and make a decision about the applicability of the findings to his or her own practice.

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SCHOOL VIOLENCE

To the Editor:

Twemlow and colleagues' (2001) article on school violence was refreshing and heartening. It encourages school consultants to expand the diagnostic assessment of a troubled youth to include a thoughtful analysis of school climate. The school community can tolerate or endorse "a covert power dynamic" or seek to structure dialogue about how "a child, teacher, or other staff member of the school . . . abusively coerces others repeatedly through humiliation and mockery. Bullying usually involves a stronger, more dominant personality coercing a weaker, more submissive personality . . . " (p. 377).

After 8 years of working in a high school as a psychiatric consultant and designing an advising program, there are some additional insights that I would like to add. The most overlooked dynamic in bullying is the role staff members may have in escalating a conflict. Often administrators, in the interest of being fair, hand out cookbook discipline that does not give students (and staff) an opportunity to be reflective about their actions but instead reinforces the coercive punitive intent of a staff member. Many times adults/staff are not held responsible for their actions—in the context of a public school culture that allows employment for life with limited accountability. To some extent, we are authorized as child and adolescent psychiatrists by administrators and teachers to have a consultative presence in schools. This may contribute to our reluctance to examine in schools the parallel process, in which students act as bullies, implicitly mirroring the aggressive climate that sometimes is endorsed by teachers. Because classrooms are relatively insulated from observations, it is only the most vulnerable students (traumatized, low frustration tolerance, etc.) who herald the covert power dynamic. Administrators who are delegated to deliver discipline in many high schools may be privy to the unfair use of power in the classroom when students share their frustration. I encourage psychiatric consultants to pay attention to the "human side of school change" (Evans, 1996). This perspective helps administrators and teachers not only to attend to the valid programmatic approach to bullying as Twemlow et al. (2001) describe, but also to support administrators and staff to analyze and confront the pathological roles of some teachers who may escalate conflict and alienate students.

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METHYLPHENIDATE AND MELATONIN FOR SLEEP DISORDER WITH OPTIC GLIOMA

To the Editor:

Children with neurological, neuropsychiatric, and developmental disabilities are predisposed to chronic sleep-wake cycle disturbances. Blindness, mental retardation, and central nervous system diseases diminish the ability of these individuals to perceive and interpret the multitude of cues for synchronizing their sleep with the environment (Jan and O'Donnell, 1996; Palm et al., 1997). Treatment options mentioned in the literature are benzodiazepines, nonbenzodiazepine and nonbarbiturate sedative/hypnotics, antidepressants, antihistamines, and alternative therapies such as melatonin (Kirkwood, 1999; Palm et al., 1997; Zhdanova et al., 1997). In this case report we describe the successful treatment of a severely disturbed circadian rhythm by use of methylphenidate and melatonin.

A 6-year-old boy was admitted to our hospital with a severe sleep disorder. Optic glioma had been diagnosed at age 11 months and had been treated by chemotherapy. The boy is blind, is mentally retarded, and has moderate spastic tetraplegia. Beginning at age 5.5 years he gradually developed a tendency to confuse day and night. Behavioral measures were used to correct his abnormal cycle. The contrast between day and night was enhanced, with activities and music during the day and reduced contact and silence at night. The parents also tried to prevent their child from sleeping during the day. In spite of continuous efforts, these measures failed to improve the disorder. Several hypnotics were also administered without success. At the time of consultation, the child was very irritable and his parents were exhausted.

A magnetic resonance imaging scan of the brain revealed no tumor progression. Sleep diaries showed sleeping times between 8:00 P.M. and 2:00 A.M. and between 1:00 P.M. and