

CDS

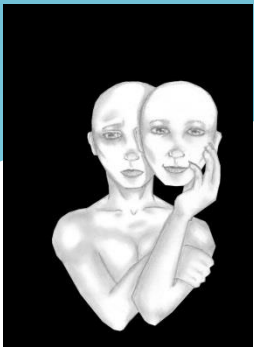
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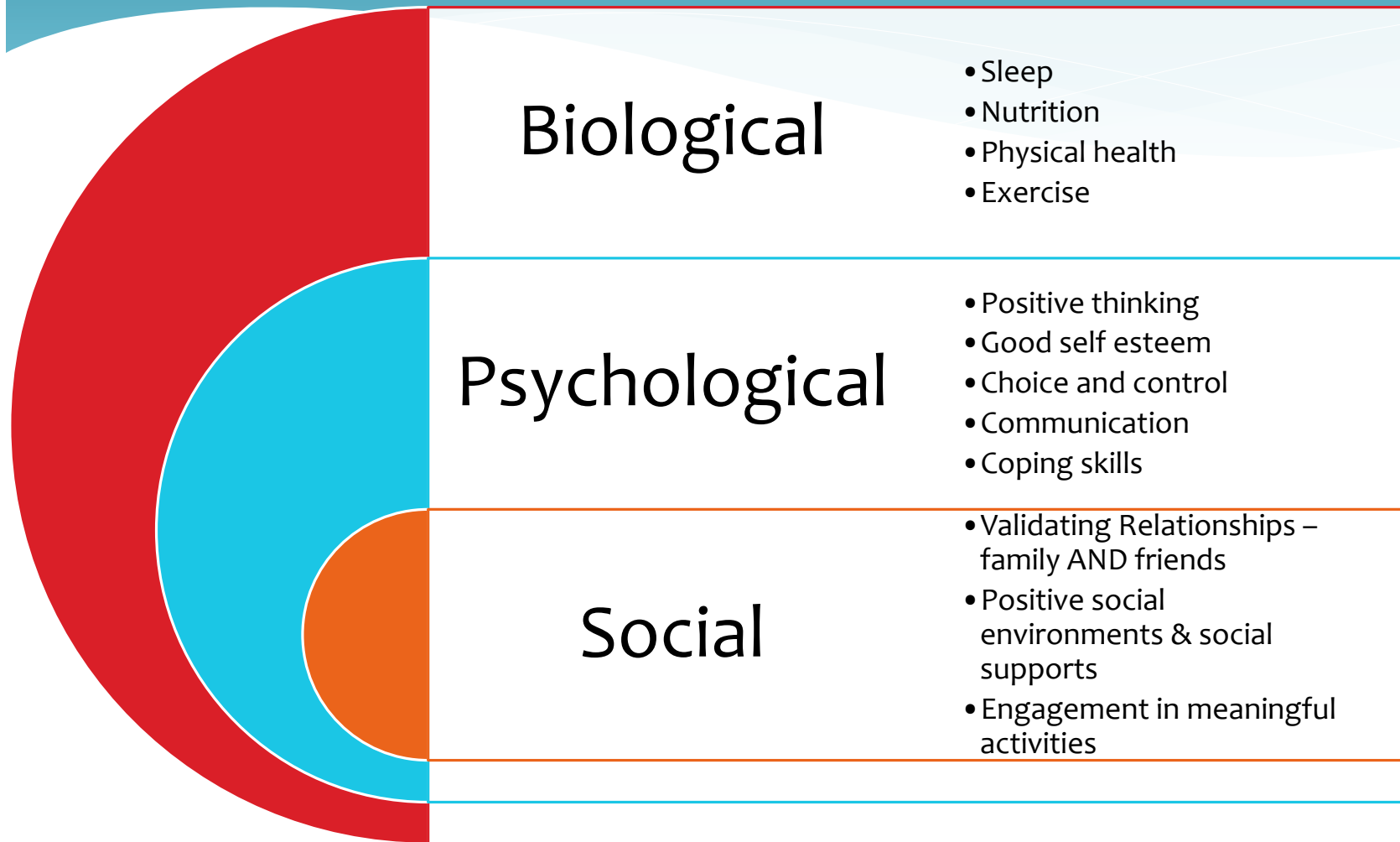
Down Syndrome NSW Health Conference 27 September 2019

Healthy Ageing and Mental Well-being




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Protective Factors for Mental Well-being



How common are mental health problems

- * 7–10% of children with DS may also fit the diagnosis of one of the autism spectrum disorders (Leshin, 2002)
- * Thyroid disorders – especially hypothyroidism affects up to 40%
- * Depression – slightly higher than general population
- * Anxiety – similar general population
- * OCD – can occur with depression or on its own (0.8%-4.5%)
- * Trauma - abuse
- * Attention-deficit hyperactivity disorder (ADHD) and bipolar disorder (manic depression) - similar prevalence to general population
- * Schizophrenia - uncommon in people with DS

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- A person with Down syndrome who is hallucinating is more likely to have either :
 - Severe depressive disorder with psychotic features (not schizophrenia) or
 - Dementia of the Alzheimer's Disease (AD) type, that may be caused by hypothyroidism

Ageing and Dementia

- Normal ageing process accelerated
- Increased risk of dementia – Alzheimer disease.
- Develop Alzheimer disease (AD) at a younger age than others.
- Almost all people with DS have changes of AD in their brains by age 40 years, but not all develop symptoms
- Only 20–25% of all adults with DS show any of the dementia or cognitive decline that is the hallmark of Alzheimer's disease
- Observe any loss of skill - have thorough assessment
 - Be aware : not always dementia and many respond positively to medical or mental health treatments

Self talk

- **Self talk** – coping strategy into adulthood: helps plan, practice alternatives, review day, entertain self and vent feelings
- **Only a problem if**
 - Changes dramatically in tone and frequency –e.g. angry, agitated, threatening or hallucinatory-like
 - Becomes increasingly self critical
 - May signal depression, anxiety, physical pain or illness, social problem
 - May be misdiagnosed as psychosis
- **Imaginary friends and fantasy life**
 - May need to redirect toward something else positive and if interfering with school or work or peer relationships

OCD

- * Ordering and tidiness are the most commonly presenting behaviours in childhood – “the groove” for order and structure coping
- * Obsessional slowness
- * Younger children with DS more compulsive behaviour than older children (developmental aspect)
- * Compulsive behaviours in children with DS more frequent and intense than children without DS
- * **Adults with OCD** - extremely repetitious activities, a slowdown in behaviour, and an overreliance on a precise way of doing things

Vulnerability to Depression

- * Biological factors –specific groups e.g. Down syndrome (Dykens, 2000)
- * Cognitive factors – negative attributional style
- * Life events : Stigma; Loss and grief; exclusion; abuse ...
- * Gender -higher in women (general & ID pop)
- * Poor self esteem
- * Parental depression and stress
- * Lack of social acceptance, loneliness



Depression

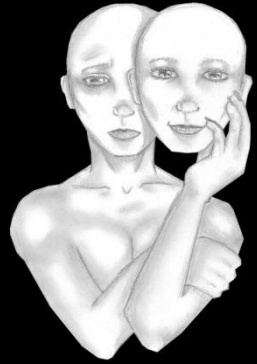
- * Often “*unrecognised, under-diagnosed and consequently under-treated, regardless of age*”
- * Symptoms of depression may be “atypical” – change in behaviour
- * Significant mood change can result from simple changes in lifestyle, environment, social networks etc.



Watch for

- * If unable to express their feelings easily in words, and use behaviour to communicate with others
- * Sudden changes in behaviour (or mood) and/or
- * Inability to engage in activities s/he could previously accomplish

Common Symptoms of Depression



- * Inability to concentrate
- * Feelings of sadness or misery and failure
- * Low self-confidence
- * Lack of pleasure and enjoyment
- * Reduced energy and activity
- * Self blame and criticism
- * Thoughts of self harm
- * Withdrawal and lack of interest in others or irritability and aggression
- * Disturbed sleeping patterns, early morning waking
- * Loss of or increased appetite
- * Wanting to stay in bed
- * Feeling unattractive

Behavioural Equivalents

Depression

- * Sad
- * Lethargy
- * Disturbed appetite
- * Sleep disturbance
- * Loss of interest
- * Irritable mood

Equivalent Behaviour

Facial expression, tears

Sitting still for several hours

Refuses to eat, eats too much

Won't go to bed/ gets out of bed often/ refuses to get up when called.

Refuses to get on bus, go to usual activities

Aggression

Practitioners & Carers

- * Can be surprised by rapid and sudden onset of functional decline
- * May fail to notice slower, less obvious signs
 - * general slowing down &
 - * loss of skills that occurs over a longer time period
 - * especially with significant staff changes and lack of data indicating previous skill levels

Detecting Thoughts-Feelings-Behaviour



angry



**staying at home
alone**



no one will want to be my friend



I will do it all wrong

ANXIETY.



**IT'S A PAIN IN
THE NECK.**

Symptoms of Anxiety Disorder

- * Nervousness or restlessness
- * Trembling
- * Trouble falling or staying asleep
- * Sweating
- * Poor concentration
- * Palpitations
- * Frequent urination
- * Muscular tension
- * Easily fatigued
- * Irritable mood
- * Light-headedness or dizziness
- * Hyperventilation
- * Shortness of breath
- * Depressed mood

Behavioural Equivalents

Anxiety symptoms

Equivalent behaviour

Worry

Repeated questioning

Restless

Pacing back & forth

Muscle tension

Clenched fists

Dry mouth

Frequent drinks

Nausea

Food refusal

Startle response

Jumps at noises

Practice Guidelines

3 steps:

- * Recognise changes
- * Conduct assessments and evaluations
- * Care management : medical, social, environmental and psychological

(Janicki, Heller, Seltzer & Hogg, 1996)

What carers can do (1)

- * Ensure that all adults have baseline assessments of cognition, function and health
- * Ensure that these are repeated periodically
- * If you are concerned that an individual may be showing signs of depression, anxiety, grief etc., organise a comprehensive assessment

What carers can do (2)

Keep records of behaviours of concern

Note: Repeated observations documenting changes are crucial to making a diagnosis

- * Information from several sources is helpful e.g. other carers, family members and friends, work colleagues
- * Information from someone who has known the person for a long period of time is invaluable
- * Take all observation records, previous assessments, medical reports, list of medications to the assessment

Practical Suggestions

- * Diet
- * Sleep
- * Exercise
- * Pleasant events & activities
- * Friendships and relationships
- * Social support
- * Support groups
- * Art and/or music therapy