The Vermont Connection

Volume 25 *Beyond the Ivy Walls: Mapping the Modern University*

Article 4

January 2004

Creating a Better Campus: Removing the Fear from Schizophrenia

Benjamin Schultze

Creating a Better Campus: Removing the Fear from Schizophrenia

Benjamin Schultze[1]

As schizophrenia may afflict a college student at any time, either before or after enrollment, do college student personnel have the knowledge and preparedness to deal with the disease? The advancement of antipsychotic drugs will inevitably mean that schizophrenic students will be able to function on college campuses in unprecedented numbers while living with the disease. This article will give a general overview of schizophrenia, perhaps one of the least understood mental health diseases, so that student affairs professionals are equipped to understand and offer support to students who develop or already have the disease.

During one academic year, as I worked in a residence hall with 480 students, two otherwise healthy students endured their first schizophrenic episodes. Suddenly caught with the need to educate myself and respond to students who witnessed their peers endure a schizophrenic episode, I began searching for literature that would aid in understanding and working with such situations. While researching, I found very little available information. I quickly learned that schizophrenia is perhaps one of the least understood mental health conditions.

Schizophrenia is one of a group of severe mental illnesses affecting six million people globally. Categorized as a disease of the brain, it is "one of the most disabling and emotionally devastating illnesses known to man [sic]." Schizophrenia is not a split personality or bipolar disorder. Rather, it is a disease that disturbs the intricate chemical and neurological network of the brain, dramatically affecting how a person thinks, feels, and behaves (Alliance for the Mentally Ill).

As the disease may afflict any student at anytime, such as the student who is earning a 4.0 in their biomedical engineering program or the student athlete, without prior notice, I began asking some general questions about the ability of student affairs professionals to address this issue. Do we have the knowledge base of schizophrenia required to: (1) help the schizophrenic student, (2) assist the family in making decisions regarding their student's educational future, and (3) educate the students who have witnessed their peer endure a schizophrenic episode? In both of the circumstances with which I dealt, I obtained a basic knowledge of the illness that enabled me to work closely with families, counselors, and doctors, often serving as a liaison between them. Through understanding the disease, student affairs professionals may be able to aid schizophrenic students, their families, and peers in making sense out of the traumatic moments when schizophrenia emerges.

Why Discuss Schizophrenia?

For every 1,000 people, eight will eventually be diagnosed with schizophrenia during their lifetime (Torrey, 2001). Considering the fact that 75% of all new diagnoses are made for people aged 17-25, there exists a strong possibility that most student affairs professionals will know a student who develops this disease while attending their institution (p. 121). Using the numbers above, one could conclude that for every eight people who get the disease, five of them will develop it during the years traditionally called "college years" (18-22) and at least one of them will have it prior to the traditional age of enrollment.

Overall, 1% of people in the United States will develop schizophrenia (Bellenir, 1996). In comparison, according to the Centers for Disease Control and Prevention (1995), one in 250 people, or two-fifths percent, of the US population will contract human immunodeficiency virus (HIV) (Torrey, 2001). The Centers for Disease Control and Prevention's (1995) most recent report examining college students and HIV states that today's college student infection rate is two out of every 1,000 students. Most student affairs professionals understand how HIV is spread and are aware of current trends regarding medical treatment and prevention. In contrast, how many student affairs professionals understand the history of schizophrenia, a disease that could possibly afflict more students than HIV? Perhaps this is attributed to the fact that collectively, many misconceptions surround persons with severe mental illnesses.

Often, due to limited understanding of the disease, people enduring schizophrenia are pushed to the outskirts of society.

Benjamin Schultze graduated from the College of Biological Sciences at the University of Minnesota in 1999. After some time in the Peace Corps and working as an environmental consultant, he returned to school and is in his second year of the Higher Education and Student Affairs (HESA) program. Currently Benjamin works for the Department of Residential Life. This is his second TVC article.

This isolation can deeply impact the social development of a college student. Limited knowledge of the disease usually induces thoughts of people with schizophrenia from popular movies like *One Flew Over the Cuckoo's Nest* (1975) and *A Beautiful Mind* (2001) as our bases for understanding and conceptualizing the illness. Unfortunately, movies like this help form societal prejudices toward persons with schizophrenia. *A Beautiful Mind*, presents the perception that schizophrenia is an easy disease to live with and conquer.

This limited understanding aids in our collective inability to help and understand persons with schizophrenia, which ultimately has an enormous cost to the United States economy. According to Anderson, Reiss, and Hogarty (1986), the disease costs the United States approximately 2-3% of its gross national product annually to help pay for the nearly 2.2 million people who have the disease in the United States today (Torrey, 2001, p. 7). Societal costs and recognition of schizophrenia are not a new phenomenon (p. 85).

Recordings of the disease date back to some of the earliest publications that humans have produced. The Biblical character Ezekiel, who had visual and auditory hallucinations, is believed to have had schizophrenia (Torrey, 2001). However, the term schizophrenia was not coined until the early part of the twentieth century. According to Torrey, it was Eugene Blueler, a Swiss scientist, who introduced the term schizophrenia, which in German means a splitting of the various parts of the thought process. Throughout history, what is evident is that the prognosis for people with schizophrenia has generally been poor. Overall, the mortality rate of schizophrenics is twice that of the general population. Additionally, the suicide rate of schizophrenics is between 10-13% compared to the 1% suicide rate of non-schizophrenics (p. 312). Clearly, discussing schizophrenia is important in combating the social mores stacked against it.

Causes of Schizophrenia

Schizophrenia has an early onset, very often in late adolescence and early adult life when one is just becoming a person of hope and promise (Anderson, Reiss & Hogarty, 1986, p. 85). In fact, the majority of people who develop schizophrenia have "normal" childhoods and are not identifiable as schizophrenics in their earliest years (Torrey, 2001, p. 122). The disease can literally sneak up on someone who is otherwise healthy and "normal." What causes the disease? Unfortunately, there is no known cause of schizophrenia (Bellenir, 1996). Recent advances in medicine are helping scientists look at different aspects of the brain, but to date, these advances have only allowed for new theories to be developed that possibly explain the causes of schizophrenia.

The brain is an intricate organ that is full of complex components that are not easily studied, and this hinders quick scientific advances. Adding to the complexity of the research that is currently progressing, according to Glynn (1998), there are no pathognomonic symptoms of schizophrenia; in other words, there are no symptoms (or set of symptoms) that are found only in schizophrenia and no other mental disorder. For example, a person with schizophrenia will often have the same symptoms as someone with bipolar disorder. Due to this fact, it can be very difficult to tell if a student who is exhibiting mental instability is in fact suffering from schizophrenia. Appendix A shows the *Diagnostic and Statistical Manual of Mental Disorders IV* (2002) criteria used to diagnose schizophrenia in an individual. These criteria are used internationally.

An Examination of the Schizophrenic Brain

It is important that student affairs professionals understand some of the basic neurology behind the disease so they know what is physiologically occurring within the student. This will give the student affairs professional an edge in discussing and understanding the illness. A very frustrating experience for patients with schizophrenia is the limited knowledge that researchers have about the brain. What is becoming clearer through research is that schizophrenia is a biological disease. There is a strong correlation with genetics at this time, but other theories do exist about why this disease occurs. It should be noted that if no person in an individual's immediate first and second generation family has schizophrenia, then there is only a 1% chance that an individual will develop the disease (Bellenir, 1996).

What is clear is that there is a problem in the way stimuli are sorted and responded to by the individual with schizophrenia. The brain is composed of over 100 billion neurons and 10 times 100 billion gilia (Torrey, 2001, p. 142). The neurons and gilia are responsible for data transmissions in the brain. Between each of the neurons and gilia are gaps, which are known as synapses. Here, pulses are transmitted between each neuron through what is called a neurotransmitter. It is this area that appears to be key for researchers trying to understand severe mental illnesses such as schizophrenia, as this area typically appears damaged in schizophrenics (Anderson, Reiss & Hogarty, 1986). Approximately 100 neurotransmitters have been identified today (Torrey, p. 142). The medications that schizophrenic

patients are prescribed to quell the disease try to reestablish these damaged or missing neurotransmitters.

Medical Treatment

Today, new anti-psychotic drugs are making it possible for persons with schizophrenia to live and function within society at a greater rate. The early 1990s brought the advent of newer (generation II) antipsychotic agents that have been accompanied by new claims and hopes that these innovations will have a greater impact on functional impairments (Scott & Lehman, 1998, p. 2). Knowing what drugs are used to treat schizophrenia can help student affairs professionals identify if a student has schizophrenia. Sometimes students will say they have a different type of mental health disorder due to the stigmatization surrounding the disease, but will be taking medication solely used for the treatment of schizophrenia. Appendix B has a list of common medications used in the management of schizophrenia.

Students and Schizophrenia

Student affairs professionals will generally not know a student has schizophrenia until they have a psychotic episode. For the purposes of this paper, a psychotic episode is defined as an abnormal, exasperated episode of incoherent altered mental state not caused by alcohol or drug use. Generally, these episodes are prolonged for days if the person does not obtain treatment.

Often,after these episodes, people with schizophrenia face a world that has little understanding of the disease. Glynn (1998) believes the disease does not have to mean a destiny of isolation. Unfortunately, not understanding the disease or being able to dialogue about it only hinders our ability to reach out to students who have schizophrenia. As reported by Davidson, Stayner, and Haglund (1998), persons with schizophrenia identify stigmatizing attitudes by health care professionals, as well as family and friends, as one of the primary contributors of their experience of rejection and loss early in the course of the illness. Student affairs professionals may be able to reduce some of this rejection. For example, by knowing a student prior to onset or relapse of the disease, student affairs professionals may be able to indicate how the student's personality has changed. This information can help others, such as a psychiatrist, find a way to help the student by determining which medication and treatment plan will best help them recover. Due to the high number of students who could have this disease on campus, we must help break down the walls that intimidate us so we can help students who have schizophrenia.

Schizophrenics, who once could not handle school, are now able to enroll in programs of higher education and thrive. Students who are admitted with schizophrenia should theoretically do just as well academically as other students. Antipsychotic drugs have the same "success" as penicillin does on pneumonia (Torrey, 2001). Additionally, provided they stay medicated, normal functioning will usually be quite possible. However, the most common reason why schizophrenics have repeat psychotic episodes is because they stop taking their medication. Males are more likely than females to stop taking their medications (Torrey).

It should be stressed that taking a pill does not make everything perfect in the short and long-term progress of the individual. Medication is part of the overall treatment of the disease with which a person will need to cope for the duration of their life. According to Anderson, Reiss, and Hogarty (1986), antipsychotic medications are not drugs that simply erase all symptoms and underlying problems, making schizophrenics' lives magically fixed. Some schizophrenics may give off the impression, through their social interactions and thought processes, that there is something different about them as they cope with the disease. It is important to note that this is not the fault of the student, but rather a normal condition that can sometimes occur during the treatment of the disease. It is quite possible that students, through the use of medication, will be attending colleges and universities and will be struggling with the disease in a manner that is not private. This loss of privacy may be enhanced when schizophrenic students live with other students. In short, people may be able to tell when a peer is dealing with a mental illness, suchas schizophrenia, even when the student has not publicly stated that this is indeed the situation.

Each schizophrenic student will function on their own individual social plane as do non-schizophrenic students. According to Scott and Lehman (1998), social functioning tends to vary among and within patients at different points in time. Every student on campus that has schizophrenia will not be comparable in terms of their actions, as their effectuations are unique. Overall, the effects of the illness may vary in terms of the patient's social functions, which may either enhance or restrict the impact of the illness (Huxley, 1998). Unfortunately, someone who has a difficult time functioning socially will typically be ostracized due to the lack of education on the part of the public regarding schizophrenia.

As students come to campuses with schizophrenia, it is important to realize that there is a huge emotional toll that is placed upon the individual. This toll may be exasperated by the difficulty a student has interacting with their peers, which is a crucial component of student development. As stated by Davidson, Stayner, and Haglund (1998), the ability to judge interpersonal situations accurately and to formulate appropriate responses are fundamental prerequisites to making connections with others. Due to this fact, it may be required of student affairs professionals to be sensitive to a schizophrenic student as they struggle with socializing. Perhaps educating nonschizophrenic students further about mental illness, specifically schizophrenia, may help them interact with a schizophrenic student. As always, there is a fine line to be walked without ostracizing an individual who is enduring the disease. Such presentations may expose all students to issues of mental health and in doing so promote the fact that looking after one's mental health communally as well as individually is okay and not something that should be stigmatized (Gonzalez, Tinsley & Kreuder, 2002).

A difficult situation can arise when a student actually begins expressing symptoms of the disease for the first time. A psychotic episode will normally dictate that time away from school will be necessary. Just as the body would need to heal after a serious car accident, so does the body after a psychotic episode. The average recovery time, according to Torrey (2001), is 42 weeks (p. 129). Treatment programs for schizophrenia today include combinations of medication, psychotherapy, education, and social-vocational rehabilitation (Bellenir, 1996). Obtaining help for a student at the onset of the disease usually involves communication with the student's family and the college counseling center. Having an understanding of the disease can help make these contacts less stressful and aid in the overall ability of an individual to cope with the stress that aiding a person with schizophrenia can sometimes cause.

While it can be very unnerving to watch a student who is suffering through a psychotic episode, worrying about whether or not the person will become violent usually becomes an issue. If the person is not expressing violent thoughts about their self or others, then there is usually very little to worry about. If they are having such thoughts, medical attention should be obtained immediately. Most states have laws that will admit a person into the hospital if there are indications that the safety of themselves or others is in jeopardy. Listening to a student who is enduring a psychotic episode will aid in determining how dangerous they are in their functioning state of mind.

The difficult part of working with schizophrenic students can be when they return after healing from a psychotic episode. Students who are returning after such an incident have more than likely (but not always) demonstrated at least modest improvement in their functioning. If a student leaves school for a while, they have a 75% chance of returning at a moderate level of improvement or better (Torrey, 2001). One of the most crucial things a school can do to ensure the student's safety, as well as other community members, is to guarantee, if possible, that the schizophrenic student is committed to taking their medications. If a student with schizophrenia stops taking their medications, a relapse is inevitable. Subsequently with each episode, further damage is done to the brain making recovery to their original level of behavior and overall functionality very difficult. Supporting students on these medications could be a tremendous benefit to the student and community.

Suicide from a medication overdose will not likely be a factor to worry about concerning a schizophrenic student. According to Torrey (2001), in fact, it is impossible to commit suicide with antipsychotic drugs; they are among the safest drugs available in medicine.

All college students are unique individuals on their own path of self discovery. Both schizophrenic and nonschizophrenic students want to know who they are as individuals. Additionally, schizophrenic students are prone to the same peer pressures to drink alcohol and try drugs as nonschizophrenic students. However, if a schizophrenic student experiments with alcohol and/or illicit drugs, such as marijuana or cocaine, serious malfunctions usually occur within the brain unparalleled to the adverse affects of those who are not schizophrenic. Marijuana may set off psychotic symptoms in an unpredictable way which may take days to recover from fully (Torrey, 2001). In fact, even caffeine can have a negative impact on students' antipsychotic medications. Making sure that schizophrenic students understand the correlation between their medication and life choices may be an important function in maintaining their own and others' overall safety. Perhaps these issues can be addressed in a behavioral contract with the student, especially if they are residing in university housing property.

Identifying Schizophrenia

How can student affairs professionals differentiate whether a student experiencing a psychotic episode might be suffering from schizophrenia? A few symptoms have been recognized as having a strong correlation with the disease.

Persons with schizophrenia often times have difficulty understanding what is being said to them, and thus, have difficulty responding appropriately. I initiated a conversation with a schizophrenic student with whom I was working by asking, "So, how are you doing?" After a pause, the student looked away and responded, "My friends and I just got out of a canoe." The response was not surprising in that patients with schizophrenia lack not only the ability to sort and interpret brain stimuli because of problems with their neurotransmitters, but they also often struggle to select appropriate responses. This inability is one of the hallmarks of the disease (Torrey, 2001).

Other early symptoms of schizophrenia are as follows: depression; changes in social behavior, especially withdrawal; changes in sleep or eating patterns; suspiciousness or feelings that people are talking about them; changes in patterns of self-care; changes in academic performance; marked weakness; lack of energy; headaches or strange sensations in the head; changes in emotional relationships with family or close friends; and confused, strange, or bizarre thinking (Torrey, 2001). Again, an obvious problem is that these early symptoms strongly correlate with other physical and mental health disorder symptoms. This makes it difficult to immediately identify someone who is developing schizophrenia. Unfortunately, at this time, there is no way to identify schizophrenia at the beginning of the disease. Additionally, simply watching for it is nearly impossible as everyone who becomes ill with schizophrenia will react uniquely. According to Glynn (1998), two persons may be diagnosed with the disease, yet share no symptoms in common (p. 68).

Usually, there are no easily discernable methods to determine whether or not someone has schizophrenia until they have an initial psychotic episode, otherwise known as a psychotic break. When these psychotic breaks happen, they can be quite frightening. Knowing how to react in these situations is crucial in helping students obtain the overall help they will need. Other students can be allies to student affairs professionals in assisting schizophrenic students who are having a psychotic episode obtain help. Sometimes, students will begin to report that one of their peers is acting "crazy," or just isn't the same as they were before. These notable changes could indicate a cross-section of problems with the student. Picking up on these signs and checking in with a student can speed recovery, or the process of preparing to function and live without further damage to themselves. The earlier a schizophrenic patient receives medication the less neurological damage occurs; quick action will usually lead to a faster recovery process.

When a person has a psychotic episode, there are generally a number of things that can be witnessed by those of us on the outside. There are a few general identifiable traits that schizophrenic patients share in common during schizophrenic episodes. Some of these typical categories of experience are hallucination and delusion, alteration of the senses, disordered thinking, and changes in emotion.

Hallucinations and delusions can be one of the most frightening experiences to watch a person endure. Working with a schizophrenic student once, I found she literally thought that God was speaking to her. Talking someone out of this type of delusion does not work and can lead to frustration. The usual solution is to simply listen until they are in a place to respond to your requests. Many patients interpret their hallucinations within a religious framework and subsequently believe they are being touched by God (Torrey, 2001). Torrey further states that delusions of a religious nature are extremely common and can be found in almost half of all people with schizophrenia. The fact that this is a common occurrence and not the schizophrenic student's fault can be communicated to those who have witnessed the hallucinations. This will help educate other students about the disease and in turn reduce some of the stigma associated with schizophrenia.

There are a range of hallucinations a schizophrenic person can endure, from believing they are being controlled by their neighbors, to believing that their thoughts are being broadcast on televisions around the world. Perhaps the most famous person to suffer from a delusional type effect was John Hinckley, who believed that voices were telling him to kill President Ronald Reagan so he would earn the respect of the movie star Jodie Foster. Unfortunately, according to Torrey (2001), most of the voices a person hears are unpleasant.

For some schizophrenic patients, a psychotic episode can take the form of altered senses. The typical schizophrenic who experiences a state of distorted sensory perception may have symptoms similar to someone with the influenza virus; perceived amplification of noises, heightened light sensitivity, and a general lack of concentration is exhibited. However, what carries the problem further for schizophrenics is the manner in which they interpret these heightened senses. A person with the flu can cognitively recognize and typically attribute noise sensitivity to their state of illness. A schizophrenic patient will sometimes have difficulty discerning these facts and can possibly react in a plethora of different avenues. Sometimes, but not always, these heightened senses are interpreted as signs from God or other forms of communication. Some react by withdrawing, others become hyper. Again, the problem discerning the stimuli is most likely due to a problem with the individual's neurotransmitters.

Dysfunctional neurotransmitters contribute to an individual appearing less than fully functional, according to societal norms. Typically, persons who have a difficult time socializing are labeled odd and sometimes dumb. Hopkins and Lewis (2000) have shown that there is generally a 3% brain size reduction in people with schizophrenia. However, this does not correlate to a loss of intelligence. In fact, studies have shown that sometimes the IQ of a person with schizophrenia drops only slightly preceding actual visible symptoms (Torrey, 2001). Therefore, students with schizophrenia can be expected to demonstrate equal intelligence with their peers. Perhaps this was one place where *A Beautiful Mind* (2001) was right, as the main schizophrenic character was absolutely intelligent and ultimately wins the Nobel Peace Prize in Mathematics.

Conclusion

Student affairs professionals should not be intimidated to work with students with schizophrenia. Every disease requires its own special attention. Schizophrenia is no exception. Understanding what schizophrenia is, knowing possible signs of the disease, and learning how to incorporate the needs of individuals with schizophrenia into the collegiate environment should not be difficult. The first part in accomplishing this is to make sure that one is informed about the disease and how it affects people. With this knowledge, working with students with schizophrenia should become easier. This, in turn, should help keep a part of our communities functioning smoother as the illness is not a curse, but something that needs some special nurturing to overcome. Student affairs professionals can play a crucial role in this nurturing process to help ensure that schizophrenic students succeed at school.

References

Alliance for the Mentally Ill/ Friends and Advocates of the Mentally Ill (AMI/FAMI). (n.d.). *Schizophrenia, Olanzapine (Zyprexa) and Risperidone (Resperdal)*. Retrieved January 31, 2003, from http://www.mwsearch.com/schizophrenia

Anderson, C., Reiss, D., & Hogarty, G. (1986). *Schizophrenia and the family: A practitioner's guide to psychoeducation and management*. New York: Guliford.

Bellenir, K. (Ed.). (1996). *Mental health disorders sourcebook: Basic information about schizophrenia, depression, bi-polar disorder, panic disorder, obsessive-compulsive disorder, phobias and other anxiety disorders, paranoia and other personality disorders, eating disorders, and sleep disorders, along with information about treatment and therapies*. Detroit: Omnigraphics.

Centers for Disease Control and Prevention. (1995). *HIV/AIDS and college students* [Electronic Version]. Retrieved January 31, 2003, from http://www.aegis.com/PUBS/CDC_FACT_SHEETS/1995/

Davidson, L., Stayner, D., & Haglund, K. (1998). Phenomenological perspectives on the social functioning of people with schizophrenia. In Mueser, K. & Tarrier, N. (Eds.), *Handbook of social functioning in schizophrenia*. Boston: Allyn and Bacon.

Douglas, M. (Producer), Goldman, B., Hauben, L., Forman, M. (Writers/Director). (1975). *One flew over the cuckoos nest*. [Motion picture]. United States: Fantasy.

Glynn, S. (1998). Psychopathology and social functioning in schizophrenia. In Mueser, K. & Tarrier, N. (Eds.), *Handbook of social functioning in schizophrenia*. Boston: Allyn and Bacon.

Gonzalez, J., Tinsely, H., & Kreuder, K. (2002). Effects of psychoeducational interventions on opinions of mental illness, attitudes toward help seeking, and expectations about psychotherapy and college students. *Journal of College Student Development*, 43(1), 51-63.

Grazer, B., Howard, R. & Peyrot, M. (Producers) & Goldsman, A., Howard, R. (Writer/Director). (2001). *A beautiful mind*. United States: Imagine Entertainment.

Hopkins, R., & Lewis, S. (2000). Structural imaging findings and macroscopic pathology. In Harrison, P. & Roberts, G. (Eds.), *The neuropathology of schizophrenia: Progress and interpretation*. Oxford, England: Oxford University Press.

Huxley, P. (1998). Quality of life. In Mueser, K. & Tarrier, N. (Eds.), *Handbook of social functioning in schizophrenia*. Boston: Allyn and Bacon.

Psychologynet.org. (2002). *Diagnostic and statistical manual of mental disorders* (4th ed.). [Electronic Version]. Retrieved January 31, 2003, from http://www.psychologynet.org/schiz.html

Scott, J. & Lehman, A. (1998). Social functioning in the community. In Mueser, K. & Tarrier, N. (Eds.), *Handbook of social functioning in schizophrenia*. Boston: Allyn and Bacon.

Torrey, E. F. (2001). *Surviving schizophrenia: A manual for families, consumers, and providers*. New York: HarperCollins.

Appendix A

Diagnostic Criteria of the *Diagnostic and Statistical Manual of Mental Disorders IV*.

A. Characteristic symptoms: Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):

1. delusions
2. hallucinations
3. disorganized speech (e.g. frequent derailment or incoherence)
4. grossly disorganized or catatonic behavior
5. negative symptoms (e.g. affective flattening, alogia, or avolition)

Note: *Only one of Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other.*

B. Social/occupational dysfunction: For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).

C. Duration: Continuous signs of the disturbance persist for at least six months. This six-month period must include at least one month of symptoms (or less if successfully treated) that meet Criterion A (e.g. active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g. odd beliefs, unusual perceptual experiences).

D. Schizoaffective and Mood Disorder exclusion: Schizoaffective Disorder and Mood Disorder With Psychotic Features have been ruled out because either (1) no Major Depressive Episode, Manic Episode, or Mixed Episode have occurred concurrently with the active-phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.

E. Substance/general medical condition exclusion: The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

F. Relationship to a Pervasive Developmental Disorder: If there is a history of Autistic Disorder or another Pervasive Developmental Disorder, the additional diagnosis of Schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).

Diagnostic Criteria of Schizophrenia Subtypes

Paranoid Type
A type of Schizophrenia in which the following criteria are met:

A. Preoccupation with one or more delusions or frequent auditory hallucinations.

B. None of the following is prominent: disorganized speech, disorganized or catatonic behavior, or flat or inappropriate affect.

Catatonic Type
A type of Schizophrenia in which the clinical picture is dominated by at least two of the following:

1. motoric immobility as evidenced by catalepsy (including waxy flexibility) or stupor

2. excessive motor activity (that is apparently purposeless and not influenced by external stimuli)

3. extreme negativism (an apparently motiveless resistance to all instructions or maintenance of a rigid posture against attempts to be moved) or mutism

4. peculiarities of voluntary movement as evidenced by posturing (voluntary assumption of inappropriate or bizarre postures)

5. stereotyped movements, prominent mannerisms, or prominent grimacing

6. echolalia or echopraxia

Disorganized Type
A type of Schizophrenia in which the following criteria are met:

A. All of the following are prominent:

1. disorganized speech

2. disorganized behavior

3. flat or inappropriate affect

B. The criteria are not met for Catatonic Type.

Undifferentiated Type
A type of Schizophrenia in which symptoms that meet Criterion A are present, but the criteria are not met for the Paranoid, Disorganized, or Catatonic Type.

Residual Type
A type of Schizophrenia in which the following criteria are met:

A. Absence of prominent delusions, hallucinations, disorganized speech, and grossly disorganized or catatonic behavior.

B. There is continuing evidence of the disturbance, as indicated by the presence of negative symptoms or two or more symptoms listed in Criterion A for Schizophrenia, present in an attenuated form (e.g. odd beliefs, unusual perceptual experiences).

Appendix B

Antipsychotic Medications

Generation 1 (I)

Antipsychotic Drug Name	Common Name
Chloropromazine	Thorazine
Thioridazine	Mellaril
Trifluoperazine	Stelazine
Thiothixene	Navane
Fluphenazine	Prolixin

Haloperidol	Haldol

Generation 2 (II)

Antipsychotic Drug Name	Common Name
Risperidone	Risperdal
Olanzapine	Zyprexa
Clozapine	Clozaril