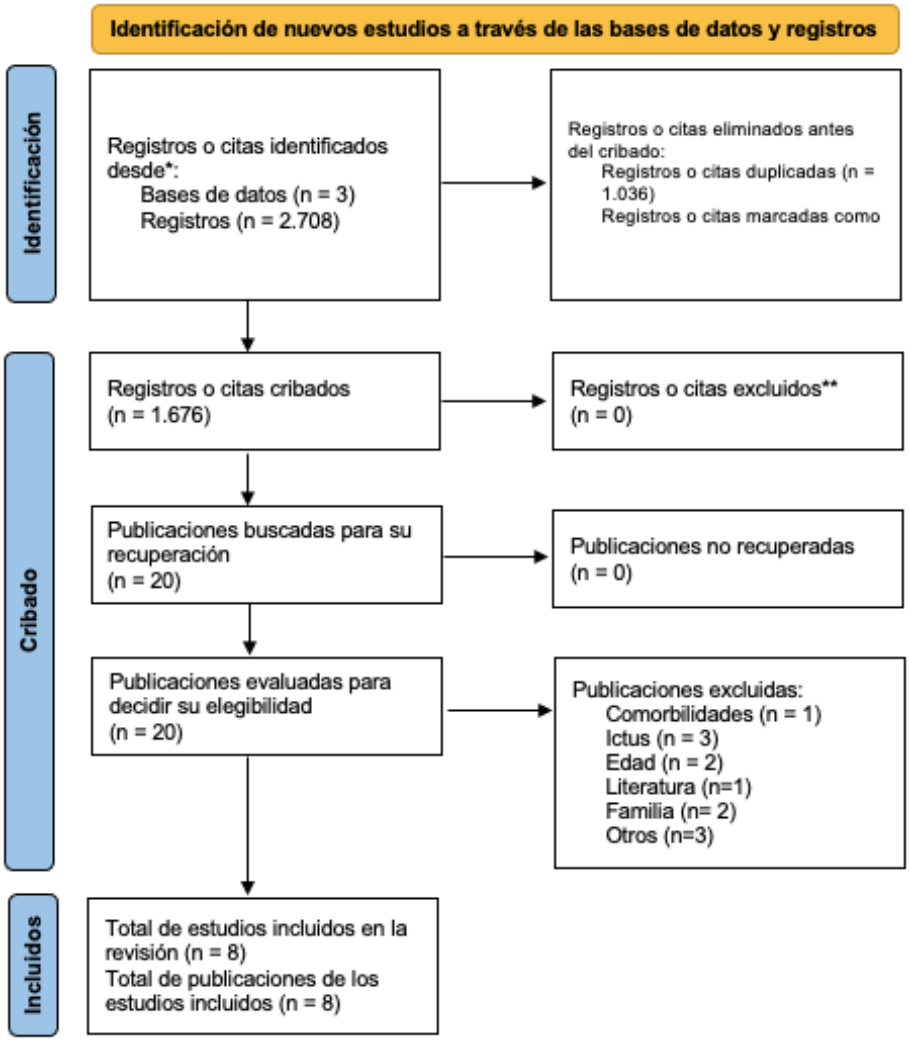
RESULTADOS

Gestión y selección

Tras buscar en las herramientas de búsqueda indicadas, se extrajeron 2.708 registros, de los cuales se eliminaron 1.035 utilizando el gestor bibliográfico Mendeley por estar duplicados. Tras cribar los 1.676 registros restantes por título y abstract, se buscaron 20 publicaciones a texto completo, y tras evaluarlas se incluyeron ocho estudios de ocho publicaciones (Anexo 3). A continuación, se puede observar la identificación, cribado e inclusión de las publicaciones en el diagrama de flujo PRISMA (Figura 4).

Figura 4

Diagrama de flujo PRISMA.



Riesgo de sesgo y nivel de evidencia

En cuanto a la evaluación de sesgos utilizando el MMAT, los artículos cumplieron los criterios de calidad (Tabla 4). El artículo de Sankar et al. (2000). no cumplió el criterio tres dentro de los criterios específicos, aun así se considera que la publicación cumple con los criterios de calidad. Por lo tanto, se observó que todas las publicaciones seleccionadas tienen un bajo riesgo de sesgo.

En cuanto al nivel de evidencia, todas las publicaciones obtuvieron un grado de recomendación A y un nivel de evidencia 1c según la jerarquía del CEBM (Tabla 1).

Tabla 1

Evaluación de sesgos mediante el MMAT y jerarquía de evidencia mediante la jerarquía del CEBM.

Referencia	1	2	3	4	5	6	7	GR	NE
Engel-Yeger, 2020.								A	1C
Forde, et al. 2021.								A	1C
Harris, et al. 2021.								A	1C
Hill, et al. 2013.								A	1C
Hill, et al. 2011.								A	1C
Kirby, et al. 2013.								A	1C
Sankar, et al.2020.								A	1C
Tal-Saban, et al. 2014.								A	1C

Datos bibliométricos

En la Tabla 2 se observan las variables bibliométricas recopiladas en la hoja de extracción de datos ad-hoc, y se destaca que todas las publicaciones han sido publicadas en los últimos 12 años: en concreto, la mitad fueron publicadas en los últimos dos años (2020 y 2021).

Reino Unido seguido de Israel son los países más frecuentes en los que se han llevado a cabo los estudios de las publicaciones seleccionadas, siendo Europa donde más cantidad de publicaciones se presentan. Finalmente, la revista en la que más aparecen las publicaciones es en la revista *Research in Developmental Disabilities,* la cual cuenta con

un factor de impacto de 3,230 en 2020 y se posiciona en el primer cuartil en sus dos categorías (Educación especial y Rehabilitación) según el *Journal Citation Reports*.

El resto de publicaciones aparecen en revistas con un factor de impacto menor en 2020 que la *Research in Developmental Disabilities*, a excepción de la *revista Journal of Mental Health*, la cual cuenta con el mayor factor de impacto de todas las revistas recogidas para la revisión sistemática y se encuentra en el primer cuartil de la categoría Piscología Clínica. La revista *Biomedical & Pharmacology Journal* no aparece en el *Journal Citation Reports*, por lo tanto no se indicó ni su factor de impacto ni la posición en su categoría.

Tabla 2

Información artículos

Referencia	**Año de publicación**	**País**	**Revista**	**Factor de impacto (2020)**	**Posición en su categoría**
Engel-Yeger., 2020.	2020	Israel	Research in Developmental Disabilities	3,230 (2020)	Q1 en Educación especial (2020) Q1 en Rehabilitación (2020)
Forde et al., 2021.	2021	Irlanda	Journal of Developmental and Physical Disabilities	1,710 (2020).	Q3 en Educación especial (2020) Q4 en Psicología, desarrollo (2020)
Harris et al., 2021.	2021	Reino Unido	Research in Developmental Disabilities	3,230 (2020).	Q1 en Educación especial (2020) Q1 en Rehabilitación (2020)
Hill, et al., 2013.	2013	Reino Unido	Journal of Mental Health.	4,299 (2020).	Q1 en Psicología, clínica (2020)
Hill, et al., 2011.	2011	Reino Unido	Journal of Adult Development.	1,909 (2020).	Q3 en Psicología, desarrollo (2020)
Kirby, et al., 2013.	2013	Israel Reino Unido	Research in Developmental Disabilities	3,230 (2020).	Q1 en Educación especial (2020) Q1 en Rehabilitación (2020)
Sankar, et al., 2020.	2020	India	Biomedical & Pharmacology Journal	No indica	No indica
Tal-Saban, et al., 2014.	2014	Israel	American Journal of Occupational Therapy.	2,246 (2020).	Q2 en Rehabilitación (2020)

Variables de las publicaciones

En la Tabla 3 se observa que las herramientas más utilizadas para el diagnóstico clínico de TDC fueron el *Adolescents and Adults Coordination Questionnaire (AAC-Q)* seguido del *Adult Developmental Co-ordination Disorders/Dyspraxia Checklist (ADC)*. También se siguieron como diagnóstico clínico los criterios de diagnóstico clínico del DSM-4 en un estudio (Hill et al., 2011) y los del DSM-5 en otro (Hill et al., 2013), ambos del mismo autor.

El tamaño muestral utilizado variaba mucho en función de la publicación, siendo los estudios de 2021 los que presentaban un mayor tamaño muestral (74 y 94). El tamaño muestral de 94 (Forde et al., 2021) fue el mayor de todos los estudios. En cambio, las publicaciones de 2020, presentaron los tamaños muestrales de menor tamaño (15 y 18). El tamaño muestral de 15 (Sankar et al., 2020) fue el menor de todos los estudios.

En cuanto al rango de edad, la mayoría eran rangos que iban entre los 18/19-60 años, aunque tres estudios utilizaron un rango de edad con población más joven que iban entre 19-27 (Hill et al., 2011), 22-29 (Tal-Saban et al., 2014) y 20-40 (Sankar et al., 2020). En la publicación más antigüa el rango de edad era 19-27, siendo este el menor rango de edad y uno de los menores tamaños muestrales (20). En el caso de la publicación de Kirby et al. (2013) se tuvieron en cuenta a toda la población mayor de 16 años, siendo esta considerada *"young adults"*. Los estudios con un rango de edad más amplio sin tener en cuenta el estudio anterior, fueron los artículos publicados en el año 2021 con unos rangos que iban de 18-63 (Forde et al., 2021) y 18-60 (Harris et al., 2021). La edad media ronda en la mayoría de los casos alrededor de los 25 años, pero se destacó que las publicaciones de 2021 cuentan con la mayor media de edad siendo esta 33,14 (Forde et al., 2021) y 37,8 (Harris et al., 2021). La edad media más baja fue en la publicación más antigua (2011) siendo esta de 23,1 (Hill et al., 2011).

La porcentaje de varones que participaron en los estudios tan solo superó en tres publicaciones el 50%, siendo el porcentaje de mujeres mucho mayor en cinco de los ocho estudios. Así, los porcentajes más bajos de varones se dieron en los estudios de 2020 y 2021, siendo los porcentajes 20% (Harris et al., 2021), 31,8 % (Forde et al., 2021) y 27,8 % (Engel-Yeger, 2020). En cambio, el porcentaje más alto pertenece también al año 2020, siendo este 66% (Sankar, et al., 2020). Finalmente, en ninguna de las publicaciones se observó la inclusión de alguna comorbilidad con el TDC.

Tabla 3

Herramientas para diagnóstico de TDC, tamaño muestral, edad, sexo y comorbilidades

Referencia	Herramienta utilizada para el diagnóstico de TDC o riesgo de TDC	Tamaño muestral	Rango edad	Edad media (DT)	Sexo grupo TDC (varón) (N (%))	Comorbilidad	Tipo
Engel-Yeger, 2020.	The Adult Developmental Co-ordination Disorders/Dyspraxia Checklist.	18	20-54	29,06 (7,04)	5 (28%)	No indica	Comparación dos grupos.
Forde, et al., 2021.	Adolescents and Adults Coordination Questionnaire.	94	18-63	33,14 (12,05)	26 (32%)	No indica	Asociación cruzada.
Harris, et al., 2021.	No indica	74	18-60	37,8 (12,1)	15 (20%)	No indica	Asociación cruzada.
Hill, et al., 2013.	Criterios DSM-5	36	19-59	29,28 (10,69)	15 (42%)	No indica	Comparación dos grupos.
Hill, et al., 2011.	Criterios DSM-4	20	19-27	23, 1 (2,447)	11 (55%)	No indica	Comparación dos grupos.
Kirby, et al., 2013.	The Adult Developmental Co-ordination Disorders/Dyspraxia Checklist.	57	>16	NI	23 (40%)	No indica	Asociación cruzada
Sankar, et al., 2020.	Adolescents and Adults Coordination Questionnaire.	15	20-40	28,8 (NI)	10 (66%)	No indica	Asociación cruzada.
Tal-Saban, et al., 2014.	Adolescents and Adults Coordination Questionnaire.	25	22-29	24,35 (0,88)	13 (52%)	No indica	Estudio longitudinal.

Nota. DT=desviación típica; NI=no indica.

Objetivos, mediciones y resultados.

El principal objetivo era observar el impacto del TDC en población adulta sobre su calidad de vida y su salud mental. Sin embargo, sólo dos publicaciones estudiaron simultáneamente la calidad de vida y la salud mental (Kirby et al., 2013; Forde et al., 2021). En dos publicaciones se tenía como objetivo el estudio de la población infantil con TDC además de la población adulta (Engel-Yeger, 2020; Harris et al., 2021): no obstante, tan solo se han tenido en cuenta la información acerca de la población adulta.

En cuanto al tipo de estudio, tres estudios fueron comparaciones de grupos, cuatro fueron asociaciones cruzadas y uno siguió un diseño longitudinal.

Con relación a las escalas que se utilizaron para medir la calidad de vida, dos estudios emplean la misma escala (*The World Health Organization Quality of Life Questionnaire, brief version [WHOQOL-BREF*]) , y en el resto se utilizan otras mediciones como la *Quality of Life Scale (QOLS),* el *Quality of Life Enjoyment and Satisfaction Questionnaire* y la *Satisfaction With Life Scale (SWLS).* Dentro de las mediciones empleadas para evaluar la salud mental, ocurre lo mismo que en las mediciones de calidad de vida. Solo se utiliza la misma medición en dos publicaciones *(The Hospital Anxiety y Depression Scale [HADS]).* Algunas de las otras mediciones que se utilizaron fueron la *Behavioral Activation Depression Scale (BADS),* la *Brief Resilience Scale (BRS)* o el *Beck Anxiety Inventory (BAI).*

Para finalizar, los resultados eran semejantes en todas las publicaciones, y reflejan que el grupo con TDC o con sospencha de TDC mostraban una peor calidad de vida y salud mental que los grupos de población con desarrollo típico. Las principales áreas de la salud mental que se evaluaron en los estudios fueron la depresión y la ansiedad, aunque en algún estudio se evaluó la soledad (Sankar et al., 2020) o la seguridad en sí mismos (Harris et al., 2021). Por ejemplo, la población adulta con TDC presentaba un nivel de ansiedad y depresión significativamente más alto (Hill et al., 2013), una menor seguridad en sí mismos en comparación con el grupo con desarrollo típico (Harris et al., 2021) y también un mayo sentimiento de soledad (Sankar et al., 2020). Otros de los resultados obtenidos son que las conductas evitativas afectan negativamente a la población con TDC, y que la población adulta con TDC con un trabajo estable tiene una mayor satisfacción con la vida que la población adulta con TDC sin un trabajo estable (Kirby et al., 2013).

Tabla 4

Objetivos, mediciones y resultados

Referencia	Objetivo	Medición calidad de vida	Medición salud mental	Principales resultados
Engel-Yeger, 2020.	Observar el impacto al ser niños y adultos del TDC en los individuos con TDC y cómo esto afecta a su calidad de vida.	The World Health Organization Quality of Life Questionnaire, brief version (WHOQOL-BREF).	No indica	Las personas con sospecha de TDC tuvieron un puntuación significativamente menor en la WHOQOL-BREF en comparación al grupo sin sospecha.
Forde, et al., 2021.	Observar si los comportamientos de evitación en población adulta con TDC afecta a la calidad de vida.	Quality of Life Scale (QOLS)	Behavioral Activation Depression Scale (BADS)	La conducta evitativa de las personas con TDC afectaba a su calidad de vida.
Harris, et al., 2021.	Observar el impacto del TDC durante la infancia y la adolescencia en términos de salud mental.	NE	The Brief Resilience Scale (BRS), The Hospital Anxiety y Depression Scale (HADS).	El grupo TDC y el grupo con sospecha de TDC presentó un mayor nivel de ansiedad y una menor seguridad en sí mismo en relación con el grupo con desarrollo típico.
Hill, et al., 2013.	Estudiar la afectación de la salud mental en adultos con TDC.	NE	40 item state trait Anxiety Inventory Form y el 21 item Beck Depression Inventory.	Tanto la depresión como la ansiedad era significativamente más alta en el grupo TDC con respescto al grupo con desarrollo típico.

Nota. NE=no evaluada.

Tabla 4 (Continuación)

Objetivos, mediciones y resultados

Referencia	Objetivo	Medición calidad de vida	Medición salud mental	Principales resultados
Hill, et al., 2011.	Observar calidad de vida en adultos con TDC.	Quality of Life Enjoyment and Satisfaction Questionnaire.	No indica.	El grupo TDC experimentó un menor nivel de satisfacción con su calidad de vida en relación al grupo con desarrollo típico.
Kirby, et al., 2013.	Observar calidad de vida, salud general, ansiedad y depresión y estatus laboral en población adulta con TDC.	The Satisfaction With Life Scale (SWLS).	The Beck Depression Inventory (BDI), The Hospital Anxiety y Depression Scale (HADS) Anxiety Subscale.	Personas con TDC y un trabajo estable tiene mayor calidad de vida y menor estado depresivo que el grupo con TDC y sin trabajo estable.
Sankar, et al., 2020.	Observar la relación entre ansiedad, soledad y respuesta sensorial entre población adulta india con TDC.	NE	Se mide la ansiedad con The Beck Anxiety Inventory (BAI) y la soledad con The short-form UCLA.	Las personas con TDC tenían altos niveles de ansiedad y soledad. Existe relación entre las tres variables.
Tal-Saban, et al., 2014.	Observar la influencia del TDC en la calidad de vida y la participación.	The World Health Organization Quality of Life Instrument (WHOQOL-BREF).	No indica.	El grupo con TDC presenta una menor calidad de vida y satisfacción en relación con el grupo control.

Nota. NE=no evaluada.

DISCUSIÓN Y CONCLUSIONES

Discusión

Se realizó esta revisión sistemática con el objetivo de explorar toda la literatura existente sobre la salud mental y la calidad de vida en población adulta con TDC.

El TDC es un trastorno del neurodesarrollo del cual se tiene poco conocimiento, tanto por parte de la población como por parte de los profesionales, recordando que tan solo un 41% de los pediatras tenían conocimientos acerca del TDC y solo un 23% lo había diagnósticado (Harris et al., 2015). De la misma manera ocurre en España, donde apenas existe un diagnóstico de TDC, siendo este un 1% en población infantil, conviene subrayar que este porcentaje proviene del diagnóstico de trastornos de habilidades motoras dentro de los trastornos del neurodesarrollo, es decir, no es un diagnóstico específico de TDC (Carballal et al., 2018). Al mismo tiempo, se estima que la prevalencia de población infantil con probable TDC en España se encuentra entre un 8% y el 13% (Delgado-Lobete et al., 2019; 2022).

Se considera que es necesario conseguir un mayor conocimiento acerca del TDC y su diagnóstico por parte de los profesionales sanitarios y por la propia población, ya que, como resultado, facilitaría el reconocimiento por parte de los padres y profesionales y en consecuencia intervenir de manera precoz. Esta intervención podría disminuir los síntomas del TDC en población adulta, ya que los síntomas pueden varíar en función de si se ha realizado o no una intervención de manera precoz (Tal-Saban & Kirby, 2018).

Se estima que entre el 30 y el 70% de la población infantil diagnosticada con TDC mantiene las dificultades en el desempeño al crecer y convertirse en población adulta, y que dos de las afectaciones más usuales en el TDC son la salud mental, en especial depresión y ansiedad, y la calidad de vida. Sin embargo, en esta revisión se ha podido comprobar la poca cantidad de información acerca de la población adulta con TDC en relación a la calidad de vida y la salud mental, ya que tan solo se obtuvieron ocho publicaciones que estudiaban la salud mental o calidad de vida en población adulta.

Todos los estudios recopilados se realizarón en países como Israel, Reino Unido o Irlanda, y no se ha obtenido ninguno de la población española; además, la totalidad de las publicaciones incluidas se han publicado en inglés. No obstante, los estudios presentaron un bajo nivel de sesgos según el MMAT y un alto nivel de evidencia según el CEBM.

Además, algunas de las revistas en las que estaban publicadas los artículos pertenecían al primer cuartil, por lo tanto, aunque sean pocas, estas pueden considerarse relevantes y de alcance.

Aunque el TDC es significativamente más común en hombres (Zwicker et al., 2012), se observó que, en la revisón, cinco de cada ocho estudios tuvieron un mayor porcentaje de mujeres que de varones. Esto puede deberse a que los estudios donde las mujeres tienen un mayor porcentaje, son estudios donde la muestra se obtiene de asociaciones e instituciones de educación superior, como universidades. Por ejemplo, la publicación con mayor porcentaje de mujeres (77%) es un estudio donde uno de los lugares de obtención de la muestra fue la Universidad de Oxford. En relación con esto, según el instituto de Estadística de la Unesco (IEU), la tasa bruta de matriculación entre 2000 y 2018 aumento de 19% al 36% en población masculina y de un 19% al 41% en población femenina, siendo este último mayor (Unesco, 2021).

En cuanto a la medición de los criterios diagnósticos del TDC utilizada en la publicaciones, tan solo siguió los criterios de DSM-5 en una de ellas (Hill et al., 2013). No obstante, se utilizó el DSM-4 (Hill et al. 2011) debido a que la quinta edición del DSM fue publicada en 2013. Por otra parte, se puede ver que en los estudios se realiza una buena evaluación del criterio B, ya que utilizan tanto el ADC como el AAC-Q, que son las herramientas recomendadas por la Academia Europea de Discapacidad Infantil para evaluar este criterio en población adulta.

Por otra parte, en el caso de las valoraciones de la salud mental, no se utilizan las mismas mediciones, a excepción del *HADS* que se utiliza en dos publicaciones y valora la depresión y ansiedad, dos de las afectaciones de la salud mental más comunes en población adulta con TDC. En otros estudios solo le valora la ansiedad y el sentimiento de soledad (Sankar et al., 2020) sin tener en cuenta la depresión. Esto refleja la necesidad de establecer unas mediciones específicas para esta población, además del uso de las ya recomendadas, para favorecer los estudios acerca de la misma. Como se ha mencionado anteriormente, dos de las afectaciones de la salud mental más comunes en población adulta con TDC son la depresión y la ansiedad (Tal-Saban & Kirby, 2018). Por lo que se refiere a los resultados de los estudios que habían evaluado tanto la ansiedad como la depresión, en todos lo estudios existió tanto un mayor nivel de ansiedad como de estado depresivo en población adulta con TDC en comparación con el grupo con desarrollo típico.

Conviene subrayar que estos resultados coinciden con lo propuesto por la Hipótesis de Estrés Ambientales, en la que el déficit en habilidades de coordinación motora expone a la persona a un abanico de estresores secundarios, y en conclusión deriva a problemas internalizantes de salud mental, se obtienen unos resultados en los que puede observar es derivación a problemas internalizantes de salud mental (depresión y ansiedad), por lo que se entiende que es posible que también existan otros problemas como baja actividad física, baja autoestima o baja participación con sus pares (Mancini et al., 2016).

En definitiva , la calidad de vida y la salud mental son unas de las principales afectaciones de la población con TDC (Tal-Saban & Kirby, 2018), y pueden afectar a su desempeño ocupacional. Por tanto, es importante promover la intervención desde Terapia Ocupacional en esta población, con el objetivo de mejorar su calidad de vida y el desemepeño ocupacional (AOTA, 2020).

Limitaciones

Se ha cometido algún sesgo a la hora de realizar la selección de los estudios. En el caso de la publicación de Kirby et al. (2013). No se cumple el criterio de selección en el cual se rechazan todos los estudios con población menor de 18 años. Sin embarg, se ha decidio incluir este estudio a pesar ya que no desagregaba resultados entre el grupo menor y mayor de edad, porque el contenido de la propia publicación es rica en contenido para la revisión que se estaba llevando a cabo y el propio estudio consideraba a la población entre 16 y 18 años como jóvenes adultos ("*Young adults*").

Otro sesgo que se ha realizado ha sido la utilización del MMAT y CEBM para valorar el nivel de evidencia y los sesgos de los estudios. Estas dos herramientas fueron utilizadas por tan solo una persona, cuando es necesario que sean dos las personas que la utilicen. Esto se hizo así debido a que esta revisión sistemática se realiza como Trabajo Fin de Grado (TFG), es decir, en un contexto de formación académica, por lo tanto no ha sido posible utilizar de manera correcta dichas herramientas de medición, por el contrario se ha aprendido el uso de las mismas para ocasiones futuras.

Líneas futuras

Los resultados que se han obtenido muestran una clara afectación de la calidad de vida y salud mental en la población adulta con TDC, siendo esta menor que en la población con desarrollo típico. Debido a esto, y a que Terapia Ocupacional es un medio para intervenir sobre calidad de vida y salud mental, se considera importante la creación de una línea futura de investigación orientada a la intervención de Terapia Ocupacional en población adulta con TDC, además de la creación de programas para la intervención con dicha población. Como se ha discutido anteriormente, los terapeutas ocupacionales tienen la capacidad para intervenir para mejorar la calidad de vida y el desempeño (AOTA, 2020), que son algunas de las principales afectaciones de la población adulta con TDC.

Por otro lado, todos los estudios obtenidos para la revisión fueron realizados en países como Reino Unido o Israel, existiendo aquí otra línea de investigación futura orientada a la población adulta con TDC en España.

Conclusiones

La población adulta con TDC tiene una significativa afectación de la calidad de vida y salud mental en relación con la población adulta con desarrollo típico, lo que puede tener consecuencias sobre su desempeño ocupacional. Aún así, existe una escasez de estudios de calidad de vida y salud mental en esta población fuera de países anglosajones, por lo que se considera que la evidencia empírica sería mayor si se contase con un mayor de estudios con poblaciones de otros contextos culturales.

Considerando lo anterior, se necesita aumentar los estudios acerca de la intervención del terapeuta ocupacional en población adulta con TDC debido a escasez de los mismos.

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ANEXOS

Anexo 1

Estrategia de búsqueda Pubmed

- ("Quality of Life"[Mesh] OR "quality of life" OR "satisfaction with life" OR "life satisfaction" OR "mental health"[Mesh] OR "mental health" OR “Well-being” OR “depression”[Mesh] OR depression OR “anxiety”[Mesh] OR anxiety OR “internalizing problems”) AND ("Motor Skills Disorders"[Mesh] OR "motor skills disorder*" OR "motor skills" OR dyspraxia OR "developmental coordination disorder") AND (“Adult”[Mesh] OR adult* OR "college student*" OR "university student*")
- Desde 1995; fecha de búsqueda: 31 de enero de 2022
- Resultados= 888

Estrategia Web of Science

- ("quality of life" OR "satisfaction with life" OR "life satisfaction" OR "mental health" OR “Well-being” OR depression OR anxiety OR “internalizing problems”) AND ("motor skills disorder*" OR "motor skills" OR dyspraxia OR "developmental coordination disorder") AND (adult* OR "college student*" OR "university student*")
- Desde 1995; fecha de búsqueda: 31 de enero de 2022
- Resultados= 773

Estrategia de búsqueda Scopus:

- ("quality of life" OR "satisfaction with life" OR "life satisfaction" OR "mental health" OR “Well-being” OR depression OR anxiety OR “internalizing problems”) AND ("motor skills disorder*" OR "motor skills" OR dyspraxia OR "developmental coordination disorder") AND (adult* OR "college student*" OR "university student*")
- Desde 1995; fecha de búsqueda: 31 de enero de 2022
- Resultados= 1.052

Anexo 2

Hoja de extracción

1. **Título:**
2. **Autores:**
3. **Año:**
4. **Factor de impacto:**
5. **Cuartil:**
    a. **Categoría:**
6. **Nombre de revista:**
7. **DOI:**

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8. **Diagnóstico clínico o riesgo de TDC:**
    a. **Herramienta:**
9. **Tamaño muestral del grupo TDC:**
10. **Edad del grupo con TDC**
    a. **Rango:**
    b. **Edad media (desviación típica):**
11. **Sexo del grupo con TDC (varón) (N(%)):**
12. **Comorbilidad con TDAH (N(%)):**
13. **Otras comorbilidades:**
14. **País:**

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15. **Objetivo del estudio:**
16. **Tipo de estudio:**
17. **Mediciones de:**
    a. **Calidad de vida:**
    b. **Salud mental:**
18. **Resultados:**

Hoja de extracción

1. **Título:** The role of poor motor coordination in predicting adults' health T related quality of life**.**
2. **Autores**: Batya Engel-Yeger.
3. **Año:** 2020.
4. **Factor de impacto:** 3,230 (2020).
5. **Cuartil:**
    a. **Categoría:** Q1 en Educación especial (2020).
    b. **Categoría:** Q1 en rehabilitación (2020).
6. **Nombre de revista:** Research in developmental Disabilities.
7. **DOI:** https://doi.org/10.1016/j.ridd.2020.103686**.**

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8. **Diagnóstico clínico o riesgo de TDC:**
    a. **Herramienta:** The Adult Developmental Co-ordination Disorders/Dyspraxia Checklist (ADC).
9. **Tamaño muestral del grupo TDC:** 18.
10. **Edad del grupo con TDC**
    a. **Rango:** 20-54.
    b. **Edad media (desviación típica):** 29.06 **(7,04).**
11. **Sexo del grupo con TDC (varón) (N(%)): 5 (27,8 %).**
12. **Comorbilidad con TDAH (N(%)):** 0 (0%).
13. **Otras comorbilidades: No indica.**
14. **País:** Israel.

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15. **Objetivo del estudio:** Observar el impacto al ser niños y adultos del TDC en los individuos con TDC y cómo esto afecta a su calidad de vida.
16. **Tipo de estudio:** estudio de comparación de 2 grupos.
17. **Mediciones de:**
    a. **Calidad de vida:** The World Health Organization Quality of Life Questionnaire, brief version (WHOQOL-BREF).
    b. **Salud mental: No indica.**

18. **Resultados:** Personas con sospecha de TDC tienen una puntuación significativamente menor en la HRQOL en todos los dominios excepto el físico respecto a la población sin sospecha de TDC.

Hoja de extracción

1. **Título:** Avoidance Behavior in Adults with Developmental Coordination Disorder is Related to Quality of Life.
2. **Autores**: John Joe Forde y Sinéad Smyth.
3. **Año:** 2021.
4. **Factor de impacto: 1,710 (2020).**
5. **Cuartil:**
    a. **Categoría: Q3 en educación especial (2020).**
    b. **Categoría: Q4 en psicología, desarrollo (2020).**
6. **Nombre de revista:** Journal of Developmental and Physical Disabilities.
7. **DOI:** https://doi.org/10.1007/s10882-021-09815-8

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8. **Diagnóstico clínico o riesgo de TDC:**
    a. **Herramienta:** Adolescents and Adults Coordination Questionnaire.
9. **Tamaño muestral del grupo TDC:** 94.
10. **Edad del grupo con TDC:**
    a. **Rango:** 18-63.
    b. **Edad media (desviación típica):** 33,14 (12,05).
11. **Sexo del grupo con TDC (varón) (N(%)): 26(31,8%).**
12. **Comorbilidad con TDAH (N(%)): No indica.**
13. **Otras comorbilidades:** Dislexia, autismo y diabetes tipo 2.
14. **País:** Irlanda

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15. **Objetivo del estudio**: observar si los comportamientos de evitación en población adulta con TDC afecta a la calidad de vida.
16. **Tipo de estudio:** asociación cruzada.
17. **Mediciones de:**
    a. **Calidad de vida:** Quality of Life Scale (QOLS; Burckhardt et al., 1989).
    b. **Salud mental**: The Behavioral Activation Depression Scale (BADS; Kanter et al., 2007).
18. **Resultados:** La conducta evitativa de los pacientes con TDC afectaba a su calidad de vida, mientras que la afectación de la coordinación motora no lo hacía tanto.

Hoja de extracción

1. **Título:** Anxiety, confidence and self-concept in adults with and without developmental coordination disorder.
2. **Autores**: Sophie Harris, Kate Wilmut y Clare Rathbone
3. **Año: 2021**
4. **Factor de impacto: 3,230 (2020)**
    a. **Categoría:** Q1 en Educación especial (2020).
    b. **Categoría:** Q1 en rehabilitación (2020).
5. **Nombre de revista: Research in Developmental Disabilities.**
6. **DOI: https://doi.org/10.1016/j.ridd.2021.104119.**

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7. **Diagnóstico clínico o riesgo de TDC:**
    a. **Herramienta: No indica.**
8. **Tamaño muestral del grupo TDC: 74.**
9. **Edad del grupo con TDC**
    a. **Rango: 18-60**
    b. **Edad media (desviación típica): 37,8 (12,1)**
10. **Sexo del grupo con TDC (varón) (N(%)): 15 (20%)**
11. **Comorbilidad con TDAH (N(%)): No indica.**
12. **Otras comorbilidades: No indica.**
13. **País:** Reino Unido.

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14. **Objetivo del estudio:** Observar el impacto del TDC durante la infancia y la adolescencia en términos de salud mental.
15. **Tipo de estudio:** Asociación cruzada.
16. **Mediciones de:**
    a. **Calidad de vida: No indica.**
    b. **Salud mental:** The Brief Resilience Scale (BRS), The Hospital Anxiety and Depression Scale (HADS).
17. **Resultados:** El grupo TDC y el grupo con sospecha de TDC presentó un mayor nivel de ansiedad y seguridad en sí mismos en relación con el grupo con desarrollo típico.

Hoja de extracción

1. **Título:** Mood impairments in adults previously diagnosed with developmental coordination disorder.
2. **Autores**: Elisabeth L. Hill y Duncan Brown.
3. **Año:** 2013.
4. **Factor de impacto: 4,299 (2020).**
    a. **Categoría: Q1 en Psicología, clínica.**
5. **Nombre de revista:** Journal of Mental Health.
6. **DOI:** 10.3109/09638237.2012.745187

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7. **Diagnóstico clínico o riesgo de TDC:**
    a. **Herramienta:** Siguiendo los criterios del DSM-5.
8. **Tamaño muestral del grupo TDC:** 36.
9. **Edad del grupo con TDC:**
    a. **Rango:** 19-59
    b. **Edad media(desviación típica):** 29,28 (10,69)
10. **Sexo del grupo con TDC (varón) (N(%)): 15 (**42 %)
11. **Comorbilidad con TDAH (N(%)): No indica.**
12. **Otras comorbilidades: No indica.**
13. **País:** Reino unido.

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14. **Objetivo del estudio:** Estudiar la afectación de la salud mental en adultos con TDC.
15. **Tipo de estudio:** Comparación de dos grupos.
16. **Mediciones de:**
    a. **Calidad de vida: No indica**
    b. **Salud mental: 40** -item State-Trait Anxiety Inventory Form Y (STAI-Y; Spielberger, 1983) y 21-item Beck Depression Inventory (BDI; Beck et al., 1988).
17. **Resultados:** Tanto la depresión como la ansiedad era significativamente más alta en el grupo TDC.

Hoja de extracción

1. **Título:** A Preliminary Investigation of Quality of Life Satisfaction Reports in Emerging Adults With and Without Developmental Coordination Disorder.
2. **Autores**: Elisabeth L. Hill,Duncan Brown y K. Sophia Sorgardt
3. **Año:** 2011.
4. **Factor de impacto: 1,909 (2020).**
    a. **Categoría: Q3 en psicología, desarrollo.**
5. **Nombre de revista:** Journal of Adult Development.
6. **DOI:** 10.1007/s10804-011-9122-2

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7. **Diagnóstico clínico o riesgo de TDC:**
    a. **Herramienta:** Siguiendo los criterios del DSM-4.
8. **Tamaño muestral del grupo TDC:** 20.
9. **Edad del grupo con TDC**
    a. **Rango:** 19-27.
    b. **Edad media (desviación típica):** 23.1 (2,447)
10. **Sexo del grupo con TDC (varón) (N(%)): 11(**55%).
11. **Comorbilidad con TDAH (N(%)): No indica.**
12. **Otras comorbilidades:No indica.**
13. **País:** Reino Unido.

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14. **Objetivo del estudio:** Observar calidad de vida en adultos con TDC.
15. **Tipo de estudio:** Comparación de dos grupos.
16. **Mediciones de:**
    a. **Calidad de vida:** Los participantes completaron el Quality of Life Enjoyment and Satisfaction Questionnaire.
    b. **Salud mental: No inidica**
17. **Resultados:** El grupo TDC experimentó un menor nivel de satisfacción con su calidad de vida en relación al otro grupo.

Hoja de extracción

1. **Título:** Self-reported mood, general health, wellbeing and employment status in adults with suspected DCD.
2. **Autores**: Amanda Kirby, Marie Thomas y Natalie Williams.
3. **Año:** 2013.
4. **Factor de impacto:** 3,230 (2020).
    a. **Categoría:** Q1 en Educación especial (2020).
    b. **Categoría:** Q1 en rehabilitación (2020).
5. **Nombre de revista:** Research in Developmental Disabilities.
6. **DOI:** 10.1016/j.ridd.2013.01.003.

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7. **Diagnóstico clínico o riesgo de TDC:**
    a. **Herramienta:** El Adult Developmental Co-ordination Disorders/Dyspraxia Checklist (ADC).
8. **Tamaño muestral del grupo TDC:** 57.
9. **Edad del grupo con TDC:**
    a. **Rango:** Mayores de 16.
    b. **Edad media: No indica.**
10. **Sexo del grupo con TDC (varón) (N(%)): 23 (**40.35 %)
11. **Comorbilidad con TDAH (N(%)): No indica.**
12. **Otras comorbilidades: No idica.**
13. **País:** Israel y Reino Unido

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14. **Objetivo del estudio:** Observar calidad de vida, salud general, ansiedad y depresión y estatus laboral en adultos con TDC.
15. **Tipo de estudio:** Asociación cruzada.
16. **Mediciones de:**
    a. **Calidad de vida:** The Satisfaction With Life Scale (SWLS).
    b. **Salud mental:** The Beck Depression Inventory (BDI), The Hospital Anxiety y Depression Scale (HADS)–Anxiety Subscale.
17. **Resultados:** Personas con TDC y un trabajo estable tiene mayor calidad de vida y menor estado depresivo que el grupo con TDC y sin trabajo estable. El 73 % no entra en el rango normal de puntuación de ansiedad. Personas sin trabajo tenía más síntomas de TDC.

Hoja de extracción

1. **Título**: Relationship between Sensory Responsivity, Loneliness, and Anxiety among Indian Adults with Developmental Coordination Disorder (DCD).
2. **Autores**: U. Ganapathy Sankar, Monisha. R, Christopher Amalraj Vallaba Doss y Palanivel R. M.
3. **Año:** 2020.
4. **Factor de impacto: No indica.**
5. **Nombre de revista:** *Biomedical & Pharmacology Journal*.
6. **DOI:** http://dx.doi.org/10.13005/bpj/1956

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7. **Diagnóstico clínico o riesgo de TDC:**
    a. **Herramienta:** Adolescents & Adults Coordination Questionnaire (AAC-Q)
8. **Tamaño muestral del grupo TDC:** 15.
9. **Edad del grupo con TDC**
    a. **Rango:** 20-40
    b. **Edad media (desviación típica):** 28.8 (no indica).
10. **Sexo del grupo con TDC (varón) (N(%)):** 10 **(**66%).
11. **Comorbilidad con TDAH (N(%)):** No indica.
12. **Otras comorbilidades:** No indica.
13. **País:** India.

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14. **Objetivo del estudio:** observar la relación entre ansiedad, soledad y respuesta sensorial entre adultos indios con TDC.
15. **Tipo de estudio:** asociación cruzada.
16. **Mediciones de**:
    a. **Calidad de vida:** No indica.
    b. **Salud mental:** Se mide la ansiedad con The Beck Anxiety Inventory (BAI) y la soledad con The short-form UCLA.
17. **Resultados:** Existe una relación entre las 3 variables, y las personas con TDC tenían altos niveles de ansiedad y soledad. Se tiene más ansiedad si se presenta evitación sensorial.

Hoja de extracción

1. **Título:** Young Adults With Developmental Coordination Disorder: A Longitudinal Study.
2. **Autores**: Miri Tal-Saban, Asher ornoy y shula Parush.
3. **Año:** 2014.
4. **Factor de impacto:** 2,246 (2020)
    a. **Categoría:** Q2 en rehabilitación (2020)
5. **Nombre de revista:** American Journal of Occupational Therapy
6. **DOI:** https://doi.org/10.5014/ajot.2014.009563

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7. **Diagnóstico clínico o riesgo de TDC:**
    a. **Herramienta:** Adults Coordination Questionnaire (AAC-Q)
8. **Tamaño muestral del grupo TDC:** 25
9. **Edad del grupo con TDC**
    a. **Rango:** 22-29.
    b. **Edad media:** 24,35 (0,88)
10. **Sexo del grupo con TDC (varón) (N(%)):** 13 (52%)
11. **Comorbilidad con TDAH (N(%)):** No indica.
12. **Otras comorbilidades:** No indica.
13. **País:** Israel.

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14. **Objetivo del estudio**: Observar la influencia del TDC en la calidad de vida y la participación.
15. **Tipo de estudio:** Estudio longitudinal.
16. **Mediciones de:**
    a. **Calidad de vida:** The Partic- ipation in Every Day Activities of Life (PEDAL), life-satisfaction questionnaire y the World Health Organization Quality of Life Instrument (WHOQOL-BREF).
    b. **Salud mental**: No indica
17. **Resultados:** El grupo TDC y el grupo borderline presenta una menor satisfacción y calidad de vida en relación con el grupo control.

Anexo 3

En este anexo aparecen en color verde los artículos incluidos en la revisión, en color azul los artículos que pasaron el primer cribado y la razón por la que no han sido elegidos y en color negro los descartes.

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Razón: Como afecta a una familia tener hijos e hijas con TDC.

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