of chronic illness has important implications for the secondary prevention of depressive disorders.

Keller *et al*,[2] in the 'National Institute of Mental Health Depression Outcome Study', found that the length of illness prior to study entry was the strongest predictor of recovery. More recent naturalistic studies suggest that the duration of illness prior to the commencement of antidepressant treatment may be the most important factor predicting outcome.[3,4] These findings are consistent with those of Alexopoulos and colleagues that the level of antidepressant treatment received during an episode predicted time to recovery in a group of depressed elderly patients.[5] Perhaps the crucial difference between the two subgroups in Lee & Lawlor's study was the intensity of antidepressant treatment received prior to referral to the psychiatric services. Treatment decisions by general practitioners are often based on the strength of presenting symptoms rather than on membership of a particular diagnostic group, so that the initial treatment of patients presenting with mixed anxiety/depression frequently consists of anxiolytics rather than antidepressant medication.[6]

Prospective studies are required to determine if the lower recovery rate in patients with comorbid anxiety/depression and dysthymia is due to the natural course of these illnesses, or, alternatively, reflects a less vigorous approach to the early treatment of such patients in primary care.

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Onset of menstruation and soiling in an adolescent girl

Sir – Estimates of the prevalence of encopresis vary depending on age and the population as well as the operational definition. However, it appears that soiling secondary to chronic constipation is common. Three percent of five year olds entering school soil reducing to 1.5% by age seven. Rutter identified 1% of 10-12 year old boys with soiling, almost always in association with significant behavioural and emotional problems (Rutter, Tizard & Whitemore, 1970).

Soiling is however often misidentified because of the shame and secrecy surrounding it . This is a report of a teenage girl who developed soiling following the onset of her periods.

Lisa, 13, was referred by her GP to child and family service. Her referral letter reads "...this pathetic looking girl who is very nervous. She has had occasional vomiting and diarrhoea over the past two weeks." Lisa had always been quiet but generally well-adjusted until two months before referral. She began to feel depressed. She was not going our and she became clingy to her mother. She became disinterested in music. She was not eating, was hiding food and losing weight. She used to cry all night, finding it difficult to get off to sleep and waking at 4am crying in bed. She cried about people not understanding how she felt. She has been dreaming about her grandmother who died eight years ago. During the day, she has been having memory flashbacks of her grandmother to whom she was close. She has a sense of worthlessness, but never contemplated suicide. Her friends at school began to refuse to go to dinner with her. "Dinner time is the worst time, I feel lonely."

She has had diarrhoea (no vomiting) for eight weeks. Her pants were stained and she would need to change her pants about six times a day. She reported having started her periods a few months before her illness began. As she was unprepared for menstruation, she thought her bleeding was due to a serious illness needing hospitalisation. She continued to believe that the periods are "dirty". At interview, she was not self-assured, she was depressed in outlook with reduced emotional reactivity. Her thought content was dominated by desire to gain weight and her not being liked by friends at school.

Diagnosis of 1) Moderate depressive disorder and 2) Encropresis (soiling type due to overflow) were made. The GP was telephoned to advise discontinuation of imodium and prescribe senekot. Lisa was reviewed two weeks later when she reported having moved her bowel, regained her appetite, stopped soiling her pants and she has become very happy and was looking forward to going back to school.

Comments: Lisa presented with depressive episode resulting from soiling which she did not disclose to her GP. Her soiling as in up to 95% of the cases (Fitzgerald, 1975) was due to chronic constipation and it responded dramatically to laxatives. What is interesting however is the aetiological role of her menstrual periods.

She was unprepared for periods and she thought she had a serious illness when she started. Although dissuaded of this notion, she continued to believe that periods "are dirty". She hated to see blood on the toilet seat and she developed fear of going to the toilet. She did not move her bowel for a long time. The resultant constipation let to overflow and soiling. She became depressed with biological symptoms.

Lisa presents an example of soiling masquerading as some other psychological illness. Direct enquiry into her bowel functioning revealed the real but less forthcoming underlying pathology. An illustration of a common problem that is not uncommonly concealed.

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