MEDICAL MEMO

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What is Depression? An Overview

Depression is probably best understood as a persistent mood of pronounced sadness which is present at least most of the day on most days for at least a month and typically interferes with normal function. Sleep, energy, motivation, pleasure, hope, concentration, temper, self esteem, physical health, libido (sex drive), interest in or ability to communicate, the ability to think rationally, and the desire to live may all, or some, be affected to some degree.

Depression may be so severe (called Major Depression) it is disabling and life threatening, or moderate but lasting years (Dysthymic Disorder), or present in varying ways (agitation, with anxiety, after giving birth, seasonal, premenstrual, after psychosis, with melancholia, etc.) with varying effects for shorter or longer periods.

Manic- Depression is now called Bipolar Disorder and is an alternation or mixture of depression and certain other elevated mood symptoms known as mania or hypomania. Depression may be caused by genes (inherited), directly or indirectly by a medical problem, by stress, trauma, loss, or grief, by substance abuse, by a medication, by life events, occur for no clear reason, or most often be due to some combination of factors. Depression may show itself somewhat differently in children, the developmentally delayed, young adults, older adults, the elderly, in men vs. women, and in different cultural or ethnic and racial groups.

Depression is the second most common psychiatric disorder, behind only anxiety. Depression often occurs along with or may be confused with other disorders such as anxiety, substance abuse, or along with or due to other mental and general health problems. At least 10-20% of all people will have an episode of Major Depression sometime in their lives. *About 1.6% of all persons have a Major Depression currently. About 3% have Dysthymic Disorder (chronic minor to moderate depression) currently while another 4-8% have a current minor to moderate depression lasting weeks to months.*

Up to 15% of people with Major Depression, especially when recurrent and on top of dysthymic disorder (known as "double depression")**, may eventually kill themselves.** Suicide risks are higher for depressed persons who also have severe anxiety such as panic attacks, abuse substances, feel chronically very hopeless, have severe depression marked by severe loss of interests and pleasure, marked insomnia, and delusional thinking, or hallucinations. Of course, other factors like increasing age, access to lethal means (especially guns), and a personal and family history of suicide, suicide attempts, and suicidal ideas, plans, and intent are also important risk factors.

75% of all depressed people never see a mental health professional. Many go to their primary care doctor where their symptoms may or may not be recognized as depression. Even so, primary care doctors treat more people for depression than psychiatrists do. This occurs because stigma keeps some from accepting or being referred to mental health caregivers, some have no or poor mental health insurance coverage, some just feel too depressed and hopeless to seek help, recognize their need, or suffer from outdated negative stereotypes or misinformation about the treatment itself.

Unfortunately, half of all people with depression are never diagnosed or treated. Too many who are treated are treated only partly and most are never referred to or never seek out a mental health professional. This is especially sad when you realize **the success rate for treating Major Depression is 70-80%**; far higher than similarly dangerous or disabling illnesses like heart disease, cancer, diabetes, arthritis, lung disease, and hypertension. There is also strong evidence that co-existing depression increases the impairment and chances of dying from other medical illnesses such as heart disease and cancer.

When depression is being considered as a possible cause of health, emotional, or behavioral problems a visit to the primary care doctor is often a good idea before, along with, or after seeing a mental health professional. An updated medical history and physical exam, perhaps even a few tests, may help ensure not missing another health problem which may cause or complicate depression. This is especially worth considering if the therapist is not a psychiatrist since only psychiatrists are also physicians. Sometimes, in complicated or

Continued on page 4

What Is Encopresis?

Warning: This article is about youth who have bowel problems. Although some readers may find the whole subject unpleasant, encopresis can become one of the most disruptive sources of family conflict and therefore may need attention.

Encopresis is the repeated accidental or intentional soiling of clothes or other places (floor, etc.) by the passage of partial or full bowel movements beyond the age, or developmental level of, at least 4 or 5. The diagnosis is usually not given unless the problem occurs at least weekly for at least 2 months (DSM IV says at least monthly for at least 3 months).

The diagnosis of encopresis is not given if some other medical condition, except constipation, causes the problem. Such causes may include laxative misuse, dietary causes like lactose intolerance, problems with absorption, low thyroid, bowel or rectal structural abnormality, sexual abuse, etc. The diagnosis generally refers to children and adolescents and does not include the incontinence that may occur in previously soiling free adults who have the symptom start but is caused by some other health problem.

Enuresis refers to a similar problem with bladder (urine) control and was discussed in detail in my *Summer 1999 Medical Memo.*

Encopresis may occur either with or without constipation and overflow incontinence. A recurrent alternating pattern of constipation and loose diarrhea-like stools is not unusual. Encopresis is 4 times more common in boys than girls. It occurs in about 1.5% of children, lessens with age and is rare in teens. It may run in the family. Higher rates are seen in the mentally retarded, developmentally delayed, sexually abused, and with seizures. Soiling can occur up to multiple times daily and may involve the hiding of dirty underwear by a youth who may seem unaware or not caring about the problem.

This paragraph may seem a bit gross to some but is important in understanding the encopretic child's perspective. The very young child often naturally experiences his or her bowel movements as a production to be proud of, even to play with - this may linger in some kids who have encopresis. The encopretic child has typically lost sensitivity to the gastro- colic reflex (see below) as well as to the smell, and to the rectal and anal area's remarkable ability to distinguish between and control the release of gas, liquid, and solid. It is natural to wonder if this is some neurologic disorder. Although not impossible, I haven't seen a neurologic cause yet. The mechanism of this seeming loss of sensation and smell is best understood if you think about what happens if you spend the next month full time with an oily smelly moist rag wrapped around your hand or leg etc. Your body would adjust to this now constant condition and the sensory messages would fade into the background as more important changing stimuli would register instead.

Encopresis, like enuresis, can be primary or secondary. *Primary* means that the youth has never had a significant period of full bowel control, such as at least 3 months. *Secondary* means the soiling returns after a significant period of bowel control.

Treatment: *The first step* is to make sure there is no other medical cause of the problem. A visit to the pediatrician or family doctor for a physical examination is advised strongly. The physical will often include a rectal and simultaneous feeling (palpation) of the abdomen (belly) to ensure there is no impaction. An impaction is a large hard mass of fecal material which often will not pass on its own without laxatives or enemas as advised by the doctor. Such cases are often marked by daily leakage of liquid or very soft stool with a formed stool being rare or nonexistent. The later steps in treatment will often be unsuccessful unless this is cleared up and kept clear. The doctor will also assess whether any other factors may be causing the problem. This is generally done by listening to the history and doing the physical and may occasionally include other tests or referral to a gastrointestinal specialist or neurologist.

The second step is standard pediatric behavior therapy which takes advantage of the natural body rhythm of the gastro- colic reflex. When food goes into the stomach (gastro) the bowels (colon) soon move. The key is re-training the child's body to do what comes naturally. This is done by having the youth sit on the toilet for 10-15 minutes after, at least, breakfast and supper (lunch too, if feasible) for which he or she is rewarded whether he produces a bowel movement or not. An extra reward is earned for production of a BM; there is no punishment for failing to produce. The rewards chosen will depend on the child and his or her interests - nintendo time, a goody grab bag, points toward a pokemon card, etc. *This is the key to the treatment*; the child who never learned or resisted and lost touch with the body rhythm will be re-trained and become able to read and will be rewarded for responding to the body cues to defecate. *Once normal control has been gained, this same basic at least twice daily toileting and reward system should be maintained for at least 2 months for mild cases, 4 months for moderate, and 6 months for severe cases in order to lessen the very high relapse rates.*

Stool softeners, not laxatives, are used as part of the on- going behavior plan for all moderate to severe cases and anytime there has been an impaction or recurrent constipation, or tendency for the child to hold in the stool. The most powerful softeners are the forms of mineral oil which prevent constipation when given daily as directed by the physician. Medical involvement is key to ensure no laxative is given (they can damage the future bowel function) and to ensure the tendency of mineral oil to deplete the body of fat soluble vitamins (E,A,D) does not occur. A milder softener such as Colace (DSS) can be advised by the physician and adjusted just right and weaned off with time.

If the youth or family cannot follow through with the above plan, psychotherapy is advisable or even necessary. There are no psychiatric medicines for encopresis. Sometimes a medication may be useful for an accompanying depression, anxiety disorder, ADHD, etc. Treatment is made more difficult by a high frequency of soiling or a long duration of the problem, resistance to the treatment plan or inability to follow the plan, and by accompanying medical, emotional, or family problems.

Generally, frequent long standing soiling is much tougher to successfully treat than bedwetting; tougher than many other childhood behavioral problems. Severe cases may also be marked by a very angry withholding child and a very frustrated angry parent wherein the parent child relationship may seem poisoned by the longstanding control and power conflicts. In these situations the child's character formation may seem at risk. Fortunately, as even these youth progress through middle school and into high school peer pressure and increasing awareness of the social costs often lead to the resolution of the encopresis.

When primary (never been successfully bowel trained) encopresis has

Continued on page 4

Teaching social skills

I have often been disappointed by my profession's inadequacies in teaching social skills. Two books and a videotape have both helped me to better understand what we have been missing and give new hope. My thanks go out to the parent and educator who exposed me to these.

An example from another area will help explain this new insight. Eighty-five percent of people learn reading and writing almost naturally. They, seemingly with little effort, catch on to the idea that letters stand for sounds, that sounds group into words, words into sentences, and that all this has meaning. This majority of kids can do "whole language" education in early elementary school with little need to have the sounds, or "phonemes" pointed out and explained more than in passing. The 15% of us who have **Dyslexia** just do not "get it" without a repetitious concrete explicit teaching process over and over (phonics and other techniques). This is due to a brain processing disorder of this type information that is known as a group of learning disorders called Dyslexia.

It turns out that an analogous problem occurs in some of us in learning and reading social skills. This is termed by some as **Dyssemia** (a learning disorder or difficulty in using and understanding nonverbal signs and signals) and by others as **NVLD** (Non Verbal Learning Disorder). In other words, some or even many of the boys, girls, and adults who seem to blindly go through life violating the unspoken rules of social interactions may be doing so (partly or mostly) **simply because the rules have not been spoken, taught, rehearsed, or practiced and they cannot get it naturally by osmosis like the rest of us do!** For most of us, the polite social courtesies and basic rules on eye contact, personal space, touching, reading facial expressions, reading body language, comprehending the significance of different tones of voice, gestures, postures, etc are all automatic, don't need to be thought about, are ingrained, instinctual, natural. This knowledge and set of skills is known as **pragmatic social language**. For those of us with dyssemia or NVLD the opposite is the case - It all must be taught, practiced, coached, rehearsed over and over. In fact, the dyssemic individual often must have it explained that these subtleties even matter, why they matter, and what is in it for them to learn to read these social cues. If you have ever wondered which fork is the salad fork or which bread plate is yours or which foot to lead a dance step with then you have a minuscule conception of what it is to not know social skills. Imagine how you are experienced by others (and may feel about yourself inside) if everything you do is out of step, a social gaffe, as if you were a stranger on Mars and don't know even the simplest social rules.

Dyssemia or NVLD may occur as the only problem a person has. Or it may occur along with a fine or gross motor coordination delay, with ADHD, with anxiety, other learning problems, etc. It is always present in Autism, Asperger's Disorder, and related conditions.

Here are four very good resources:

1. Teaching Your Child the Language of Social Success by Drs. Duke and Nowicki, Peachtree Press,1996, $14.95, paperback. This book gives concrete teaching examples do-able at home and includes suggestions for a school curriculum.

2. Helping The Child Who Doesn't Fit In by Drs.Nowicki and Duke, Peachtree Press, 1993, $14.95, paperback. This is the first book on the subject by these two expert social skills researchers and targets youth with severe deficits in decoding and using nonverbal communication.

3. Asperger's Syndrome - A Guide For Parents and Professionals by Tony Attwood, JK publishers, 1998, paperback. This is the best single book for parents wanting to learn in depth about this condition.

4. Learning Disabilities and Social Skills - Last One Picked...First One Picked On with Richard Lavoie, on PBS Home Videos, 1994. Rick Lavoie is a fantastic speaker. This and his videotape presentation "F.A.T. City" on learning disabilities are great.

In the News

U.S. Surgeon General fights stigma

David Satcher M.D., current United States Surgeon General, is the highest government medical official charged to advocate for the health needs of Americans. Prior Surgeons General have publicly highlighted the devastating health effects of the epidemics of smoking and AIDS. Dr. Satcher has already called attention to the health costs of the escalating rates of obesity and the fact that because suicide causes 50% more deaths than homicide much more attention is needed to address the problem of suicide in our country. Last month, Dr. Satcher furthered his efforts on Mental Health in a report which includes these statements:

> "One in every five Americans (currently) has a mental disorder; most can be successfully treated, but nearly half don't even seek help"!
>
> "Mental disorders are not character flaws but are legitimate illnesses that respond to specific treatments just as other health conditions respond to medical treatment. They are treatable. That's good news."
>
> "A revolution in science has shown that mental health problems are also physical health problems. Blame and stigmatization have been based on the myth that the mentally ill have character flaws. But we now know there are changes in the brain associated with mental problems. These are real illnesses."
>
> "Our society no longer can afford to view mental health as separate and unequal to general heath."
> "The causes of most mental disorders lie in some combination of genetic and environmental factors."

Dr. Satcher plans to continue educating the country by releasing future reports about racial and cultural factors in mental illness, about suicide prevention, and about substance abuse treatment.

Depression (contd)

confusing situations, in depth psychological tests done by a Psychologist are very helpful in clarifying the diagnosis. (See the summer ' 97 Medical Memo article "What Is A Psychiatrist?")

Left untreated, half of all persons with Major Depressions will recover completely in about 6 months. Even so, treatment often saves enormous pain, agony, societal, work, relationship, and other costs. Of course, the other 50% either recover more slowly, have higher rates of chronic or relapsing patterns, have other complications, or may even die. Persons who have 2, or certainly 3, episodes of depression in any 5 year period are very likely to have more episodes in the future. Medication helps prevent recurrence as well as treat the current episode.

Some research indicates a first episode of Major Depression in one's youth, especially when severe, indicates a higher likelihood of future recurrences. Treatment for all illnesses are aided by improving basic health habits, eating nutritiously, getting rest and exercise, and keeping connected with both activities and other people. Spiritual and creative pursuits help many.

The core treatments for Depression are psychotherapy and medication. 25% respond well to psychotherapy alone, 25% to medication alone, and 50% to a combination of both. Cognitive Therapy and Interpersonal Therapy are two forms of psychotherapy which have repeatedly been shown to be very powerful in treating depression. **Cognitive Therapy** focuses on correcting and changing the negative and distorted thoughts that are a core finding in depression. **Interpersonal Therapy** focuses on addressing dysfunctional and problematic relationships and interactional styles that are also noted in many depressions. There is a substantial and growing number of **medication** options for depression and related or co-occuring conditions. Medicines are becoming more and more focused in their effects and show less and less side effects. In fact, most of the modern antidepressant side effect possibilities are in the range of nuisance and are not dangerous; some side effects can even be used to be helpful in some situations. Medications are especially important ,if not essential, for Major Depression and Bipolar Disorder. Stopping alcohol or drug use, especially abuse, is also strongly advised. Electro-convulsive therapy, known as **ECT**, is another option which is remarkably effective for severe depression. Despite the media's distortions, ECT is a very safe and rapidly effective option appropriate when other options have failed or are too slow. Hospitalization continues to have a role, especially when danger to self or others is severe, and when other efforts fail or are unavailable.

No "alternative" herbs, supplements, vitamins, homeopathic remedies, etc. have been shown to be effective in Major Depression or Bipolar Disorder. A good US study of St. John's Wort is due to begin soon, if it hasn't already, for treatment of only minor depression. Many "complementary" treatments such as biofeedback, hypnosis, special breathing techniques, massage, etc. have nonspecific but possibly positive effects on depression. Adequate sleep, a healthy diet, and regular exercise are also helpful but also not enough alone, especially for Major Depression or Bipolar Disorder. Research into a special type of magnetic therapy, although not yet usable, shows some promise.

Treatment options have both expanded greatly and become much more effective with much lower side effect risks in the last 10 years. This improvement in the number, quality, and convenience of treatment options is simply remarkable and wonderful ! This is one reason the 90's have been referred to medically as The Decade of The Brain. This next decade looks equally promising. It is a rewarding time to be doing this work.

The next two Medical Memos will delve further into first Major Depression and then into Dysthymic Disorder and Depression NOS. Please refer to the Fall '99 Medical Memo about Seasonal Affective Disorder (SAD), the Summer '99 Medical Memo about Bipolar Disorder, and my Depression Medication Charts for more information on these topics.

Encopresis (contd)

been present for a short period of time and is uncomplicated by serious psychiatric problems like attachment disorder, serious developmental delays, or abuse and molest, the treatment is often a matter of improving the basic toilet training routine as outlined above. Inadequate, inconsistent, or punitive toilet training is the usual cause and can be addressed by working with the parents primarily. The same is true for brief duration mild to moderate secondary encopresis (soiling has returned). Frequently some stressful event is the trigger and needs addressing. These events may include a move, starting or changing schools, parental separation, divorce or conflict, birth of a sibling, or a traumatic event. Obviously, complications and severe cases usually indicate the need for counseling, psychotherapy, and/or behavior management therapy for the family.

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