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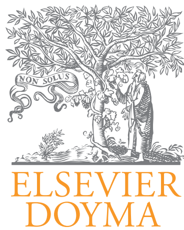

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PSYCHOPEDAGOGICAL ADVANCES

Depression and Down syndrome

B. Garvía Peñuelas

Clinical psychologist at the Down Medical Centre and Therapeutic Care Service Coordinator at the Catalan Down Syndrome Foundation, Barcelona, Spain

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Abstract
Like anyone else, people with Down syndrome can suffer mental health problems that require diagnosis, treatment and prevention. The higher number of depressions seen in recent years is a cause for concern and must be taken on by health professionals and families.
Depression is difficult to diagnose in people with Down syndrome as its symptoms can be mistaken with those of other conditions. This paper sets out to define depression, highlight the specific manifestation of symptoms and give guidelines on how it can be diagnosed and treated. Importance is also placed on prevention.
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PALABRAS CLAVE
Depresión;
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Depresión y síndrome de Down

Resumen
Las personas con síndrome de Down, como el resto de la población, presentan problemas de salud mental que se deben diagnosticar, tratar y también prevenir. El aumento de depresiones en los últimos años resulta ser un tema preocupante que merece la atención de los profesionales y de las familias.
En esta población el diagnóstico de depresión es complicado, ya que sus manifestaciones pueden confundirse con otras patologías. En este artículo se define la depresión, se destaca la manifestación específica de los síntomas y se dan pautas para su diagnóstico y tratamiento. También se hace hincapié en la prevención.
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E-mail address: beatriz@fcsd.org

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In the last ten years the number of people with Down syndrome who are diagnosed with depression has risen sharply. Although there has also been a general increase in depression and affective disorders across the board, this fact is nevertheless striking.

Furthermore, it is important to bear in mind that until very recently depression in Down syndrome was neither diagnosed nor treated —perhaps slipping through the net because the clinical manifestations differ to those in people without a disability and are confused with other illnesses, or because any behavioural or conduct disorders were put down to the disability itself. Whatever the reason, depression was undefined, undiagnosed and not properly treated. However, clinical practice, better understanding of people with Down syndrome and the relatively recent attention to their psychological and affective issues has enabled us to discover and treat the mental disorders they experience.

The term depression comes from the Latin *depressio,* which means "to press down" or "sink". A depressed person feels sad and down, may lose the will to live and feels that their life is a burden. Depression is an affective disorder ranging from passing dips in mood, which are a common feature of life, to a severe and longer lasting clinical syndrome with associated signs and syndromes that are clearly not normal. It is a treatable illness with various manifestations: endogenous, neurotic, psychotic, bipolar, primary, secondary depression and so forth.

People with Down syndrome who have mental disorders usually experience disorganised conduct and thinking, a separation between self and surroundings and other symptoms which fall into the category of psychotic traits. This highlights the mental fragility and vulnerability of this group of people. It is therefore necessary to undertake prevention from an early age by monitoring the patient and helping parents and relatives to be on the lookout for any changes, both in mood and from the relationship, family and social perspective.

Affective disorders in people with Down syndrome, including depression, are often put down to the syndrome ("he's just like that...") and can go unnoticed, without diagnosis or treatment. It is thus vital that the symptoms be properly assessed. Indeed, it is estimated that 20% of people with Down syndrome are likely to experience a depressive disorder at some point in their lives.

Depressive disorders in people with Down syndrome are usually preceded by some kind of loss: the death of a loved-one, a new roommate, a different caregiver, a sibling leaving home, loss of an important or cherished object, and so on. However, depression is increasingly widespread in puberty and adolescence as a result of the identity crisis commonly linked to this time of life, as these young people perceive their disability and struggle to come to terms with it, the body changes and it is hard to meet and make significant friendships. Early aging and low activity levels can also contribute to the appearance of depressive syndromes.

Stress is another factor that can trigger depression. Amongst young people who are new to the world of work and adults who have been working for some time, stress-related depression is also on the rise. Tension and struggling to do a job can make people feel that they are not up to the challenge.

Medical conditions must also be taken into account as triggers of depression: persistent, chronic pain; sleep apnoea due to fatigue and oxygen deprivation; hypothyroidism, alongside lethargy and a lack of interest in things; coeliac disease and other digestive disorders that cause discomfort and a feeling of ill health, in addition to poor sight and hearing which isolate the patient and cause an array of additional difficulties.

Diagnosing depression in individuals with Down syndrome is complicated by their difficulties in communication and concrete thought and the cognitive problems they have. Therefore, in addition to interviewing the patient, information must be gathered from the family and teachers or professionals in other fields with whom they have contact.

The symptoms of depression in the general population usually include sadness, apathy, feeling useless, tired of life, slowness, loss of energy, sleeping disorders and appetite loss. Sufferers can usually talk about these feelings. However, people with Down syndrome rarely convey their depression in words and are likely to manifest different symptoms: loss of skills and memory, slowdown in activity, little motivation, attention loss, changes in appetite or rhythm of sleep, altered cognitive capacities, a tendency to disconnect and isolate oneself, talking to oneself and delirious notions (psychotic traits), mood swings, passiveness, and weeping.

As has already been mentioned, many depressive disorders can also be manifest as somatic symptoms. It is therefore necessary to provide a differential diagnosis with purely medical conditions by carrying out the right explorations.

In the short term, the *prognosis* for depression in adults with Down syndrome is rather bleak, although it may be better the younger the patient is and the sooner it is diagnosed. Ascertaining whether the patient feels suicidal is vital as some, albeit few, cases of suicidal conduct have been found in individuals with Down syndrome who can identify their feelings and talk about them.

A four-pronged strategy is used to *treat* depression:

—Identifying possible stressors that can be avoided or removed.
—Medication.
—Psychological intervention: advice, psychological support and psychotherapy.
—Encouraging leisure activities and physical exercise.

Stressors, as has been mentioned, can bring on a depressive disorder in both children and adults, which is usually linked to excessive demands being placed on the person (either at school or at work), deficient or ill-focused support, condescending or deceiving treatment which clashes with the individual's own perceptions, and to not having previously worked on identity, accepting the disability and exploring one's capacities. Loss, death, job changes and so forth without prior preparation are also factors that lead to stress and a higher risk of depression.

Antidepressants are the most efficient medication: tricyclic, selective serotonin reuptake inhibitors and other mixed action drugs. MAO (monoamine oxidase) inhibitors

have been little used, largely because greater care is required in administering them. The drug is chosen on the basis of the patient —tolerability, prior experience and so on. All drugs must be taken for at least a few weeks before their efficacy can be tested. Complementary medication may also be required to treat concomitant symptoms: antipsychotics if there is a clear psychotic component (hallucinations, delirium, extreme agitation) and anxiolytics and hypnotics in the event of anxiety or very disturbed sleep affecting not only the patient but those around him.

Psychotherapy aims to bring about changes or adjustments in behaviour, adaptation to surroundings, physical and mental health, and bio-psychosocial wellbeing. Psychotherapeutic treatment has proven to be extremely beneficial in cases of depression. For many years it was thought that psychotherapy would not be suited to people with Down syndrome because of their communication difficulties, although it has now been recognised as a vital tool in treating depression among people of all ages in this collective. For Brendan McCormack, "psychotherapy provides the opportunity to establish discourse on the meaning of the deficiency and allows the patient to recover or obtain his/her own personal history".

Lastly, *leisure activities, relationships with others and sports* have a very positive impact on people with Down syndrome and depression. All too often, people with Down syndrome do little besides going to work (a protected or integrated place) and going home again, where many are in the sole company of their parents. They have little social life, few relationships and their social skills are extremely limited. A group of friends, social and sports activities, affective relationships, and future projects help to boost mood, increase self-esteem and develop social and interpersonal skills, and as such are a coadjuvant in treating depression. Therefore, strategies and means of personal and social relationships must be organised and set up as a normal part of life from an early age with a view to preventing the future onset of depression in people with Down syndrome.

Prevention is vital in avoiding and mitigating depression. One of the basic assumptions of prevention is working on identity (explaining Down syndrome, support in accepting it, exploring one's own capabilities and so forth) from childhood. Identity construction is a highly complex process which begins at birth with separation-individuation and develops with different experiences through self-image as perceived in others. Supporting individuals with Down syndrome in this process circumvents many depressive disorders in adolescence and early youth. Health plans to ensure good fitness, a range of social and personal relationships, a rewarding job and leisure time shared with peers are all other vital components in the emotional wellbeing of a person with Down syndrome.

Conflict of interest

The author declare she have no conflicts of interest.

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