Eating disorders

What are eating disorders?

Anorexia nervosa and bulimia nervosa are the two most serious eating disorders.

Each illness involves a preoccupation with control over body weight, eating and food.

- People with anorexia are determined to control the amounts of food they eat.
- People with bulimia tend to feel out of control where food is concerned.

Anorexia may affect up to one in every hundred teenage girls, although the illness can be experienced earlier and later in life. Most people who have anorexia are female, but males also develop the disorder.

Bulimia may affect up to three in every hundred teenage girls. More females than males develop bulimia.

While these rates show that few people meet the criteria for eating disorders, it is far more common for people to have unrealistic attitudes about body size and shape. These attitudes may contribute to inappropriate eating habits or dieting practices.

Both illnesses can be overcome and it is important for the person to seek advice about either condition as early as possible.

What are the symptoms of anorexia?

Anorexia is characterised by:

- a loss of at least 15 per cent of body weight resulting from refusal to eat enough food, despite extreme hunger
- a disturbance of perceptions of body image in that the person may regard themselves as fat, overestimating body size the thinner they become
- an intense fear of becoming 'fat' and of losing control
- a tendency to exercise obsessively
- a preoccupation with the preparation of food
- making lists of 'good' and 'bad' food.

Usually, anorexia begins with a weight loss, either resulting from a physical illness or from dieting.

Favourable comments cause the person to believe that if thin is good, thinner is better.

The body does not react well to starvation, and erratic eating behaviour begins to dominate the person's life.

About 40 per cent of people with anorexia will later develop bulimia.

What are the symptoms of bulimia?

Bulimia is characterised by:

- eating binges, which involve consumption of large amounts of calorie-rich food, during which the person feels a loss of personal control and self disgust

- attempts to compensate for binges and to avoid weight gain by self-induced vomiting, and / or abuse of laxatives and fluid tablets
- a combination of restricted eating and compulsive exercise so that control of weight dominates the person's life.

A person with bulimia is usually average or slightly above average weight for height, so is often less recognisable than the person with anorexia.

Bulimia often starts with rigid weight reduction dieting in the 'pursuit of thinness'. Inadequate nutrition causes tiredness and powerful urges to binge eat.

Vomiting after a binge seems to bring a sense of relief, but this is temporary and soon turns to depression and guilt.

Some people use laxatives, apparently unaware that laxatives do not reduce kilojoules or fat content, and serve only to eliminate vital trace elements and to dehydrate the body.

The person can make frantic efforts to break from the pattern, but the vicious binge / purge / exercise cycle, and the feelings associated with it, may have become compulsive and uncontrollable.

A person with bulimia may experience chemical imbalances in the body which bring about lethargy, depression and clouded thinking.

What causes anorexia and bulimia?

The causes of anorexia and bulimia remain unclear. Biological, psychological and social factors are all involved. For some people, some of the following may compound low self-esteem, and contribute to the onset of anorexia or bulimia.

Social influences

This includes media and other presentations of the ideal shape in Western societies as slim and fit, and a tendency to stereotype fat people in a negative manner.

Personal factors

- changes in life circumstances such as the onset of adolescence, breakdown of relationships, childbirth or the death of a loved one
- fear of the responsibilities of adulthood
- poor communication between family members or parental reluctance to allow independence as children mature
- a belief that love from family and friends depends on high achievement.

Biological factors

This includes chemical or hormonal imbalances (perhaps associated with adolescence).

What are the effects of anorexia and bulimia?

Physical effects

The physical effects can be serious, but are generally reversible if the illnesses are tackled early. If left untreated, severe anorexia and bulimia can be life-threatening. Responding to early warning signs and obtaining early treatment is essential.

Both illnesses, when severe, can cause:

- harm to the kidneys
- urinary tract infections and damage to the colon
- dehydration, constipation and diarrhoea
- seizures, muscle spasms or cramps (resulting from chemical imbalances)
- chronic indigestion
- loss of menstruation or irregular periods
- strain on most body organs.

Many of the effects of anorexia are related to malnutrition, including:

- absence of menstrual periods
- severe sensitivity to the cold
- growth of down-like hair all over the body
- inability to think rationally and to concentrate.

Severe bulimia is likely to cause:

- erosion of dental enamel from vomiting
- swollen salivary glands
- the possibility of a ruptured stomach
- chronic sore throat and gullet.

Emotional and psychological effects

These are likely to include:

- difficulties with activities which involve food
- loneliness, due to self-imposed isolation and a reluctance to develop personal relationships
- deceptive behaviours relating to food
- fear of the disapproval of others if the illness becomes known, tinged with the hope that family and friends might intervene and provide assistance
- mood swings, changes in personality, emotional outbursts or depression.

What treatment is available?

Changes in eating behaviour may be caused by several illnesses other than anorexia or bulimia, so a thorough physical examination by a medical practitioner is the first step.

Once the illness has been diagnosed, a range of health practitioners can be involved in treatment, as the illnesses affect people physically and mentally. These may include psychiatrists, psychologists, physicians, dietitians, social workers, occupational therapists and nurses.

Outpatient treatment and attendance at special programs are the preferred method of treatment for people with anorexia. Hospitalisation may be necessary for those severely malnourished through lack of food.

Treatment can include medication to assist severe depression, and to correct hormonal and chemical imbalances.

Dietary education assists with retraining in healthy eating habits.

Counselling and specific therapies are used to help change unhealthy thoughts about eating, and educating the person that family and friends are supportive.

Depression

What is depression?

The word *depression* is often used to describe the feelings of sadness which all of us experience at some stage of our lives. It is also a term used to describe a form of mental illness called clinical depression.

Because depression is so common, it is important to understand the difference between unhappiness or sadness in daily life and the symptoms of clinical depression.

When faced with stress, such as the loss of a loved one, relationship breakdown or great disappointment or frustration, most people will feel unhappy or sad. These are emotional reactions which are appropriate to the situation and will usually last only a limited time. These reactions are not regarded as clinical depression, but are a part of everyday life.

The term *clinical depression* describes not just one illness, but a group of illnesses characterised by excessive or long-term depressed mood which affects the person's life. Clinical depression is often accompanied by feelings of anxiety. Whatever the symptoms and causes of clinical depression, treatment is very effective.

What are the main types of depressive illness?

Adjustment disorder with depressed mood

People with this illness are reacting to distressing situations in their lives (for example, the failure of a close relationship or loss of a job) but to a greater degree than is usual.

This depression is more intense than the unhappiness experienced in daily life, it lasts longer and the symptoms often include anxiety, poor sleep and loss of appetite.

The time which this form of depression lasts may vary from weeks to years.

It usually goes away when the cause is removed or when the person finds a new way to cope with the stress. Many people require intensive professional help and treatment to overcome this type of depression.

Postnatal depression

The so-called 'baby blues' affect about half of all new mothers. They feel mildly depressed, anxious, tense or unwell, and may have difficulty sleeping even though they are tired and lethargic most of the time. This type of depression may last only hours or for a few days, then disappear.

However, in about 10 per cent of mothers this feeling of sadness develops into a serious disorder called postnatal depression. Mothers with this illness find it increasingly difficult to cope with the demands of everyday life.

They can experience anxiety, fear, despondency and sadness. Some mothers have panic attacks or become tense and irritable. There may be a change in appetite and sleep patterns.

A severe, but rare form of postnatal depression is called puerperal psychosis. The woman is unable to cope with her everyday life and can be disturbed in her thinking and behaviour.

Depressive episode

This is, in general, a more severe form of clinical depression. It can come on without apparent cause, although in some cases a distressing event might trigger the condition.

The cause is not well understood but is believed to be associated with a chemical imbalance in the central parts of the brain.

A depressive episode can develop in people who have coped well with life, who are good at their work and happy in family and social relationships.

They become low-spirited, lose their enjoyment of life and suffer disturbed sleep patterns. People experiencing a depressive episode lose their appetite, lack concentration and energy, and may lose weight. Feelings of guilt are also common.

Sometimes their feelings of hopelessness and despair can lead to thoughts of suicide.

The most serious form of this type of depression is called psychotic depression. During this illness, the person loses touch with reality, may stop eating and drinking and may hear voices saying they are wicked or worthless and deserve to be punished.

Others develop false beliefs (delusions) that they have committed bad deeds in the past and deserve to be punished, or that they have a terminal illness such as cancer, despite there being no medical evidence.

A depressive episode or a psychotic depression are serious and painful illnesses with real risks to the person's life and wellbeing. Professional assessment and treatment is always necessary and, in severe cases, hospitalisation may be required initially.

Bipolar mood disorder (previously called manic depression)

A person with bipolar mood disorder experiences depressive episodes alternating with periods of mania involving extreme happiness, over-activity, rapid speech, a total lack of inhibition and, in more serious instances, delusions of grandeur.

Sometimes only periods of mania occur, without depressive episodes.

For more information on bipolar mood disorder, read the mental health information brochure 'What is bipolar mood disorder?'.

What causes depression?

Often there are many interrelated factors associated with depression.

Heredity

It is well established that the tendency to develop depression runs in families. This is similar to a predisposition to other illnesses, such as heart disease and high blood pressure.

Biochemical imbalance

As already stated, depressive episodes are thought to be due in part to a chemical imbalance in the brain. This can be corrected with anti-depressant medication.

Stress

Depression is associated with stress after personal tragedies or disasters. It is more common at certain stages of life, such as at childbirth, menopause and retirement, and common in young adults, women, and people with physical health problems.

Personality

People with certain personality characteristics are more prone to depression.

Depression occurs more commonly in people who are sensitive, emotional and prone to experience feelings which are upsetting to them.

Perfectionists who set high standards for themselves and others, and who find it difficult to adjust their ideas and standards to changing circumstances, are often easily depressed. Also, those who are very dependent on others are susceptible to depression if they are let down.

Learnt response

In some cases, people exposed to repeated losses or stress throughout their lives lose their optimism and feel helpless and depressed.

What treatment is available?

People experiencing feelings of sadness which have persisted for a long time, or which are affecting their life to a great extent, should contact their family doctor or community health centre.

Modern treatments for depression can help the person return to more normal feelings and to enjoy life. Treatment depends on each person's symptoms, but will take one or more of the following forms:

- psychological interventions help individuals understand their thoughts, behaviours and interpersonal relationships
- general supportive counselling assists people to sort out practical problems and conflicts, and helps them understand the reasons for their depression
- antidepressant medications relieve depressed feelings, restore normal sleep patterns and appetite, and reduce anxiety. Unlike tranquillisers, antidepressant medications are not addictive. They slowly return the balance of neurotransmitters in the brain, taking one to four weeks to achieve their positive effects
- specific medications help to manage mood swings
- lifestyle changes such as physical exercise assist people who suffer from depression
- for some severe forms of depression, electroconvulsive therapy (ECT), or shock treatment, is a safe and effective treatment. It may be lifesaving for people at high risk of suicide or who, because of the severity of their illness, have stopped eating and drinking, and will die as a result.

Anxiety disorders

What is anxiety?

Anxiety is a term which describes a normal feeling people experience when faced with threat or danger, or when stressed.

When people become anxious, they typically feel upset, uncomfortable and tense.

Feelings of anxiety are caused by experiences of life, such as job loss, relationship breakdown, serious illness, major accident or the death of someone close. Feeling anxious is appropriate in these situations and usually we feel anxious for only a limited time. These feelings are not regarded as clinical anxiety, but are a part of everyday life.

What are the anxiety disorders?

The anxiety disorders are a group of illnesses, each characterised by persistent feelings of high anxiety. There are feelings of continual or extreme discomfort and tension, with the fear of panic attacks, usually without discernible cause.

People are likely to be diagnosed with an anxiety disorder when their level of anxiety and feelings of panic are so extreme that they significantly interfere with daily life and stop them doing what they want to do. This is what characterises an anxiety disorder as more than normal feelings of anxiety.

Anxiety disorders affect the way the person thinks, feels and behaves and, if not treated, cause considerable suffering and distress.

They often begin in early adulthood, and are often triggered by a series of significant life events.

Anxiety disorders are common and affect one in 20 people at any given time.

What are the main types of anxiety disorders?

Most types of anxiety disorder are characterised by heightened anxiety and fear of panic. Obsessive compulsive disorder and post-traumatic stress disorder are considered types of anxiety disorder, as both feature high levels of anxiety, which people try to control.

Generalised anxiety disorder

People with this disorder worry constantly about themselves or their loved ones being harmed by, for example, financial disaster, their health, work or personal relationships. These people experience continual apprehension.

Agoraphobia

Agoraphobia is a fear of being in places or situations from which it may be difficult or embarrassing to get away, or the fear that help might be unavailable if needed.

Agoraphobia is the most common anxiety disorder and constitutes about half those with anxiety disorders who seek professional help.

People with agoraphobia most commonly experience fear in a cluster of situations: in supermarkets and department stores, crowded places of all

kinds, confined spaces, public transport, lifts, freeways and heights.

People experiencing agoraphobia may find comfort in the company of a safe person or object. This may be a spouse, friend, pet or medicine carried with them.

The onset of agoraphobia is common between the ages of 15 and 20, or between 30 and 40, but we do not understand why this is. Many more women than men seek treatment.

Panic disorder (with or without agoraphobia)

People with this disorder experience extreme panic attacks in situations where most people would not be afraid.

The attacks are accompanied by all the unpleasant physical symptoms of anxiety, with a fear that the attack will lead to death or a total loss of control.

It is because of this that some people start to experience a fear of going outside (agoraphobia) and of being in places where help is not at hand.

Specific phobia

Everyone has some irrational fears, but phobias are intense fears about particular objects or situations which interfere in our lives. These might include fear of heights, water, dogs, closed spaces, snakes or spiders.

Someone with a specific phobia is fine when the feared object is not present. However, when faced with the feared object or situation, the person can become highly anxious and experience a panic attack.

People affected by phobias can go to great lengths to avoid situations which would force them to confront the object or situation which they fear.

Social phobia

People with social phobia fear that others will judge everything they do in a negative way. They believe they are permanently flawed and worthless if any sign of poor performance is detected.

They cope by either trying to do everything perfectly, limiting what they do in front of others, especially eating, drinking, speaking or writing, or they withdraw gradually from contact with others.

Obsessive compulsive disorder

This disorder involves constant unwanted thoughts, and often results in the performance of elaborate rituals in an attempt to control or banish the persistent thoughts.

The rituals are usually time consuming and seriously interfere with everyday life. For example, people may be constantly driven to wash their hands or continually return home to check that the door is locked or the oven is turned off.

People with this disorder are often acutely embarrassed and keep it a secret, even from their families.

Post-traumatic stress disorder

Many people who have experienced major traumas such as war, torture, vehicle accidents, fires or personal violence continue to feel terror long after the event is over.

They may experience nightmares or flashbacks for years. The flashbacks are often brought about by triggers related

to the experience, but not necessarily central to it.

What causes anxiety disorders?

The causes of each disorder may vary and it is not always easy to determine the causes in every case.

Personality

People with certain characteristics are more prone to anxiety disorders.

Those who are easily aroused and upset, and are very sensitive and emotional, are more likely to develop anxiety disorders.

People who, in childhood, were inhibited and shy may also be prone to develop certain anxiety disorders, such as social phobia.

Learnt response

Some people exposed to situations, people or objects that are upsetting or anxiety-arousing may develop an anxiety response when faced with the same situation, person, or object again, or become anxious when thinking about the situation, person, or object.

Heredity

The tendency to develop anxiety disorders may run in families, or a person may also 'learn' anxious responses from their family or parents.

Biochemical processes

Although there is no clear evidence, it is possible that some anxiety disorders result from chemical processes in the brain.

In all cases, there is a need for a thorough examination of the person to help determine the nature of the problem and how it may best be treated.

What treatment is available?

Anxiety disorders, if they are not managed, continue to interfere significantly with the person's thinking and behaviour, causing considerable suffering and distress.

Many professionals such as your general practitioner, psychologists, social workers, counsellors or psychiatrists can assist in the treatment of anxiety disorders.

Treatment will often include education and counselling to help the person understand their thoughts, emotions and behaviour. People develop new ways of thinking about their anxiety and how to deal more effectively with feelings of anxiety.

Medication is sometimes used to help the person control their high anxiety levels, panic attacks or depression.

The benzodiazepines (like diazapam or valium) are used for the temporary relief of anxiety, but care has to be taken as these medications may cause dependence.

Antidepressants play an important role in the treatment of some anxiety disorders, as well as associated or underlying depression. Contrary to common belief, antidepressants are not addictive.

Bipolar mood disorder

What is bipolar mood disorder?

Bipolar mood disorder is the new name for what was called manic depressive illness.

The new name is used as it better describes the extreme mood swings – from depression and sadness to elation and excitement – that people with this illness experience.

People with bipolar mood disorder experience recurrent episodes of depressed and elated moods. Both can be mild to severe.

The term 'mania' is used to describe the most severe state of extreme elation and overactivity.

Some people with bipolar disorder only have the episodes of elation and excitement.

What are the symptoms of bipolar mood disorder?

Mania

Common symptoms include varying degrees of the following:

- elevated mood – the person feels extremely high, happy and full of energy. The experience is often described as feeling on top of the world and being invincible
- increased energy and overactivity
- reduced need for sleep
- irritability – the person may get angry and irritable with people who disagree or dismiss their sometimes unrealistic plans or ideas
- rapid thinking and speech – thoughts are more rapid than usual. This can lead to the person speaking quickly and jumping from subject to subject
- lack of inhibitions – this can be the result of the person's reduced ability to foresee the consequences of their actions, for example, spending large amounts of money on buying items which are not really needed
- grandiose plans and beliefs – it is common for people experiencing mania to believe they are unusually talented or gifted or are kings, film stars or prime ministers. It is common for religious beliefs to intensify, or for people with this illness to believe they are an important religious figure
- lack of insight – a person experiencing mania may understand that other people see their ideas and actions as inappropriate, reckless or irrational. However, they are unlikely to recognise the behaviour as inappropriate in themselves.

Depression

Many people with bipolar mood disorder experience depressive episodes.

This type of depression can be triggered by a stressful or unhappy event, but more commonly occurs without obvious cause.

The person loses interest and pleasure in activities enjoyed before. They may withdraw and stop seeing friends, avoid social activities and cease simple tasks such as shopping and showering.

They are overwhelmed by a deep sadness, lose their appetite, subsequently lose weight, cannot concentrate, and may experience associated feelings of guilt or hopelessness.

Some attempt suicide because they believe life has become meaningless or they feel too guilty to go on.

Others develop false beliefs (delusions) of persecution or guilt, or that they are evil.

For more information on depression and its treatment, see the mental health information brochure, 'What is depression?'.

Normal moods

Most people who have episodes of mania and depression experience normal moods in between. They are able to live normal lives, manage household and business commitments and hold down a job.

Everyone experiences mood swings from time to time. It is when these moods become extreme and lead to a failure to cope with life that medical attention is necessary.

What causes bipolar mood disorder?

Bipolar mood disorder affects two people in every hundred of the Australian population.

Men and women have an equal chance of developing the disorder. It is most common in people in their twenties.

It is believed that bipolar mood disorder is caused by a combination of factors including genetics, biochemistry, stress and even the seasons.

Genetic factors

Studies on close relations, identical twins and adopted children whose natural parents have bipolar mood disorder strongly suggest that the illness is genetically transmitted, and that children of parents with bipolar mood disorder have a greater risk of developing the disorder.

Biochemical factors

Mania, like major depression, is believed to be associated with a chemical imbalance in the brain which can be corrected with medication.

Stress

Stress may play a part in triggering symptoms, but not always. Sometimes the illness itself may cause the stressful event (such as divorce or a failed business), which may then be blamed for the illness.

Seasons

Mania is more common in spring, and depression in early winter. The reason for this is not clear.

What treatments are available?

Effective treatments are available for depressive and manic episodes of bipolar mood disorder.

For the depressive phase of this illness, antidepressant medications are effective. Antidepressants are not addictive. They slowly return the balance of neurotransmitters in the brain, taking one to four weeks to achieve their positive effects.

Medication should be adjusted only under medical supervision, as some people may experience a switch to a manic phase.

It may be necessary to admit a person with severe depression to hospital for a time.

When people are in a manic phase, it can often be difficult to persuade them that they need treatment. It may sometimes be necessary to admit the person to hospital if the symptoms are severe.

During acute or severe attacks of mania, several different medications are used. Some are specifically used to calm the person's manic excitement: others are used to help stabilise the person's mood.

Medications such as lithium are also used as preventive measures, as they help to control mood swings and reduce the frequency and severity of depressive and manic phases.

Psychotherapy and counselling are used with medication to help the person understand the illness and better manage its effects on their life.

With access to appropriate treatment and support, most people with bipolar mood disorder lead full and productive lives.

Schizophrenia

What is schizophrenia?

Schizophrenia is a mental illness which affects one person in every hundred.

Schizophrenia interferes with the mental functioning of a person and, in the long term, may cause changes to a person's personality.

The first onset is usually in adolescence or early adulthood. It can develop in older people, but this is not nearly as common.

Some people may experience only one or more brief episodes in their lives. For others, it may remain a recurrent or life-long condition.

The onset of illness may be rapid, with acute symptoms developing over several weeks, or it may be slow, developing over months or even years.

During onset, the person often withdraws from others, gets depressed and anxious and develops extreme fears or obsessions.

What are the symptoms of schizophrenia?

Major symptoms of schizophrenia include:

Delusions – false beliefs of persecution, guilt or grandeur, or being under outside control. People with schizophrenia may describe plots against them or think they have special powers and gifts. Sometimes they withdraw from people or hide to avoid imagined persecution.

Hallucinations – most commonly involving hearing voices. Other less common experiences can include seeing, feeling, tasting or smelling things, which to the person are real but which are not actually there.

Thought disorder – where the speech may be difficult to follow, for example, jumping from one subject to another with no logical connection. Thoughts and speech may be jumbled and disjointed. The person may think someone is interfering with their mind.

Other symptoms of schizophrenia include

Loss of drive – where often the ability to engage in everyday activities such as washing and cooking is lost. This lack of drive, initiative or motivation is part of the illness and is not laziness.

Blunted expression of emotions – where the ability to express emotion is greatly reduced and is often accompanied by a lack of response or an inappropriate response to external events such as happy or sad occasions.

Social withdrawal – this may be caused by a number of factors including the fear that someone is going to harm them, or a fear of interacting with others because of a loss of social skills.

Lack of insight or awareness of other conditions – because some experiences such as delusions and hallucinations are so real, it is common for people with schizophrenia to be unaware they are ill. For this and other reasons, such as medication side-effects, they may refuse to accept treatment which could be essential for their wellbeing.

Thinking difficulties – a person's concentration, memory, and ability to plan and organise may be affected, making it more difficult to reason, communicate, and complete daily tasks.

What causes schizophrenia?

No single cause has been identified, but several factors are believed to contribute to the onset of schizophrenia in some people.

Genetic factors

A predisposition to schizophrenia can run in families. In the general population, only one per cent of people develop it over their lifetime. If one parent suffers from schizophrenia, the children have a 10 per cent chance of developing the condition – and a 90 per cent chance of not developing it.

Biochemical factors

Certain biochemical substances in the brain are believed to be involved in this condition, especially a neurotransmitter called dopamine. One likely cause of this chemical imbalance is the person's genetic predisposition to the illness.

Family relationships

No evidence has been found to support the suggestion that family relationships cause the illness. However, some people with schizophrenia are sensitive to any family tension which, for them, may be associated with relapses.

Environment

It is well recognised that stressful incidents often precede the onset of schizophrenia. They often act as precipitating events in vulnerable people. People with schizophrenia often become anxious, irritable and unable to concentrate before any acute symptoms are evident. This can cause relationships to deteriorate, possibly leading to divorce or unemployment. Often these factors are then blamed for the onset of the illness when, in fact, the illness itself has caused the crisis. It is not, therefore, always clear whether stress is a cause or a result of illness.

Drug use

The use of some drugs, especially cannabis and LSD, is likely to cause a relapse in schizophrenia.

Myths, misunderstanding and facts

Myths, misunderstanding, negative stereotypes and attitudes surround the issue of mental illness and, in particular, schizophrenia. They result in stigma, isolation and discrimination.

Do people with schizophrenia have a split personality?

No. Schizophrenia refers to the change in the person's mental function, where thoughts and perceptions become disordered.

Are people with schizophrenia intellectually disabled?

No. The illness is not an intellectual disability.

Are people with schizophrenia dangerous?

No. People with schizophrenia are generally not dangerous when receiving appropriate treatment. However, a minority of people with the illness become aggressive when experiencing an untreated acute episode, because of their fears. This is usually expressed to family and friends, rarely to strangers.

Are people on medication for schizophrenia addicted to the medication?

No. The medication helps to reduce the severity of the symptoms. The specific medications for treatment of schizophrenia are not addictive.

Is schizophrenia a lifelong mental disorder?

Not necessarily. Most people, with professional help and social support, learn to manage their symptoms and have a satisfactory quality of life. It is also a fact that about 20 to 30 per cent of people with schizophrenia have only one or two psychotic episodes in their lives.

What treatment is available?

The most effective treatment for schizophrenia involves medication, psychological counselling and help with managing its impact on everyday life.

The development of anti-psychosis medications has revolutionised the treatment of schizophrenia. Now, most people can leave hospital and live in the community. Not all people with schizophrenia have to go to hospital and care can be delivered in the community.

These medications work by correcting the chemical imbalance associated with the illness. New but well tested medications are emerging which promote a much more complete recovery with fewer side effects.

Schizophrenia is an illness, like many physical illnesses. For example, just as insulin is a lifeline for a person with diabetes, anti-psychosis medications are a lifeline for a person with schizophrenia.

As with diabetes, some people will need to take medication indefinitely to prevent a relapse and keep symptoms under control.

Though there is no known cure for schizophrenia, regular contact with a doctor or psychiatrist and possibly a multidisciplinary team of mental health nurses, social workers, occupational therapists and psychologists can help a person with schizophrenia organise and do the important things in life.

Sometimes specific therapies directed towards symptoms such as delusions may also be useful.

Counselling and support can be helpful for problems with finances, accommodation, work, interaction with others and loneliness.

Effective treatment can assist the person in leading a productive life.