*Drs. Keller and Ryan reply:*

Drs. Silveira, Jainer, and Singh raise general questions about the conduct and reporting of the clinical trial assessing paroxetine and imipramine in the treatment of adolescent depression (Keller et al., 2001) and some specific issues about the study design. They propose that a diagram that displays the number of patients at each stage of the study would have been useful. Also, they request additional details about the randomization and blinding methodology that was used.

We accept that a diagram would be helpful, but the Results section of the report does describe the more important features of patient flow, i.e., the number of patients randomized, how many completed the study, how many withdrew prematurely, and reasons why. The process of randomization and blinding is also described, albeit briefly. To that already described in the report, we can add that specific care was taken to maintain the blind. This included using identically appearing bluish-green opaque locking capsules that contained either placebo, imipramine, or paroxetine tablets. These capsules were packaged in blister cards that contained 1 week's supply of study medication. One kit of cards was prepared for each patient and contained all dosage possibilities, identified only as levels 1, 2, 3, 4, 5, and 6. The kits were identical in appearance, differing only by a five-digit code number. A computer-generated list randomly assigned patients to one of the codes. The identity of the study medication code was not revealed to anyone associated with patient care, including those who completed the HAM-D assessments. It is conceivable that some effects of the higher doses of imipramine may have compromised the blind. This seems unlikely, however, given that response rates in the placebo group were as high as 60% in patients who completed the trial.

Finally, the correspondents raise the question that the use of rigorous inclusion and exclusion criteria reduced the generalizability of the results. We agree that the study had many restrictions. However, we argue that heterogeneity of study populations has been proposed as a possible reason for negative trials assessing antidepressants in children and adolescents (Ryan and Varna, 1998). In addition, comorbidity could confound the interpretation of the findings. For example, we note that the study did enroll patients with comorbid attention-deficit/hyperactivity disorder, and in this subgroup we observed relatively poor efficacy results.

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## ZERO TOLERANCE AND SEARCHING FOR PREMEDITATED SCHOOL SHOOTERS

*To the Editor:*

Twemlow and colleagues' practical suggestions about conducting threat assessments to discern students with premeditated violent plans for lethal shootings in schools highlight the urgent need for definitive empirical research in the area of school violence (Twemlow et al., 2002). Currently the majority of public schools are conducting "Zero Tolerance" with zero research to demonstrate that these policies have made our schools safer (Skiba and Knesting, 2001). These policies translate to educators sometimes responding to trivial potential threats with mandatory expulsion, leaving some of our most vulnerable students with a sense of despair.

Many of the "alternative placements" where students serve their time, usually up to 1 year before the possibility of returning to a regular educational setting, often warehouse the students' brain power. Rather than fortifying students, they are frequently exposed to a redundant, watered-down curriculum. This further reinforces the vulnerable students' sense of being devalued and discarded. Many child and adolescent psychiatrists and other mental health clinicians are called upon to do damage control and make sense of bewildering and sometimes-inconsistent policies.

In one of the districts where I currently consult, a visionary director of special education and superintendent have looked at the threat of expulsion for special education students as an opportunity for intensive assessment and treatment planning. A child and adolescent psychiatrist conducts up to 12 to 20 hours of evaluation and treatment planning, which includes a home visit, interviews with school personnel, and an interview with the student. This is delivered in a timely way to help provide a prudent assessment of the student's potential for violence and determine how to strengthen the safety net. The opportunity for engaging a student and family in treatment can be capitalized on when they are motivated to maintain regular educational access.

Our knowledge of how to assess threats and the potential for violence is at a fairly rudimentary level. As Verlinden et al. (2000) point out in their comprehensive review of available instruments, past threat does not provide a predictive value of potential for violence and assessments are extremely time-limited. Some clinicians, parents, and fellow students may sur-

mise that expelling some innocent students along with those who are dangerous is justified if it will secure our schools. My concern is that with these policies we escort our most vulnerable students out of school doors and we are basking in a false sense of security. Witness the recent surprise multiple school shooting in Germany (Andrews, 2002). If we emphasize our preventive focus and closely monitor students, we can capitalize on sustaining our commitment to holding students accountable while also exercising a measured, cautious response. This demonstrated tolerance gives our students a reason to hope.

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## WEIGHT GAIN ASSOCIATED WITH ATYPICAL ANTIPSYCHOTICS

*To The Editor:*

We were pleased to read Dr. Ratzoni and colleagues' (2002) timely article on weight gain in adolescents treated with atypical antipsychotics. Like the authors, we are quite concerned, observing faster and more severe weight gain in our patients on these medications, particularly olanzapine. Recent pediatric literature reports that obesity in adolescence is of epidemic proportion, even without medication (Flegal et al., 1998).

We do have some concerns about the study, however. Rather than randomization, patients were directed into one group or another at the physician's discretion. An anxious patient might be directed to the olanzapine group as opposed to the haloperidol group. Many anxious patients eat to relieve anxiety symptoms, contributing to even greater weight gain. Increases in medication that may increase appetite were also at the physician's discretion. These are particularly critical, since all patients do not bear the same risk for weight gain.

Did previous medication affect which group was selected for the patient? Forty-one of the 50 patients had received antipsychotics prior to the study, but we were not told how long they were off medication before restarting. It seems that many patients rapidly gain when they begin a medication such as olanzapine, but may plateau. We were not given information to determine whether any of these patients had reached a plateau prior to entry into the study.

We wondered whether our psychotic patients with schizophrenia would accurately answer questions about fears of becoming fat or worries about weight gain. Our experience is that judgment questions on a 5-point scale can be even more difficult for these particular adolescents.

Finally, we wondered whether the gender difference would hold up during a longer follow-up period. Although we agree that girls may be more concerned about their weight, would careful monitoring sustain over time? Girls are reported to have more difficulty with obesity due to less physical activity than teenage boys (Molnar and Livingstone, 2000). Girls taking antipsychotics may be even less active, promoting more weight gain.

Nonetheless, we applaud Dr. Ratzoni and colleagues for examining this important question and look forward to continued research about this problem.

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*Dr. Ratzoni et al. reply:*

In response to the letter by Dr. Hermida et al. concerning our article on weight gain associated with olanzapine, risperidone, and haloperidol (Ratzoni et al., 2002), we appreciate the authors' thoughtful remarks.

This was, as they point out, an open study. Patients were allocated to the three study groups according to the clinical judgment of the department directors. We cannot rule out the role of anxiety in the choice of the medication and its effect on weight gain. We agree that nonrandomization is a major limitation and further randomized double-blind investigations are needed to validate our initial findings.

The average period off medication before the initiation of the study was about 5 days, and no correlation was found between previous antipsychotic treatment and the medications used in the present study. Thus it seems that previous treatment affected only partially the psychiatrist's choice of the current medication.