may be safer. When prescribing SSRIs, all clinicians must take into account the mania symptoms even if there is no comorbid disorder and no family history. We believe that we need to be more cautious when a patient has a history of affective disorder and hyperactivity.

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HALOPERIDOL FOR TOURETTE’S DISORDER PLUS SELECTIVE MUTISM

To the Editor:

Selective mutism was first reported in 1877, although most of the literature has been based on case reports and a few small treatment series which have looked at the use of psychoanalysis, behavior modifications, fluoxetine, phenelzine, and fluvoxamine (Baker and Cantwell, 1991). Because of the low incidence of selective mutism (fewer than 1% of patients), research has been sparse and efficacy of a particular treatment strategy is difficult to generalize from individual case studies (Baldwin, 1994). Studies have suggested high levels of comorbidity including obsessive-compulsive disorder, oppositional defiant disorder, Tourette’s disorder, and anxiety disorders, especially social phobia (Black and Ulhe, 1995). In this letter I report on a child whose selective mutism improved while she was being treated with haloperidol for Tourette’s disorder.

M. was 5 years old when selective mutism was initially diagnosed. She had been adopted, and her biological family history was unknown. There was no history of trauma or abuse. There was no evidence of a communication disorder. She would speak to her mother and peers, but not in the presence of adults.

M. was started in play therapy, and a behavioral plan for gradually increasing nonverbal communications at school was instituted. She made small improvements, such as being able to leave recorded, whispered messages for her teacher or therapist.

After 1 year, M.’s parents agreed to the addition of pharmacotherapy because of worsening symptoms, which included throat-clearing and eye-blinking after a new baby was adopted into the family. She was started on fluoxetine at a dose of 5 mg/day, which was gradually increased to 20 mg/day. Her non-verbal communications showed improvement in 2 months, and spontaneous speech with extended family in 3 months. Eight months later, noticeable regression was seen with her behavior plan at school. She was exhibiting aggressive behaviors along with a worsening of motor and vocal tics. Clonidine was added at a dose of 0.025 mg b.i.d.; attempts to increase the dose caused sedation and interfered with school functioning.

M.’s mother noted an association of her aggression with frustration/embarrassment due to the uncontrolled tics. Haloperidol 0.5 mg at bedtime was started for the treatment of the Tourette’s disorder, in addition to fluoxetine 30 mg. She is currently taking haloperidol 0.5 mg b.i.d. without adverse effects, and clonidine has been gradually tapered. In 1 month she was speaking at home, at school, and at office visits; vocal and motor tics were minimal.

Caution in the use of antipsychotics in children is warranted because of the possibility of tardive dyskinesia. Further research is needed to investigate their use in the treatment of selective mutism. This case illustrates the importance of evaluating and treating comorbid diagnoses, especially those affecting social functioning.

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EYE MOVEMENT DESENSITIZATION AND REPROCESSING

To the Editor:

Eye movement desensitization and reprocessing (EMDR) is a relatively new therapeutic technique that has been proposed as a treatment for posttraumatic stress disorder (PTSD) (Shapiro, 1995). During EMDR, the therapist induces rapid, lateral eye movements while the patient imaginatively exposes himself or herself to aversive memories. After each set of eye movements, the patient briefly reports his or her images, feelings, and/or thoughts. This procedure is repeated until the negative affect associated with the traumatic or aversive memory habituates. Furthermore, the therapist encourages cognitive restructuring. That is, the patient is prompted to change negative cognitions about himself or herself or about the traumatic event into more functional cognitions.
Some therapists use EMDR to treat psychopathology in children. Yet systematic research concerning EMDR and childhood psychopathology is sparse. Admittedly, there are a few case studies that are suggestive of positive effects of EMDR in this domain of psychopathology. For example, Pellicer (1993) describes the treatment of a 10-year-old mentally retarded girl who met DSM criteria for dream anxiety disorder. More specifically, she was plagued by nightmares of snakes. These nightmares were experienced almost nightly and produced high levels of anxiety and awakening. The most aversive scene of the nightmare was subjected to EMDR. A single EMDR session resulted in a complete remission of the nightmares. This improvement was maintained at 6-month follow-up.

So far, only two controlled studies have examined the effects of EMDR in children with anxiety disorders (see Muris et al., 1998). In these studies, the efficacy of EMDR was compared with that of exposure in vivo in the treatment of a specific phobia (i.e., spider phobia). Results showed positive effects of EMDR, but also indicated that it is especially self-report measures that are sensitive to EMDR. Behavioral improvement was less pronounced, and exposure was found to be superior in reducing the key feature of phobic disorder, namely avoidance behavior.

Effective treatment methods of PTSD and other trauma-related complaints are urgently needed, and this is particularly true for children (Bernstein and Borchardt, 1991). Behavioral techniques such as imaginal exposure are effective, but a substantial minority of patients prematurely drop out because they have difficulties in coping with prolonged high-anxiety levels. EMDR does not require patients to extensively describe traumatic or aversive experiences. In fact, during EMDR, exposure to the traumatic image is relatively short. It is for that reason that EMDR therapists claim that patients will find this treatment method more endurable (e.g., Shapiro, 1995).

Meanwhile, practitioners should be cautious in applying EMDR to children. To begin with, support for the efficacy of EMDR predominantly relies on case studies (see Lohr et al., 1998). Although this material is substantial, it cannot serve as a substitute for controlled research. The number of well-conducted empirical studies on the efficacy of EMDR is small. Studies that compare the effects of EMDR with those of more traditional treatment methods (e.g., behavioral and cognitive therapy) are especially warranted. Second, the theoretical underpinnings of EMDR are weak. That is, there is no clear and satisfactory explanation for the effects of EMDR (see Lohr et al., 1998).

Many clinicians who apply EMDR are enthusiastic and report positive results in both children and adults. Empirical research is necessary to evaluate the merits of these claims and to give EMDR a sound, theoretical foundation.

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