

TREATMENT OF PRESCHOOL OCD

To the Editor:

I read with great interest Tolin's case study on the treatment of preschool obsessive-compulsive disorder (OCD) in the September 2001 issue of the *Journal*. Although Dr. Tolin describes his treatment as a form of cognitive-behavioral therapy, it is not clear which factors were actually mutative in achieving remission for this child. As I read Dr. Tolin's description of the treatment, I was struck by how it had many of the hallmarks of a psychodynamically oriented therapy, with a focus on conflict resolution using symbolic play. Dr. Tolin helps the child find and use therapeutic metaphors, such as the Star Wars battle against "the dark side of the Force." The boy's symptoms began several days after he sustained the trauma of seeing a pedestrian severely injured by a car, and it appears that the therapy provided an opportunity for the boy to find an appropriate channel for expressing his "squashy" and "striking" feelings. The boy's need to destroy "the OC flea" suggests that the OC symptoms had become a vehicle for communicating his conflicts about aggression.

In my clinical experience treating preschool children with OCD, I have similarly achieved virtually complete remission of OCD symptoms over a similar time course of 2 to 3 months. I generally see the child in once- or twice-weekly play therapy and meet with the parents separately once or twice monthly, focusing on behavioral management techniques. With the child, I use a play therapy technique that emphasizes understanding the reasons for anxiety as they present themselves symbolically in the play, and I work largely in displacement to assist the child in overcoming his or her anxiety.

I have certainly treated many school-age children with OCD who require combined behavioral and medication approaches and who appear to be more refractory to treatment consisting primarily of symbolic play therapy. I am doubtful that OCD in preschool children is a fundamentally different disorder from OCD as it presents in older children and adolescents. It is quite possible, however, that different treatments will be more or less effective, depending on the age of the child. I have wondered whether the difference in response rate is attributable to the fact that preschool children are developmentally so poised to engage in symbolic play. If given the opportunity, young children will readily use this modality to work through issues that cause them distress.

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Tolin DF (2001). Case study: bibliotherapy and extinction treatment of obsessive-compulsive disorder in a 5-year-old boy. *J Am Acad Child Adolesc Psychiatry* 40:1111-1114

Editor's Comment:

Dr. Clarkson's letter highlights one of the most interesting challenges facing our field: to detect and then demonstrate empirically which elements of successful psychotherapy are essential. When skilled psychotherapists treat young children, cognitive interventions and behavioral techniques such as exposure and response prevention and contingency management by parents and schools may be interwoven with dynamic and symbolic strategies. In view of all of the financial and manpower limitations on available mental health treatment for children, we are challenged to distill what is most efficient and effective in our therapy.

Mina K. Dulcan, M.D.

PAROXETINE IN ADOLESCENT MAJOR DEPRESSION

To the Editor:

Many thanks to the many authors of the multicenter study of paroxetine reported in the July 2001 issue of the *Journal* (Keller et al., 2001). Such studies are of enormous help to clinicians in private practice who are looking to the academic communities for this kind of excellent research. Although the article on fluoxetine (Geller et al., 2001) in the same issue was also useful, the attention to detail in the former was particularly helpful.

In view of practitioners' concerns regarding safety and, even more so, parents' concerns about side effects and adverse effects of medications, I would like to have seen a more detailed description of the adverse effects found in the 11 patients receiving paroxetine who withdrew prematurely. In particular, I am interested in the five patients who withdrew because of "emotional lability (e.g., suicidal ideation/gestures)." As I previously reported in a Letter to the Editor (Weintrob, 2001) and as has been confirmed anecdotally by some psychopharmacologists, there have been instances of adolescents on selective serotonin reuptake inhibitors who have cut themselves. (Whether this is related to induction of a manic state is unclear.) This effect appears to have been causal. A more detailed description would thus be appreciated, particularly whether the "suicidal gestures" included self-mutilation.

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Geller DA, Hoog SL, Heiligenstein JH et al. (2001). Fluoxetine treatment for obsessive-compulsive disorder in children and adolescents: a placebo-controlled clinical trial. *J Am Acad Child Adolesc Psychiatry* 40:773-779

Keller MB, Ryan ND, Strober M (2001), Efficacy of paroxetine in the treatment of adolescent major depression: a randomized, controlled trial. *J Am Acad Child Adolesc Psychiatry* 40:762-772
 Weintrob A (2001), Paxil and self-scratching (letter). *J Am Acad Child Adolesc Psychiatry* 40:5

To the Editor:

As a busy clinician, I read with interest the multicenter trial of paroxetine for the treatment of adolescent depression (Keller et al., 2001). It was encouraging to read a study showing positive results, though the overall impact was not impressive compared with the placebo.

I was concerned, however, by the report that 11 patients in the paroxetine group suffered serious adverse effects. This was in comparison with five in the imipramine group and two in the placebo group. This finding would appear to be statistically significant, though this was not specifically addressed in the study. I took particular note of the statement that "Of the 11 patients, only headache...was considered by the treating investigator to be related to paroxetine treatment." I would like to know on what basis the investigator dismissed the possibility that emotional lability, worsening depression, suicidal ideation or gestures, conduct problems, or behavioral disturbance could be due to the paroxetine.

In the past decade I have treated hundreds of adolescent patients with selective serotonin reuptake inhibitors (SSRIs), and in my view all of these mentioned adverse effects have been temporally associated with the prescription of SSRIs. A degree of emotional lability and increased defiance is so common, in fact, that I routinely warn parents that this is likely to happen during the first few weeks on medication. I have not really formed an opinion as to whether one SSRI is more likely to cause this than another. Certainly I have seen it in association with paroxetine.

I certainly believe that paroxetine and the other SSRIs are useful medications, and as stated I am pleased to have a reasonably encouraging study that supports their use. I would value future studies, however, that look specifically at the issue of behavioral or cognitive side effects. Reports of these side effects have circulated since the advent of SSRIs and continue to be controversial. I also suggest that the reviewers of this article should have questioned more closely the dismissal of these symptoms as being unrelated to medication. This is particularly true in light of the fact that this study was funded by Glaxo-Smith-Kline, the makers of Paxil™.

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Keller MB, Ryan ND, Strober M et al. (2001), Efficacy of paroxetine in the treatment of adolescent major depression: a randomized controlled trial. *J Am Acad Child Adolesc Psychiatry* 40:762-772

Dr. Keller et al. reply:

We thank Drs. Parsons and Weintrob for their words of encouragement and for their questions about adverse effects associated with paroxetine in our study of adolescents with major depression (Keller et al., 2001). In particular, Dr. Parsons was interested in our decision-making process for determining that adverse effects in the paroxetine-treated group were not attributable to the selective serotonin reuptake inhibitor. In the 11 paroxetine-treated patients with serious adverse effects, 1 experienced headache and 10 experienced psychiatric symptoms, including emotional lability, suicidal ideation, conduct problems, and behavioral disturbance. The psychiatric symptoms were chronologically related to a variety of situational factors. Acute psychosocial stressors (e.g., arguments with boyfriend and parents, torment by peers), medication non-compliance, and/or untreated comorbid disorders (e.g., conduct disorder) were judged by the investigators to account for the adverse effects in all 10 patients. Only headache in the one patient was judged to be related to paroxetine.

Both Drs. Parsons and Weintrob do raise the importance of safety considerations when prescribing antidepressants to youths. It is noteworthy that approximately 14% of patients in the imipramine group were withdrawn because of significant cardiovascular side effects, including prolonged QT interval, postural hypotension, and tachycardia. Careful monitoring of cardiovascular functioning (pulse, blood pressure, and electrocardiogram) must be done if a clinician prescribes tricyclic antidepressants to children and adolescents. In our opinion, the selective serotonin reuptake inhibitors, including paroxetine, represent safer therapeutic alternatives to the tricyclic antidepressants.

We agree that further studies are needed to understand more completely the role of antidepressants, including the selective serotonin reuptake inhibitors, in the treatment of adolescents with major depression. It is encouraging that such studies are currently under way, and we await their findings with great interest.

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