MEDICAL MEMO

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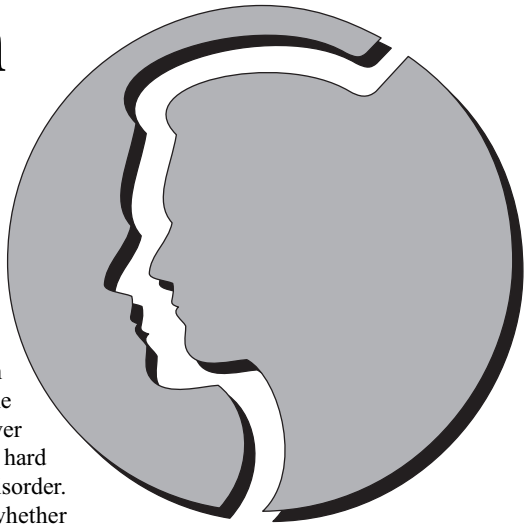
VOLUME 3, ISSUE 3 www.leeheymd.com SUMMER 1999

One Doctor's Opinion

Is Bipolar Disorder over diagnosed?



I believe the answer is both yes and no.

First let's address *"no, it's actually being under diagnosed"*. There is no doubt that Bipolar Disorder exists and is present in around 1% (1 person out of every 100) of adults. It is definitely not rare; many cases are in fact being misdiagnosed or being missed completely. Many people with Bipolar Disorder never seek help, end up in jail, cover it up with substance abuse, or never see a clinician experienced enough and knowledgeable enough about the disorder to recognize it. Others with Bipolar Disorder have hard to recognize forms of it or don't ask for help when the recognizable signs are present. Only about 25% of people with any mental illness or disorder ever see a psychiatrist, psychologist or clinical social worker.

Now let's address the *"yes, it's being over diagnosed"* part. This does not conflict with the far greater number of under diagnosed persons. The over diagnosing problem is my opinion and is shared by some other, but not all, clinicians. The over diagnosis occurs partly because it is so hard to recognize some forms of Bipolar Disorder. There is debate in the field about whether some forms of Bipolar even exist and about their frequency. This debate revolves around 1) making the diagnosis in children, 2) whether "soft Bipolar II and Bipolar III exist, and 3) the frequency of "Mixed", "Rapid Cycling" and Bipolar II types. The debate is made more important by the question of whether currently available Bipolar treatments

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Bedwetting and Approaches to Treatment

The diagnosis of **Enuresis**, or **Bedwetting**, requires accidental or voluntary urination into clothes, bedclothes, or bedding at least twice a week for at least three months after the age of five. Enuresis can occur only at night (*nocturnal*), which is more common, or only in the day (*diurnal*), or both. Enuresis can be *primary* or *secondary*. In primary enuresis the child was never successfully toilet trained for bladder control while secondary enuresis means that wetting has resumed after having been free of wetting for at least several months, and sometimes years. Bedwetting frequently runs in families and is often inherited. It is also more common in boys. Encopresis refers to fecal staining or lack of bowel control and is not covered in this article although it may occur along with enuresis, especially in more severe cases. This article also does not address the incontinence that may occur with older age, multiple childbirths, or specific health problems in some adults.

Fortunately, the prognosis of bedwetting is usually good. Most youth outgrow bedwetting during their elementary school years or teens probably due to the natural course of neurologic maturity which comes with development. However; 1% of young adults, especially males, still wet the bed at least once a week.

The *first step in treating* enuresis is determining whether or not it happens only at night, whether or not it occurs after a prior period of bladder control, and whether or not there may be some other associated or causal medical or psychiatric problem(s). If neurologic problems (such as seizures or paralysis,etc.), health problems (such as urine infections, diabetes, kidney or bladder disorders), or psychiatric problems (such as sexual abuse, developmental delays, sleep disorders, or ADHD), exist, they are usually treated first. Medications that overly sedate the child (antihistamines, sleep aides, etc.) or increase urine flow (diuretics, aminophylline, caffeine, lithium, etc.) can cause bedwetting to recur or increase.

The *second step* is to next decide whether the bedwetting or day wetting even needs any additional treatment. If the wetting does not lead to social, self esteem, family, or other problems or if it is mild, it may be left untreated. Frequently however, the result of bedwetting is embarrassment, avoidance of sleep- overs, lessened self esteem, and / or family conflict. Wetting during the day is often even more of a concern.

Once the decision to explore **treatment** has been made there are several possible approaches. The first is to provide the family with basic toilet training guidance emphasizing routine toileting scheduling and rewarding the child for success. This helps

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Bipolar (contd.)

are even effective in these atypical cases. There hasn't been enough time and research to settle this debate yet.

Let me next briefly summarize the types of Bipolar Disorder. Our current diagnostic manual, DSM IV, contains *7 bipolar related categories*; Type I (the classic manic depression with separate clear depressed and fully manic episodes), Type II (episodes of depression alternating with less than full manic periods but clearly "higher" than normal periods referred to as hypomania), NOS (Not Otherwise Specified - which is essentially " atypical" or "other"); Rapid Cycling (the severe ups and downs cycle occur at least 4 times a year and may be much more frequent); Mixed (in which episodes have mixed features of mania and depression simultaneously); Schizoaffective-Bipolar (schizophrenia and Bipolar intermingle or overlap); and Cyclothymia (less severe but troubling mood irregularities that cycle). Some more aggressive diagnosers of Bipolar Disorder now argue for the addition of even less clear cut categories such as "soft" Bipolar type II and Bipolar Type III. There are some doctors and therapists making these two diagnoses and some, I think, are stretching the diagnoses of Mixed or Rapid Cycling too far.

There are important reasons to be careful with this diagnosis. Although there are, and have been, many successful and even very successful and very admirable people with Bipolar Disorder, it is frequently a disabling chronic and recurrent life long disorder with a worrisome prognosis. There is reason to believe that early life onset is even more of a concern. The label of Bipolar Disorder too often negatively affects one's life, including employment, licenses, and obtaining insurance coverage. Bipolar Disorder is strongly inherited and thus may have a big impact on family planning. Treatment response is often quite good, although patient compliance with the needed long term maintenance treatment is too often a problem.

The standard medications, mood stabilizers (see my information chart on my website **leeheymd.com**), are "big guns" that often require blood levels, at least twice daily dosing, and have a longer list of potential minor and even (uncommon) major side effects than other simpler medicines for depression, anxiety, and ADHD. Treatment results for the more controversial ("soft" Bipolar II and Bipolar III) and less clear forms of the disorder (Mixed or Rapid Cycling) is often less satisfactory than for the more accepted forms. Thus one can question the usefulness of a diagnosis that doesn't clearly lead to effective treatment. Although this should improve with research, some believe this disparity is the case because the person really has some other condition like a personality disorder, substance abuse, anxiety disorder, or another form of depression; not Bipolar Disorder. This type of diagnostic error may be more likely when the doctor's knowledge of the patient is limited by a short time of working together, seeing the patient only at their worst (like a brief hospital stay or brief clinic contact), or little history is available about the person and family background.

How to make the diagnosis of Bipolar Disorder in **children,** especially before puberty, is a very big controversy currently. There is no doubt Bipolar exists in children 12 and under, but how does it show itself? Some see it hidden in severe ADHD, some see it in "rage attacks", "affective storms", etc. Bipolar in kids is seen as more chronic, less episodic, and more mixed than it appears in teens and adults. The newer views of how Bipolar shows in kids often does not fit the criteria in DSM IV. Thus there is more room for mistake, disagreement, and confusion. Additionally, there is uncertainty about treatment efficacy; more so than with adults. The field of Child Psychiatry is making substantial progress in the diagnosis and treatment of Bipolar Disorder in children, but we have quite a ways to go. New ideas about how Bipolar Disorder shows in children include that it is often more chronic and continuous, less episodic, more often mixed and rapid cycling, with little or no periods of normal function in between, and little or no seperation between the depressed and manic times. To seperate Bipolar in children from severe ADHD we look for grandiosity, elated mood, racing thoughts, flight of ideas, and much increased inappropriate behavior (silly laughing, daredevil, less sleep, hypersexuality) and even hallucinations and delusions which all point to Bipolar while irritablity, rapid speech, high energy, and distractibilty often occur in both.

Since the unique feature of Bipolar Disorder is mania, w**hat is Mania?** The pure and clear form of classic mania is typified by at least a week of dramatically decreased need for sleep, decreased need for eating, being too energized with fabulous new ideas or creative projects to pursue to have time to waste on such mundane tasks as eating or sleeping, thoughts that come so fast ("racing") that the mouth or writing can't keep up, talking so fast ("pressured") others can't get a word in edgewise, the ideas though seeming logical to the manic are expressed and change so quickly that others can't follow the "flight of ideas", the manic is so overwhelmed by urges and thoughts that he or she is very easily distracted, social judgment is lost, the person becomes overly sexual, spends money excessively and unwisely, the manic's mood is euphoric and elated "happier than happy" or very very irritable, the view of self is now "grandiose" such that he or she believe the normal rules of life no longer apply to him or her. The character change in an episode of classic mania is typically dramatic and severe enough to cause marked impairment in work, relationships, activities of life, and / or endanger the person or others. Severe forms of mania may include hallucinations or delusions and is then called psychotic. "Hypomania" is between normal mood ("euthymia") and mania, and is less severe than mania. These criteria are available for review in the DSM IV.

In summary, for many people with Bipolar Disorder there is no doubt of the diagnosis. Once a clear episode of mania has occurred the diagnosis is definite. Many people respond very well to the mood stabilizers lithium, valproic acid (Depakote), and carbamazepine (Tegretol). New medicines are being studied, such as Neurontin and Lamictal, but are not yet well proven. A strong family history of Bipolar Disorder is one of the better guides in clarifying the diagnosis. If Bipolar Disorder is definite or clearly the most likely condition, a treatment plan including mood stabilizers is often advised. If Bipolar Disorder is only suspected or not definite the more conservative treatment, in my view, is to proceed with easier and milder medication and other interventions while watching for more clear signs of Bipolar to emerge. With time, the correct diagnosis for an individual patient will generally become clear.

Also with time, consensus in the field of psychiatry on how to best diagnose and best treat all types of Bipolar Disorder will continue to develop.

Internet Spotlight

I have added several new links to my website at **leeheymd.com** I'd like to highlight two here. Each can be accessed directly from the address given below or linked to from my website's **health and mental health links** section on my home page. Both these sites represent not for profit patient, consumer, and family support organizations with seemingly good clinical advisers and backing.

bpso.org is a very informative site about bipolar disorder (the old term was manic depression) run by "significant others" (parents, spouses, friends, etc.) of bipolar patients. There is lots of very useful information about the condition, its effects, its treatment, and useful links.

ocfoundation.org is the website for the Obsessive- Compulsive Foundation. They also provide surprisingly in depth information and links about OCD (obsessive compulsive disorder) in all ages, effects, and treatments.

What Are Behavioral Side Effects?

Behavioral Side Effects (BSE's) are medication side effects that show up by worsening a person's behavior. Although a number of treatments (medicine and others) may cause BSE's this article will focus on what I call "Revving Up". This is a possible side effect mainly of serotonin reuptake inhibiters (SRI's) such as Prozac, Zoloft, Paxil, Celexa, and Luvox. *I refer to this as " revving up" or "disinhibiting" or making the person too "bold", brave, risk taking, or adventuresome.* It usually occurs along with increased energy, "hyper-ness", and / or a usually unpleasant internal "jittery" feeling. Thus I see it as part of an increased energizing effect that the patient may even enjoy, but may go too far.

Although uncommon, BSE's are certainly not rare. It can be mild and even helpful such as by giving moderately more energy to someone who needs it, or it can be severe and quite disruptive and anywhere in between. Generally, revving up goes away after a few days to weeks and is less at lower doses; so that starting low, giving extra time at a low dose, or backing down on the dose will usually resolve the side effect without substantial problem. Changing the medicine or trying to counteract a mild revving up are also options. Revving up is, I believe, more frequent with the SRI most likely to increase energy, Prozac, is less with Zoloft and Paxil, is probably even less frequent with Celexa, and is least likely with the least likely to energize option, Luvox. However; I have seen it occur with each SRI medicine and I have even seen it with Luvox, but not with Prozac, in a few people . Most who experience revving up with one medication will not with at least one other medicine.

There are some who, I believe, confuse this "revving up" with signs of mania in Bipolar Disorder. Although antidepressants, including the SRI's, may bring out mania in people with underlying Bipolar Disorder; this "revving up" is not mania and can happen in persons without a tendency to Bipolar Disorder.

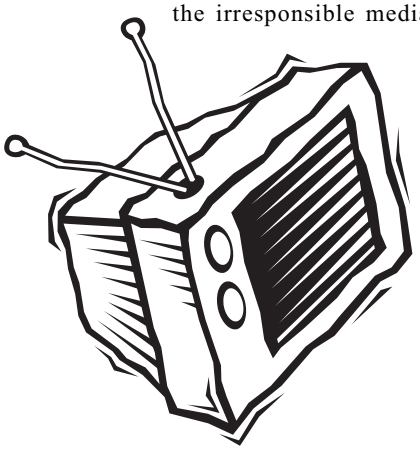
The opposite Behavioral Side Effect is also possible. In this situation the person can become sluggish, too unmotivated, and not care enough. If you think about how the medicine works to reduce the "excessive caring or worrying too much about things" in anxiety disorders you can see how the medicine, in reducing this symptom, could go too far and cause or increase apathy. Reducing or changing the medicine generally solves this side effect.

All or almost all medicines (whether prescription or over the counter), vitamins, supplements, and herbs have possible side effects as well as their intended good effects. Often it is even possible to use "side effects" to be helpful (such as sedation to help sleep or energizing to lessen fatigue, etc.). The SRI's have relatively few side effects and most of those are rarely more than a nuisance, if they occur at all. The 3 most common side effects of SRI's are an effect on energy (up or down), nausea (GI effects), and decreased libido (sex drive or function). Often, your psychiatrist can fine tune SRI's to acheive the desired benefits with no significant side effects. If you or your loved one shows a substantial "out of character" behavioral change while taking a medicine (or other treatment), talk with the doctor. Typically time, reducing the dose, or changing the treatment will help or resolve the problem.

In The News... Again...
The Colorado School Shootings

There are only a few points to add to the detailed discussion of this topic I did in the "Did You Know?" section of the **Summer '98 Medical Memo** (available online at **http://www.leeheymd.com/medmemo/summer98.html**).

A big concern has been the epidemic of copy cat threats and acts, both locally and nationally, caused, I believe, by the irresponsible media overplay of inappropriate publicity. We've gone from "Crisis In The White House" to "Crisis In Kosovo" to " Tragedy In The Rockies" to... Don't think kids haven't noticed how to get our attention.



The sad thing is the media (TV, radio, magazines, and newspapers) should know better. In the mid 80's the media overdramatized the rising problem of youth suicide with made for TV movies actually portraying such acts for kids to watch. The result was an immediate increase in completed suicides in the few days after such TV shows! This was documented by Dr. David Shaffer, a leading researcher on youth violence and suicide. Many clinicians advised local and national media about how to responsibly address such issues given the tendency of youth, especially troubled youth, to imitate what they see in the media (see my book **Teens at Risk** pages 10-13, 58, 94-5 and 97). These youth too often follow and copy what they see, especially when it is dramatic, attention grabbing, shocking to adults, or impresses (good or bad) their peers. If the media influence on all of us and especially on youth is not so powerful then why does advertising exist? The advice on how media can do their job reponsibly was ignored or forgotten with the Columbine High School events.

The most surprising disregard for privacy and decency to me has been the competition between networks to do "live" interviews of students in the heat of the moment. Newsworthy? maybe; ethical and appropriate? I doubt it.

School staff, parents, and police have also now swung from lack of concern to overconcern about potentially violent youth. Here's hoping this balances out soon to a healthy concern with readiness to act along the lines I outlined in my summer '98 newsletter article. More good advice can be found in Dennis Embry PhD's article Two Sides Of a Coin which you can read online at: *www.paxis.org/campus/library/EmbryFlannery.pdf*

Bedwetting (contd.)

the primary enuretic (never successfully toilet trained) child learn to read and act appropriately on the body signals that urination is needed. Restricting fluids after supper and ensuring voiding just before sleep is advisable. This broad approach along with helping the family provide supportive understanding to the child who has resumed wetting (secondary) due to a move, birth of a sibling, parental separation, divorce, new parental relationship, or traumatic event; is often all that is necessary. These steps are what is called "standard pediatric management" and is often effective.

Some cases need more in-depth treatment. The two most common treatments at this stage are psychotherapy, especially using specialized behavioral techniques, or medications. These approaches can also be used together.

Let's explore the special *behavioral techniques* first. These can be broken into two categories; bladder training and the bell or alarm pad method. Both are highly effective (60 to 80% for people able and willing to stick through the treatment) and may even cure but require sustained intensive effort and compliance by the child and parents. This approach is most effective with a dedicated family and child working with a skilled behavioral therapist. I refer the family to an expert for this.

Medications have a lower rate of success and primarily suppress the problem until maturation and training kick in, but are generally easier to use. The two most reliable options are **Imipramine** (Tofranil and cousins) and DDAVP. Imipramine has been around for many years, is well known and studied, is very cheap, and has many other uses such as for depression, sleep, attention deficit, chronic pain, and preventing migraines. (See my medicine chart on the tricyclic antidepressants). The dosage for bedwetting is on the low end of the range, usually 25 to 100 mgs, and may require some monitoring of blood and heart rhythm (EKG). Response is generally partial and helps a lot about 40 to 60% of the time. **DDAVP** is a synthetic version of the body hormone Vasopressin which is also known as anti-diuretic hormone. DDAVP was invented to treat Diabetes Insipidus (not "sugar" diabetes which is known as Diabetes Mellitus) in which people don't produce enough Vasopressin. We don't fully understand how Imipramine or DDAVP work but the theory on DDAVP is that it boosts the apparently inadequate nighttime body production of Vasopressin in uncomplicated enuretic patients. DDAVP may rarely unbalance electrolytes (sodium, potassium, chloride, etc) in the blood and thus a check of a blood test after being on it awhile may make sense, especially if negative effects occur. This is probably not routinely necessary. I have not seen a single side effect with this medicine as of this writing. DDAVP comes in both a nose spray and a newer pill form. The success rate of DDAVP is higher than Imipramine but may not be as high as with behavioral treatment. DDAVP is easy to use. Both medicines are generally given at night and are most effective given every night. They can be given morning and night if wetting also occurs in the day. The only negative I have seen with DDAVP is its high price which puts it out of reach for some. The medicine is generally taken for about six months and then stopped to see if wetting recurs. If it recurs the medicine may be restarted for another six months and the cycle repeated. The medicine success rates may appear lower at least partly because the treatment dropouts or refusers are typically subtracted before calculating the success rates with behavior treatment and may not be with the medicine treatments.

In **summary**, enuresis may affect day and or night; may be primary or secondary; may be mild or complicated; may be caused by genetic, psychiatric, or other medical reasons; and is often successfully treatable by more than one technique.

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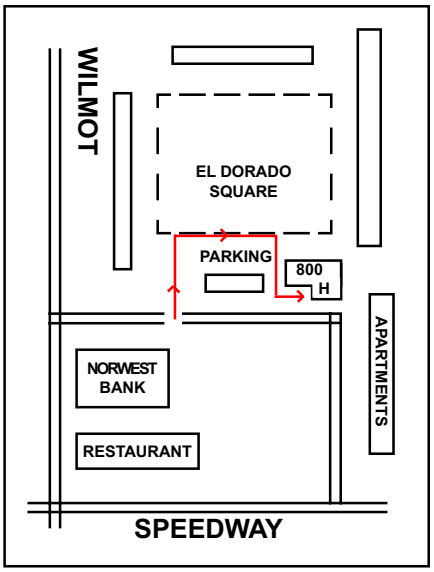

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