Prolixin, Thorazine, and Mellaril. A major breakthrough in the treatment of schizophrenia occurred in 1990 with the introduction of the drug clozapine to the U.S. market. Clozapine, which affects the neurotransmitters in the brain (specifically serotonin and dopamine), has been dramatically successful in relieving both positive and negative symptoms of schizophrenia, especially in patients in whom other medications have not been effective. However, even clozapine doesn’t work for all patients. In addition, about 1% of those who take it develop agranulocytosis, a potentially fatal blood disease, within the first year of use, and all patients on clozapine must be monitored regularly for this side effect. (Clozapine was first developed decades ago but could not be introduced until it became possible to screen for this disorder.) The screening itself is expensive, creating another problem for those using the drug. Risperidone, a new, safer medication that offers benefits similar to those of clozapine, was introduced in 1994 and is now the most frequently prescribed antipsychotic medication in the United States. Olanzapine, another in the new generation of schizophrenia drugs, received FDA approval in the fall of 1996, and more medications are under development. Electroconvulsive therapy (ECT, also called electric shock treatments) has been utilized to relieve symptoms of catatonia and depression in schizophrenics, especially in cases where medication is not effective.

Although medication is the most important part of treatment, psychotherapy can also play an important role in helping schizophrenics manage anxiety and deal with interpersonal relationships, and treatment for the disorder usually consists of a combination of medication, therapy, and various types of rehabilitation. Family therapy has worked well for many patients, educating both patients and their families about the nature of schizophrenia and helping them in their cooperative effort to cope with the disorder.

Further Reading

Further Information

In March 1994, the test formerly known as the Scholastic Aptitude Test became the Scholastic Assessment Test (SAT). The name change reflects the test’s objectives more accurately, that is, to measure a student’s scholastic ability and achievement rather than his or her aptitude. The format of the SAT remains basically the same, however; it is a series of tests, given to groups of students. The tests measure verbal and mathematical abilities and achievement in a variety of subject areas. It is offered on Saturday mornings seven months of the year at locations across the United States. Over 2,000 colleges and universities use the test scores as part of the college admissions process. The SAT scores provide an indicator of the student’s ability to do college-level work. Intended as an objective standard for comparing the abilities of students from widely different cultural backgrounds and types of schools, the test can also help students, their parents, and guidance counselors make decisions in the college application process.

The two major components of the test are SAT I: Reasoning Test, and SAT II: Subject Tests (formerly called Achievement Tests). All SAT test-takers complete SAT I, a three-hour multiple-choice test. The Test of Standard Written English, which prior to 1994 comprised a half-hour section of SAT I, has been eliminated. The new SAT I has three verbal reasoning and three mathematical reasoning sections. However, not all of these are half-hour sections. For both the verbal and mathematical components, two sections take 30 minutes, and the third takes only 15. This brings the total test time to 2.5 hours. The remaining half hour is devoted to an experimental section called Equating, which can be either a math or a verbal section. This section is not counted in the student’s score, but the test-taker does not know which one is the Equating section while taking the test.

The Verbal Reasoning sections in the SAT I no longer contains antonym questions, and a greater emphasis has been placed on reading comprehension (called Critical Reading), which, in some cases, requires the student to answer questions on two different text passages instead of just one. As before, the Verbal Reasoning sections also include sentence completion and analogy questions.
The Mathematical Reasoning sections consist of multiple-choice questions covering arithmetic, algebra, and geometry; quantitative comparison (which are also multiple choice); and a section of problems requiring students to calculate their own answers (multiple-choice answers are not provided). Students are allowed (and encouraged) to use calculators for the math sections.

SAT II includes a variety of tests in subjects such as English, foreign languages, math, history and social studies, psychology, and the sciences. SAT I and II cannot be taken on the same day. Raw SAT scores are calculated based on the number of correct answers minus a fraction of a point for each wrong answer. Subtracting points for wrong answers compensates for guesses made by the test-taker, and is called the “guessing penalty.” The raw score is converted using a scale ranging from 200 to 800, with separate scores provided for the verbal and math sections, and for each subject test in SAT II. Scores are reported about six weeks after the test date to students and their high schools, and to the colleges of their choice. Students may take the SAT more than once, and many do, hoping to improve upon their initial scores.

The SAT has been criticized on grounds of cultural and gender bias, charges that the revised version has attempted to rectify. The widespread use of test preparation courses and services for the SAT has also generated controversy, with detractors arguing that the test is unfair to economically disadvantaged students, who have limited access to coaching.

Further Reading

School phobia/School refusal

Reluctance or refusal to attend school.

School phobia is an imprecise, general term used to describe a situation in which a child is reluctant to go to school. According to the American Academy of Child and Adolescent Psychiatry, refusal to go to school is most common in the period from preschool through second grade. In most cases, school phobia is a symptom of an educational, social, or emotional problem the child is experiencing.

The child with school phobia develops a pattern of predictable behavior. At first, the child may begin the day complaining that he is too sick to go to school, with a headache, sore throat, stomachache, or other symptom. After the parent agrees that the child may stay home from school, he begins to feel better, although his symptoms often do not completely disappear. By the next morning, the symptoms are back in full intensity. When the child repeats this pattern, or simply refuses to go to school without complaining of any symptoms of illness on a chronic and consistent basis, school phobia is considered to have evolved into school refusal (or school refusal syndrome).

School refusal is a diagnostic criterion for separation anxiety disorder, a mental condition characterized by abnormally high anxiety concerning possible or actual separation from parents or other individuals to whom the child is attached. When school refusal is related to separation anxiety disorder, it is likely that the child will also display aversion to other activities (after-school clubs and sports, birthday parties, summer camp) that involve being away from the person to whom the child is attached. In addition, he may cling to the person, and refuse to allow her out of his sight for even short periods of time. Children experiencing separation anxiety disorder and school refusal may express feelings of fear when left alone in a room.

Refusal to go to school may begin as a result of any of the following stresses: birth of a sibling; death of a family member, close friend, or pet; change in school, such as a new teacher; loss of a friend due to a move or change in school; or a change in family, such as divorce or remarriage. It may also follow summer vacation or holiday break, when the young child has spent more time with his primary caregiver.

Almost every child will display behavior to avoid going to school—for academic or social reasons—at some point during his school career. In these cases, the situation the child is trying to avoid is usually temporary—an argument with a friend, the threat of a bully, or the consequences of a missed homework assignment, for example. When the avoidance of school becomes a chronic pattern, the child may develop serious social and academic problems. A professional counselor or child psychiatrist working with the child’s teacher and other school personnel can all support the family in overcoming a child’s refusal to go to school.

Returning the child to school is the highest priority so that disruption to the child’s educational and emotional development is minimized. Depending on the severity of the fears that produced the symptom of school refusal, ongoing counseling or psychiatric treat-