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LIVING *with* **SCHIZOPHRENIA**



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Schizophrenia

According to the World Health Organization at least 26 million people are living with schizophrenia worldwide, and many more are indirectly affected by it. The illness affects a person's well-being, shortens life and is among the top causes of disability globally. It is often neglected and misunderstood, but imposes a heavy toll on the individuals who experience it, and their family members and caregivers. And the high level of stigma associated with schizophrenia is an added burden.

While the illness is severe, new approaches are resulting in improved outcomes over time for many who have it. A challenge facing the mental health advocacy community is to create public pressure to change national mental health policies around the world, so that they take into consideration the scientific, clinical and social advances of recent decades. The World Federation for Mental Health (WFMH) has chosen the theme "Living with Schizophrenia" for its 2014 World Mental Health Day campaign in order to highlight changes in current thinking about the illness. The aim is to improve public understanding of schizophrenia and draw attention to ways in which better care can be provided.

What is Schizophrenia?

Schizophrenia is a serious mental illness that affects how a person thinks, feels, and acts. Many people find it difficult to tell the difference between real and imagined experiences, to think logically, to express feelings, or to behave appropriately. Schizophrenia often develops in adolescence or early adulthood. People suffering from the illness experience a range of symptoms that may make it difficult for them to judge reality. While there is no cure for schizophrenia at the moment, treatments are available which are effective for most people.

Not everyone who is diagnosed with schizophrenia has the same symptoms. The definition of the disorder is quite wide, includes many different possible combinations of symptoms, and can vary across countries. Schizophrenia will normally be diagnosed by a psychiatrist, but there are many symptoms which occur in schizophrenia that everyone can be aware of. For some people, schizophrenia begins with an "early psychosis" or "prodromal" stage. Key features of this stage include: Sleep disturbance, Appetite disturbance, Marked unusual behaviour, Feelings that are blunted (flat) or seem incongruous (inconsistent) to others, Speech that is difficult to follow, Marked preoccupation with unusual ideas, Ideas of reference - thinking unrelated things have a special meaning, ie, people on TV talking to you, Persistent feelings of unreality, Changes in the way things appear, sound or smell

Some people may experience early psychosis or a prodromal stage and never develop schizophrenia. Others who develop schizophrenia never show signs of early psychosis/prodrome and therefore have no option for early treatment, while there are people who have symptoms and obtain early treatment but nevertheless go on to develop schizophrenia. Symptoms which may then occur are often grouped in to three categories: positive, negative and cognitive. The terms "positive" and "negative" can be confusing. Essentially, positive symptoms suggest that something is present which should not normally be there. A negative symptom is something that is not present, but should be.

Schizophrenia can occur anywhere, and affect anyone. However, variations exist in the numbers of people diagnosed in different communities, the symptoms that they experience, how they are diagnosed, and how different communities view and react to someone who has schizophrenia. There is significant inequity in access to treatment for people with schizophrenia depending on where they live. The World Health Organization reports that more than 50% of people with schizophrenia cannot access adequate treatment, and 90% of people with untreated schizophrenia live in the developing world.

Schizophrenia is a treatable disorder. For the millions of people worldwide living with this disorder, there are treatments that can help to reduce symptoms and improve the ability to function at home, at work, and at school. For many people, long-term medication is necessary but a number of other treatment options/services may also be helpful including talk therapy, self-help groups, vocational rehabilitation, community programs and peer-support. People with schizophrenia should work with their healthcare professionals and families to develop a treatment plan that works for them.

Schizophrenia: it's still pretty much what it used to be

Schizophrenia is a set of symptoms psychiatry has labeled as a disorder. According to DSM-IV-TR (the Diagnostic and Statistical Manual of Mental Disorders, text revised, published by the American Psychiatric Association in 2000), the diagnostic criteria for schizophrenia are: Two (or more) of the following, each present for a significant portion of time during a 1-month period (1) delusions (2) hallucinations (3) disorganized speech (4) grossly disorganized or catatonic behavior (5) negative symptoms, i.e., affective flattening, alogia (poverty of speech), or avolition (lack of motivation). Only one of these 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 if there are two or more voices conversing with each other. 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. There have been continuous signs of the disturbance persisting for at least six months.

Thirteen years later, in DSM 5, there were no major changes in the diagnostic criteria. In DSM 5 two or more symptoms are always required and the subtypes of schizophrenia have been deleted. Subtypes had been defined by the predominant symptom at the time of evaluation, but these were not helpful because patients' symptoms often change from one subtype to another over time and there are all too often overlapping features amongst the subtypes. The etiology of schizophrenia remains outside our reach. While we have moved beyond the "schizophrenogenic mother", theories of etiology are about as wide-ranging as one can imagine: prenatal influenza or other prenatal factors; a determined enzymatic error, postnatal brain injury; early childhood trauma; or *Toxoplasma gondii*.

Schizophrenia remains a group of symptoms that may be one or many diseases; has a yet to be determined cause; and has a cornucopia of medications ranging from first generation to third generation that can treat its symptoms, but at the cost of significant side effects. Overall the picture is not pretty.

However, a fundamental shift in our thinking have taken place. Schizophrenia is now thought of as a disorder that an individual can manage, with a combination of treatments, in order to live a life in recovery. According to the US Substance Abuse and Mental Health Services Administration (SAMHSA), recovery is “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.” A person with schizophrenia can be a person in recovery.

Living With Schizophrenia : A Personal Story, *the first 35 years....*

I've been living with my diagnosis of schizophrenia for over 35 years now. I got it when I was a teenager. It wasn't my first diagnosis but it was the one that stuck. When I first got it, I thought my life was over. I was studying for exams and I wanted to be an economist. I didn't think anyone would want a schizophrenic economist.

Expectations

I wasn't alone in thinking that. One of the things that struck me most was the low expectations that followed. This was particularly apparent amongst medical staff, all they saw was a label-the person I used to be, or might become, vanished. If enough people, particularly professionals, treat you like a lost cause, then sooner or later you end up believing it. I was fortunate that people who really understood my experience still expected me to achieve things. One in particular persuaded me to get actively involved in a local support organisation, expecting me to get on and do things for myself and others rather than becoming a passive patient.

Friends and relationships

Fortunately I had friends who believed in the old me. I also developed new friendships with people, many of whom had shared my experiences of psychiatric care. Spending time with people who shared my experience, but had survived and thrived in spite of it, was an inspiration and many of these people remain good friends to this day. Not all my friends were able to cope with me and sometimes I felt very lonely and isolated, but there were times when it was only my friends that kept me going.

Treatments and services

Attitudes towards treatments were often unhelpful. It should be simple, the treatments either help or they don't. If they do, that's good. People should have access to the best available; if they don't, it's no one's fault and treatments that don't work shouldn't be forced on people. Self-help, self-management and peer support are starting to help a lot of people. They have helped me and have given me the ability to help others.

Jobs

My work has always been important to me, both before my time working in mental health and since. I have not always been able to work, and my best employers have been very supportive when I have been at my most unwell. Although work can sometimes be stressful, I have always found being out of work much worse. My work has given my life meaning and purpose, a chance to contribute.

My work in mental health has enabled me to take my experience of mental ill-health and use it to help others. I have had the

opportunity to meet many people who have been directly affected by mental ill-health and still achieved great things. Together we have become part of an international community and are stronger for it.

Future

When I first got my diagnosis, I thought my life was over. Now, 35 years later, I just think it's part of who I am. The people I care about, the people who matter, don't see a diagnosis, they see a person. It's been an interesting 35 years and I'm looking forward to many more.

Illness prevention and health promotion in Schizophrenia

Schizophrenia is one of those life-changing illnesses, but it does not have to be life-defining. Just like people with diabetes, hypertension, rheumatoid arthritis or heart disease, people with schizophrenia frequently have to keep their illness at bay with medications, life-style changes or psychological therapies or a combination of those. By focusing on the positive and healthy aspects of their life, people who suffer from schizophrenia begin to gain confidence and self-esteem and become more independent and empowered in their life. Eventually, they can start defining their life and themselves as persons rather than patients and start focusing on their health rather than their illness. By doing so, they enhance their ability to achieve psychological well-being and also cope with adversity.

While this approach can yield great rewards for people with schizophrenia, managing to adhere to it is easier said than done. The difficulty lies in that one needs to keep their illness at bay while focusing on the positive aspects of their life. Keeping the illness at bay is complicated by the fact that schizophrenia is one of the few illnesses that affect the person's ability to recognise that they, in fact, have an illness. Lacking that insight makes people believe that they don't need therapy, be that with medications or any other kind, and slowly but surely the illness returns with a vengeance. This tension can create major problems with carers as well as health care professionals. That is why it is very important for people with schizophrenia to remember that, in addition to their own individual strengths and virtues, they also have an illness that needs to be tamed in the same way as other chronic conditions are managed.

Focusing both on prevention and promotion can serve to help in multiple ways: Improving one's health can lead to preventing mental illness and vice versa. As shown in the case of depression, people with low positive health can be vulnerable to illness, and conversely, by increasing positive mental health one may also manage to prevent illness. Using prevention and promotion makes logical sense; on the one hand prevention is better than cure, and on the other hand improving one's life is an end in itself. Furthermore, mental illness prevention and mental health promotion are supported by mounting evidence on their effectiveness and cost-effectiveness, which is reflected in the fact that they have been endorsed by major bodies such as the European Parliament and the World Health Organisation.

Health promotion may be the most important intervention in Schizophrenia

Some people with schizophrenia experience a gradual decline in their ability to function at a high level. This is due to a number of factors some of which are intrinsic to schizophrenia, including, for example disorganisation and depression, but others are to do with stigma and social exclusion.

For those who experience it, this functional decline can be very frustrating, especially as it is often persistent. Treating schizophrenia appropriately means that some of the symptoms may go away, but even that does not guarantee that the person's life experience will improve.

Treating the illness is not enough to achieve true quality of life. Preventing the illness from occurring in the first place (primary prevention) would be a very attractive option, as symptoms and functional decline would not have developed yet in these early stages. However, as a practical matter, in most cases prevention in schizophrenia is tackled at a secondary or tertiary level, i.e. once the disorder has already taken hold or has already caused symptoms and/or functional decline. In fact, one of the main difficulties in recognising schizophrenia at primary preventive level is that it is exactly those symptoms that reveal it, and therefore almost by definition it is very difficult to "catch" it early. Regardless of that, preventing relapses and consequences of the illness (secondary and tertiary prevention) can be useful, as preventing relapses also prevents further functional deterioration, and consequently improves quality of life. Although the usefulness of prevention may be rather limited for those who have already had functional decline, health promotion can still play a key role.

In order to improve quality of life for patients, a different approach is needed, and that would be to reinforce those factors in a person's life that would empower them to build on their own strengths and improve their quality of life, regardless of the state or stage of their illness. Health promotion can be applied way before the illness manifests itself and will contribute towards primary and secondary prevention as a bonus effect. Health promotion may be considered to be the most important intervention in schizophrenia as it can benefit everyone, regardless of the state or stage of their illness, can be applied to the wider population, can offer an improvement in quality of life as opposed to the mere absence of illness, and can be cost-effective and therefore indirectly beneficial for the health of many more people. Given the evidence, mental health professionals need to embrace mental health promotion. However it appears that often this is not the case. More effort is therefore required, particularly in order to communicate this message to mental health professionals, but also to patients and their carers and families.

Schizophrenia & social inclusion

Schizophrenia is often a no-go word; it is a word that spells stigma - stigma from the rest of the world and stigma from inside. No wonder campaigns are running to change the terminology, but whatever we call it, we need to dedemonize it, if we are to succeed in bringing social inclusion to those who live with it.

The first assumption is that people with schizophrenia are dangerous. The media choose to portray the condition as violent and a risk to people in the street. But the reality is that few have violent episodes and most of those are cases of self-harm. The second assumption is that one cannot be treated or cured and so the person should not be out of a hospital. The reality is that some 25% of people with schizophrenia do recover fully, a further 25-35% improve considerably and live relatively independent lives, some 20% improve but need extensive support, and between 10 and 15% remain unimproved in

hospital. A further 10-15% die prematurely, mostly by suicide.

Schizophrenia is a condition which can be managed and self-managed with supportive treatment, social care and with doors opening to social inclusion and not slamming shut through the ignorance of pre-judging and stigma. Social inclusion is a meaningless term unless we break it down into its component parts. It is not just communication and outreach services, although it may involve both. It is listening and respecting and assuming a can-do ability on the part of the individual - or a could-do one, if obstacles were removed and encouragement given. It is opening doors to advice and advocacy; it is making possible opportunities to work or to volunteer, to take as much responsibility as feels comfortable for now; it means educating media, communities, employers, trade unions, police, health professionals and managers and policymakers to revise old assumptions and old prejudices; it means ensuring the law, regulations and procedures are reviewed and made relevant; it means treating co- and multi-morbidities; it means having a benefits system and housing provision that help recovery and stability and it means caring for the carers and assessing their needs. It means all of us posing the question to ourselves: 'If it is me or my child or my spouse or partner, what would I fear, what would I hope for and how could I be helped to cope.

Interventions

Early intervention in Schizophrenia

Early intervention for the serious mental illnesses, like schizophrenia, aims to prevent the onset illness, and failing that, to minimise the symptoms and distress associated with the illness, and to maximise the chances of the best possible recovery without ongoing disability. Preventing the onset of a serious mental illness means firstly determining who is at risk of developing the illness, and then how to intervene to prevent the illness. In case of schizophrenia, we are yet not well aware of the biology of the disease and the techniques cannot be applied. However, the research effort to date has allowed clinicians to identify criteria that indicate that a young person is at greater risk of developing a serious mental illness. These include being aged between 14 to 29 years, because this is when most serious mental illnesses first appear; and seeking help for distressing symptoms such as depression, anxiety and low-level psychotic symptoms.

Recognising that this group of young people is at ultra-high risk of developing a serious mental illness has allowed clinicians and researchers to develop a number of treatment approaches that aimed at relieving their symptoms and distress, pre-empting the development of ongoing disability, and preventing the onset of more serious illness. These treatments are tailored to the stage of the young person's illness, and at this very early stage are most likely to include counselling, education and supportive monitoring. If symptoms persist or worsen, cognitive behavioural therapy may be offered, and antidepressant or anti-anxiety medications trialled. Low-dose antipsychotic medication has also been tested in this patient group, but is not recommended as a first line of treatment due to the greater risk of side-effects. Early intervention is particularly important for these vulnerable young people, because although many of them will not go on to develop schizophrenia, their mood and anxiety symptoms have the potential to evolve into more established illness if they are not treated effectively right from the start.

For those young people who do have a first episode of psychosis, early intervention means recognising the illness quickly, and beginning appropriate treatment as early as possible. Initial treatment involves low-dose antipsychotic medication to manage symptoms and distress. However, recovery involves more than just eliminating symptoms; for a young person with a serious mental illness, it also means maintaining or regaining their normal developmental pathway-getting back to work or school, enjoying their social life again, and living a full and meaningful life while moving on into independent adulthood. Hence, early intervention for these young people also means surrounding them and their families with a comprehensive, integrated continuing care system for the first 2-5 critical years after the onset of illness, when the risk of accumulating ongoing disability is highest.

Integrated care involves a small continuing case management team providing medication and psychological treatments to help the young person manage their symptoms and illness, complemented by a suite of interventions with a strong focus on promoting social, educational and vocational recovery, preferably within a specialist early psychosis service. These services offer a developmentally appropriate, youth-friendly, and inclusive environment where young people can be supported in their recovery by a multidisciplinary team with specialist medical, psychosocial, vocational and educational expertise and a particular interest in youth mental health.

These treatment approaches have been shown to be very effective for young people in the early stages of illness, and are highly valued by both young people and their families. They are also cost-effective, and the growing recognition of the importance of young people's mental health issues, together with popular demand for mental health services that recognise young people's unique mental health care needs, have led to service reforms and new service development in countries like Australia, Ireland, England, Denmark, Canada, and most recently the United States. Many researchers and clinicians working in this field feel in common with the general public that they have watched long enough, and that young people and their families deserve active engagement and evidence-informed care that is proportionate to their needs. Approaches like these have already shifted thinking in mental health care, from what has traditionally been a palliative approach, to a pre-emptive approach that offers the potential for better outcomes for young people, their families, and the society as a whole.

Psychological interventions in Schizophrenia

Psychological treatments are important in helping people with a diagnosis of schizophrenia and their families. Coping with troublesome beliefs and upsetting unusual experiences can be difficult when others don't believe the person. Talking about them with a skilled mental health worker often helps. Psychological treatment is a general term used to describe meeting with a therapist to talk about feelings and thoughts and how this affects a person's life and wellbeing.

Cognitive Behavioural therapy and arts therapies: Cognitive behavioural therapy for psychosis is a form of psychological treatment for which there is large body of research evidence showing that it can be helpful. The evidence suggests that about one half to two thirds of people who have this type of therapy show benefits.

The therapy involves meeting with a therapist on a one-to-one basis for at least 16 sessions, over the course of 6-12 months. It will focus on the problems which are identified by the service user as important, which might include, for example, feeling anxious and avoiding situations, low mood and inactivity, sleep problems, worry, coping with voices, dealing with paranoid concerns or traumatic experiences, or managing stresses which lead to relapse. The primary goals chosen by the person, and often is to reduce the distress associated with psychotic symptoms, such as voices and worrying beliefs (paranoid ideas and delusions), and to work together to get back on the road to recovery. The sessions may involve talking about how problems started, discussing what has happened to the person and how they have interpreted it, understanding the unusual experiences they have, and exploring new ways of thinking and acting when problems occur. For some people, it may help to keep a diary of these thoughts, identify particular patterns in problems, find out more about their beliefs, and how they might be affecting them, and test out if trying to do something new makes them better or worse. The therapy is based on the assumption that the person's own experiences should be taken seriously and that they can be helped to take control of their thinking and behavior.

The research has also found that arts therapies, which do not involve so much talking but make structured use of music, drama or art as therapy, can be helpful, particularly when people have symptoms such as withdrawing from family and friends and losing interest in things that were once enjoyable. These therapies should usually take place in groups with people with similar problems.

The role of Families and Family therapy: Families are often on the front lines of care for persons with schizophrenia. The role of a long-term caregiver is accompanied by many burdens and needs for family members, which can leave them emotionally depleted and desperate for help. Family members need support to best assist their ill family member and cope with the stress associated with schizophrenia.

The well-being and clinical outcome of a person with schizophrenia can be significantly affected by the behaviours of family members. This does not mean that families cause the illness, which was an unfortunate misperception that originated in early work with families. However, particular family variables strongly influence recovery from schizophrenia. Expressed emotion (EE), which includes criticism, hostility, and over involvement, has been shown to be a strong predictor of outcome in schizophrenia.

When families of patients with schizophrenia have high EE, there are more frequent relapses in comparison to families that have lower EE. Engaging families in treatment allows the mental health worker to address relational stress that may exacerbate problems, support families in their care of mentally ill person, and access a family's skills and resources to help the patient in need.

Family psychoeducation (FPE), also called Family Intervention in some countries, has been shown to be effective in the treatment of schizophrenia and is now deemed an evidence-based practice for reducing relapse and hospitalisations. FPE is a collection of programs aimed at providing information about the illness, medication management, and treatment planning to family members as they cope with their family member's symptoms and the effects of illness on the family.

These programs assume that 1) the actions of family members impact the person coping with illness and his treatment and 2) family members need information and support in caring for a family member with severe mental illness. FPE is increasingly offered in a group format, where families join together to decrease social isolation and stigmatization and reap the benefits of mutual support.

Examples of interventions in FPE are assess the family's strengths and limitations in their ability to support the patient, help resolve family conflict through sensitive response to emotional distress, address feelings of loss, provide an explicit crisis plan and professional response, help improve communication among family members, encourage the family to expand their social support networks, and flexible in meeting the needs of the family.

Although international research supports the use of these psychological treatments, it is important to note that treatments can take many forms. They need to be tailored to meet the persons' and family's circumstances and culture. Staff, therefore, need specialized training and skills to undertake this work, with regular support and supervision.

Co-morbidity and Schizophrenia: physical health in people with Schizophrenia - the facts

People with schizophrenia suffer from an increased risk of morbidity and mortality compared to the general population. Unaddressed physical illnesses in this population can lead to a reduced life expectancy of up to 20 years. Two thirds of the premature deaths in this population are due to physical illnesses, with cardiovascular disease (CVD) being the major contributor. Those suffering from schizophrenia are twice as likely to die from CVD as those in the general population. People with schizophrenia are also more likely to be overweight, smoke, and have diabetes, hypertension and dyslipidaemia (abnormal fats). This cluster of risk factors, including impaired glucose

tolerance, central obesity, hypertension and dyslipidaemia, has been described as metabolic syndrome.

The incidence of metabolic syndrome in people with severe mental illnesses is 2-3 times greater than the general population. Whilst cardiovascular and metabolic diseases occur more commonly in people with schizophrenia than the general population, other physical health problems such as infections, neoplasm and medical complications of alcohol and drug misuse are also more frequent and have a greater impact on individuals with schizophrenia. Therefore it is essential to recognise physical illnesses early on and treat them without delay.

Although many risk factors, modifiable and non-modifiable, contribute to the poor physical health of people with schizophrenia, the increased mortality is largely due to the modifiable risk factors - many of which are related to lifestyle choices which we can alter. Exercise and physical activity are more limited due to lack of mental wellbeing, poor motivation/drive, lack of structure to life, and at times lack of prioritising financial resources. They are more likely to smoke excessively and misuse alcohol and drugs, resulting in worse mental, physical and social outcomes, with increased relapse rates, homelessness, unemployment, family breakdown and criminality. In addition, people with schizophrenia are less likely to seek medical treatment for physical illnesses, which can delay making a diagnosis and getting treatment for many years. This can lead to a poor prognosis and ultimately reduced life expectancy.

Health checks for people with schizophrenia are essential to monitor cardiovascular and metabolic risk factors along with general health screening. The World Psychiatric Association recommends the checks listed in table 1. Simple lifestyle changes with regular health checks and review of medications can optimise treatment and improve the overall quality of life for people with schizophrenia.

Measurements for monitoring physical health in SMI patients with baseline values

	Baseline	6 weeks	3 months	At least at 12 months and annually thereafter
Personal and family history	X			
Smoking, exercise, dietary habits	X	X	X	X
Weight	X	X	X	X
Waist circumference	X	X	X	X
Blood pressure	X	X	X	X
Fasting plasma glucose	X	X ¹	X	X
Fasting lipid profile	X	X ¹	X	X
ECG parameters	X			
Prolactin	X ²		X ³	X ³
Dental health	X			X

¹ This early blood sugar and lipids assessment has been recommended in Europe, but not in the US

² If possible to have some reference values, or, if this is too expensive, only in case sexual or reproductive system abnormalities are reported

³ Only in case of sexual dysfunction that coincided with antipsychotic treatment or dose change

WPA recommendations De Hert et al., *World Psy* 2011

Living Beyond Schizophrenia-recovery Is Possible

In the twentieth century the traditional dogma of the field of mental health was that a diagnosis of schizophrenia led to a lifetime of deterioration. In essence, schizophrenia was seen as a life sentence of mental health decline. The myth was that most people with schizophrenia were “deteriorating with schizophrenia”, in contrast to the current fact that many people with schizophrenia can recover- and are “living beyond schizophrenia”. While there are many definitions of recovery from schizophrenia, an early, succinct definition of recovery was, “the development of new meaning and purpose in one’s life as one grows beyond the catastrophe of schizophrenia” (Anthony, 1993). While diagnosticians of the 20th century believed that the most common outcome of schizophrenia was “acute exacerbations with increasing deterioration between episodes” (American Psychiatric Association, 1987), the more recent quantitative and qualitative research findings suggest otherwise (Anthony & Ashcraft, 2010).

Two important developments occurred late in the twentieth century that have led to the understanding that recovery was possible. One factor was the writing of people with psychiatric diagnoses, including schizophrenia. Beginning in the 1980s first person accounts of people’s recovery from severe mental illnesses began to appear regularly in the literature (e. g., Deegan, 1988; Leete, 1989; Mead & Copeland, 2000). Also qualitative studies of people’s recovery experiences became commonplace (e. g., Jacobson, 2001; Jenkins et al., 2007; Spaniol et al., 2003).

The second development supporting the factual basis of recovery from schizophrenia was the long term, followup studies of people with schizophrenia that were being conducted all over the world. Harding and her colleagues reviewed a number of these long term research studies and reported that a deteriorating course for severe mental illnesses, including schizophrenia, was not the norm (Harding, 1994; 2003). As a result of these two developments there is now both anecdotal and empirical support for the fact that there can be healing and growth after a person has been diagnosed with schizophrenia. People with schizophrenia are no longer defined by their schizophrenia diagnosis and symptoms, but rather by their long term success and satisfaction in numerous living, learning, working and socializing roles. People with schizophrenia can experience a meaningful life after diagnosis, not a deteriorating life.

Based on this new understanding of recovery, now in the twenty first century we find a revolution brewing in the field of mental health. It is a revolution in vision-in what is believed possible for people diagnosed with schizophrenia. In the previous century it was thought that people living with schizophrenia must endure a lengthy duration of severe disability, with a deteriorating course over their lifetime. New empirical and anecdotal evidence indicates that this belief was erroneous. We are increasingly convinced by this current anecdotal and empirical data that recovery from schizophrenia is possible for many more people than was previously believed. Furthermore, it appears that much of what we thought was the chronicity of schizophrenia was due to the way society and the mental health system treated people with schizophrenia, and not the illness itself. Where once there was little hope for much more than a deteriorating, long term disability for people diagnosed with schizophrenia, there is now

a research based hope for a meaningful life beyond schizophrenia. A vision of the possibilities of recovery changes how we treat people with schizophrenia.

Living a healthy life with Schizophrenia: paving the road to recovery

People with schizophrenia can recover. The service users, their families, communities and the health and social care providers need to recognize such a possibility and maintain realistic hope during treatment. However, for most of the affected population in the real world, especially those with poor psychosocial support, this would be a lengthy and strenuous journey. One extreme for people living with schizophrenia is immediate and complete recovery; the other is enduring disability. The gray zone in between embraces the majority of affected people.

Improving physical health by addressing the premature mortality, comorbid conditions, unhealthy life styles, and access to better integrated health system needs to be recognized for the patient groups suffering from mental illness like schizophrenia. Promoting collaboration between mental and physical health is vital for improving care of people with severe mental illness. The diagnosis of physical conditions is commonly overshadowed by a psychiatric diagnosis and delayed diagnosis makes interventions less effective or even impossible.

In many countries efforts have begun to better improve the physical health of people with schizophrenia, whilst simultaneously encouraging the social and education sector to provide better access to service for people with severe mental illness. Treatments should not be limited to pharmacotherapy. Non-pharmacological psychosocial interventions are gaining an increasing importance and should be considered an adjunctive component of mental disorder management. Psychosocial interventions are also effective at preventing some of the side effects of antipsychotic medications.

The way forward

WHO’s Mental Health Action Plan, endorsed by the World Health Assembly in 2013 envisions and plans for all different aspects of services required to provide a healthy life for people living with mental disorders including schizophrenia. The global plan emphasizes that persons with mental disorders should be able to access, without the risk of impoverishing themselves, essential health and social services that enable them to achieve recovery and the highest attainable standard of health. WHO promotes global actions using guidelines that are not only based on evidence but also observe the human rights of service users, which is why obtaining recovery has been observed as one of the favourable outcomes of access to services.

Source: *World Mental Health Day 2014 publication from WFMH.*

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SZMCH, Bogra

Dr. Swapan Kumar Singha

FCPS (Medicine)
Sadar Hospital, Moulvi Bazar

Dr. Ashfak Ahmed Milon

MD (Neurology)
Purnova Diagnostic Center, Dinajpur

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Md. Musfiqur Razzaque
e-mail: musfiqur-pmd@squaregroup.com
Cell: 01787672703

For further information: **Product Management Department**, Square Centre, 48 Mohakhali C/A, Dhaka-1212 **web:** www.squarepharma.com.bd

Prepared by: **Rains.com**, Dewan Complex (1st Floor), 60/E/1, Purana Paltan, Dhaka-1000, Cell : 01715380902, e-mail: rains.com@gmail.com