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Schizophrenia ICD-10 V F 20-29

The term schizophrenia is composed of the Greek word skizo (split) and phren (mind). At the beginning of this century, as Bondy already mentioned, schizophrenia was defined by the Swiss psychiatrist Eugen Bleuler for a group of illnesses in which the dissension of thinking and feeling is striking (Bondy B, 2008).

As already mentioned by Andrawis, Kraepelin defined the appearance of this disease as early as 1898 under the term "dementia praecox" (premature dementia). In 1911 Bleuler formulated the term "schizophrenia" (splitting of consciousness) for this endogenous psychosis, more strongly related to the psychogenic cross-sectional picture. In modern classification systems, the concept of schizophrenia was modified according to ICD-10 and DSM-IV in order to reach international consensus. Modern empirical findings and the need for operationalisation were included (Andrawis A, 2018).

Definition

The appearance of this disease is diverse and manifests itself in the form of ego disorder, delusion, hallucinations, formal thinking disorders, psychomotor disorders and affect disorders. In order to speak of a pathological disorder, these criteria must be met over a longer period of time.

Quote from the point of view of a subjectively affected patient, who describes how it feels internally when suffering from this disorder:

„Zwei Seelen wohnen, ach in meiner Brust, und ’ne inn’re Stimme hab ich auch noch! (Was ihn nicht schlafen lässt, was ihn antreibt zu jeder Stund, ist sein inn’rer Schweinehund!“).

„Two souls live, oh in my breast, and I also have an inner voice! (What does not let him sleep, what drives him to every hour, is his inner temptation!”). (ibid.).

7.1 Epidemiology

Who is affected by this disturbance? Is it to be found equally among all peoples and classes? The answer to these questions gives us, as Bondy already describes, epidemiological research, because it not only deals with numbers, but also with the cause of a disease. There are striking geographical differences. In Verona/Italy, for example, the initial illness rate was 0.08% per year for 1000 inhabitants, whereas in Rochester/USA it was ten times higher (Andrawis A, 2018).

The risk of suffering from this disease is 1% for the average population and equal for women and men.

As Möller already mentioned, the frequency of the outbreak lies between puberty and the age of 30, with men contracting the disease somewhat earlier than women. The Hebephrenie sub-type manifests itself mainly in puberty, the paranoid-hallucinatory subtype from the age of 30, from the age of 40 one speaks of late schizophrenia. The suicide rate for this disease is 10% worldwide. (ibid.).

7.2 Etiopathogenesis of Schizophrenia

Triggering factors can be cerebral damage or psychosocial factors of a socio-cultural nature and a genetic predisposition. In the case of first-degree relatives, for example, the disease risk, as Möller has already explained, is in the order of 10%, in the case of second-degree relatives it is about 5%. The risk of this disorder increases to 40% if both parents are affected. The genetic disposition of identical twins is 50 % and 15 % of identical twins and of two identical twins respectively (ibid.).

It is important to understand that consciousness and intellectual abilities are not impaired. As already Dilling et. al. emphasizes, a personality change occurs in the advanced stage with the loss of the feeling of individuality, freedom of decision and uniqueness.

The affected person loses his connection to reality and his fellow human beings, feels driven by unknown forces. As Bondy has already pointed out, it is difficult to put oneself in the inner world of an affected person and to understand this disease. This disease occurs without any visible external cause and changes the personality of the person affected. Healthy parts of the personality often remain alongside the sick parts (ibid.).

7.3 Schizophrenia from a Biochemical Perspective

Central nervous dopaminergic structures act, as Möller has already shown, overactivated in the mesolimbic system. They are considered the most important biochemical correlate of acute schizophrenic symptoms. Pharmacological findings support this hypothesis because neuroleptics block the dopaminergic receptors (post-synaptic dopamine D2 receptors) and thus exert their antipsychotic effect (ibid.).

It is still unclear whether dopaminergic overactivity is the cause of the disorder. It is assumed that an excess of dopamine or hypersensitivity of dopaminergic receptors is the starting point. As Möller already described, this is an excess of dopaminergic activity in relation to other neurotransmitter systems.

The serotonergic and glutamatergic systems play an important role in schizophrenia, as Möller emphasizes. This hypothesis is still being discussed today. Neuroleptics are the antagonists (dopamine D2 antagonists), they trigger acute symptoms and cause hallucinations. Amphetamines are also the cause of increased dopamine transmission. The glutamatergic and dopaminergic systems are closely linked. The serotonergic system is also receiving increased attention, as all neuroleptics have a serotonin-5HT2A antagonism in addition to the aforementioned dopamine D2 antagonism. The psychosocial factors play an important role as cause and trigger of schizophrenia. This disease is more common in lower social classes. Stress caused by overstimulation also has a negative effect on the development of this disease (ibid.).

7.4 The psychoanalytic view of schizophrenia

As Möller already describes, from a psychoanalytical point of view, a weak ego in childhood favours the outbreak of the disease, as does the coincidence of genetic risks with an unfavourable family atmosphere. As Mentzos has already described, mental disorders often arise from an early conflict and its pathological processing. This is the emergence of structural

deficiency, primary and secondary disorders of the self. In particular, the primary ones lead to the development of further 5 groups of disorders (narcissistic, schizoid and paranoid personality disorder, psychosis and borderline)

7.5 A Clinical Sample of the Frequency of Psychopathological Disorders

The clinical sample of 81 patients who had already Andrawis (2018), described the relative frequency of psychopathological symptoms:

Affectivity disorder (96%):

- euphoric behaviour, lapish behaviour (9% each)

- Panic and anxiety (21%)

- Parathymias (31%)

- depressed mood (26%)

- Dysphoria / irritability, aggressive tension (23%)

- Distrust (28%)

- I disorder (46%):

- Spreading of thoughts / foreign influence of thinking (20%)

- Depersonalisation / Derealisation (31%)

- other external influences (13%)

- Autism (15%)

Formal thinking disorder (68%):

- Overtalking (19%)

- Aborting thoughts / blocking thinking (30%)

- Perverse thinking (35%)

Disorder of drive and social behaviour (63%):

- increased exhaustibility (10%)

- Aggression tendency (19%)

- Tendency to neglect / need for care (13%)

- Lack of contact (45%)

Delusion (79%):

- Love delusion (3%)

- Delusions of grandeur/religious delusion (11%)

- Delusion of impairment/delusion of persecution (59%)

- Paranoia (48%)

- disorders of will and psychomotor function (60%)

- Mannerism (11%)

- Negativism / Autism (8% each)

- Catalepsy (4%)

- Agitation / apathy / stereotypes (13% each)

- Abulie / Decrease in interests (28%)

- Stupor (9%)

Hallucinations (49%):

- Comments/dialogues (36%)

- body hallucinations (14%)

- Optical hallucinations (18%)

- Other acoustic hallucinations and different voices (15%)

(Andrawis A, 2018).

7.6 Symptoms of schizophrenia

Schizophrenia has different manifestations. According to Bleuler, the affectivity disorder, the so-called formal thinking disorder and ego disorder, are defined as typical basic symptoms. Schneider distinguishes between symptoms of the first and second rank. The first rank includes interpretive voices, thought deprivation, delusional perception, and the sound of thought. Second rank includes delusions, other delusions, etc.

As Möller already points out, it is important to bear in mind when diagnosing schizophrenia that it does not necessarily have to run parallel to delusion and hallucination. There are types of schizophrenia that do not form these symptoms. Some of the symptoms can also be found in other mental illnesses. What is striking, however, is that 80% of patients develop insane symptoms. One symptom alone does not clearly define schizophrenia as a disease.

In order to make a clear diagnosis, it makes more sense to summarize symptoms in groups.

As Möller has already described, the following is a subdivision of the symptoms that occur together and are particularly important for diagnosis:

1.

a) Withdrawal, inspiration, expression or dissemination of thought.

b) Control mania, influence mania, delusional perceptions. Feeling of what has been made, related to body and limb movements or certain thoughts, activities or sensations.

c) Dialogical or commenting voice or other voices coming from a part of the body talking about the patient and his behavior.

d) Completely unrealistic, long-lasting delusion, such as being a political or religious personality or possessing supernatural powers (e.g. being in contact with aliens or having the power to control the weather).

2.

a) Hallucinations, accompanied by indistinct, persistent, trained delusions without clear affective involvement or fleeting thoughts. These symptoms occur daily for weeks or even months.

b) The flow of thought is impaired by mental abstractions, absentmindedness or neologisms.

c) Waxy flexibility or postural stereotypes, catatonic symptoms such as agitation, negativism, stupor and autism (Andrawis A, 2018).

d) Negative symptoms, as already described by Andrawis: flattened or inadequate effects, conspicuous apathy, speech impoverishment, social withdrawal, impairment of performance. It is important that these symptoms are not caused by neuroleptic medication or depression.

3.

Aimlessness manifests itself in an attitude lost in the self, inertia and social withdrawal. These symptoms are typical of schizophrenia simplex (F20.6).

In order to make a diagnosis, at least one symptom must be unambiguous, and at least two to three if the symptoms are not unambiguous (from the groups I. - III. mentioned above). In addition, the symptoms must last for at least one month and beyond. If the duration is shorter, one should think of an acute schizophrenic psychotic disorder (F23.2).

If schizophrenic and affective symptoms appear simultaneously and with the same intensity, one speaks of a schizoaffective disorder (F25).

If the brain is affected by withdrawal symptoms or intoxication, schizophrenia should never be diagnosed. Similar manifestations of schizophrenia in epilepsy or other brain diseases are defined under (F06.2).

F1.5 is brain damage caused by drugs (as well as caffeine).

F1.0 is a brain disorder caused by alcohol.

7.7 Classifications of schizophrenia (ibid.).

Classification of Schizophrenia ICD-10 F20.0 - F20.9

(Dilling H, Mombour W, Schmidt M H, 2008)

7.7.1 Paranoid schizophrenia

Paranoid schizophrenia (ICD-10 F20.0)

The most common appearance, as already confirmed by Bondy, shows hallucinations and delusions. Patients feel bugged and threatened, remote-controlled and influenced. Her thoughts show leaps and bounds and absentmindedness. In the acute phase, severe, incomprehensible emotional outbursts occur, "as if possessed by demons". A little too much of all the symptoms: too active, too loud. The basic symptoms take a back seat, while productive symptoms are in the foreground (Andrawis A, 2018).

7.7.2 Hebephrene schizophrenia

Hebephrene schizophrenia (ICD-10 F20.1)

As already described by Andrawis (2018), it occurs especially in adolescence. Affective disorders are in the foreground, in the sense of not age-appropriate behavior or indifference, combined with thinking disorder, especially unpredictable, cheeky, cheeky, no more inhibitions in social behavior (Andrawis A, 2013).

7.7.3 Catatonic schizophrenia

Catatonic schizophrenia (ICD-10 F20.2)

This form of schizophrenia, as Andrawis describes it, is (2013).

characterized by drive and movement disorders. The symptoms suddenly appear in severe form: Excitement, strong restlessness with numbness (catatonic stupor) or irritability and aggressiveness. Madness and hallucination as a basic disorder recede into the background. The course of catatonia in numerous episodes is relatively short. Personality doesn't change as much as the other guys.

7.7.4 Undifferentiated schizophrenia

Undifferentiated schizophrenia (ICD-10 F20.3)

This type involves several symptoms without a clear indication of the diagnosis. As already explained by Dilling et. al., patients show either too few or too many symptoms (F20.0,

F20.1, F20.2, F20.4, F20.5). The above criteria must be met in order to make the diagnosis (ibid.).

7.7.5 Postschizophrenic depression

Postschizophrenic Depression ICD-10 F20.4

As already explained by Andrawis (2013), this disorder follows schizophrenia, typical symptoms are still present, but in a moderate form. Negative symptoms often predominate. It is not so important for the diagnosis of these depressive symptoms. This is only temporary as a result of no longer existing psychotic symptoms. This is consequently a reaction to the disease. One should not diagnose a depression prematurely here (F32.2, F32.3 according to: ICD-10 chapter -V.). It is not easy to determine which symptoms are due to the effect of neuroleptic drugs, which are part of depression or have their origin in the flattening of affects, reduction of the drive of schizophrenia. This phase is characterized by a high suicide risk.

If three criteria are met, a diagnosis can be made:

1. typical schizophrenic symptoms are still present

2. the person suffered from schizophrenia symptoms within the last 12 months

3. depressive, agonizing symptoms have been in the foreground for at least 2 weeks (ibid.).

7.7.6 Schizophrenic Residuum Type

Schizophrenic Residuum Type ICD-10 F20.5

This guy develops schizophrenic psychosis. As Möller has already described, a change in personality is initially noticeable due to poor performance, affective levelling, a tendency to hypochondriac symptoms, concentration disorders and depressive moods. In severe cases there is a massive lack of drive and interest, neglect of personal hygiene and autistic withdrawal from social contacts. The chronic condition is called negative symptomatology. If chronic or negative symptoms mix with positive symptoms, one speaks of "mixed residual" (ibid.).

7.7.7 Schizophrenia Simplex

Schizophrenia Simplex ICD-10 F20.6

This is a disorder that, as Andrawis already describes (2013), begins almost imperceptibly, very often during puberty. The course is not so dramatic, madness and hallucinations are not present. Patients with this disorder are characterized by a lack of drive, have no more interests and affections and live in seclusion. Professional and social contacts have atrophied. Course of the disease: The disease progresses slowly until the personality finally dissolves.

7.7.8 Other schizophrenia

Other schizophrenia (ICD-10 F20.8)

- These include forms of schizophrenia that are not known in detail

- zonesthetic schizophrenia

Three different types of schizophrenia are excluded:

1. cyclic schizophrenia (ICD-10 F25.2)

2. latent schizophrenia (ICD-10 F20.1)

3. acute schizophrenic disorder (ICD-10 F23.2)

7.7.9 Unspecified schizophrenia

Unspecified schizophrenia ICD-10 F20.9

This includes forms of schizophrenia that are not known in detail.

7.7.10 Schizophrenia with a tendency to violence

In public opinion, as Bondy has already described, schizophrenic people are considered violent. However, this only refers to individual acts of violence committed by individual mentally disturbed persons. It is not true that the majority of crimes are committed by mentally ill people. A study conducted in Germany between 1955 and 1964 shows that only 3% of the perpetrators of violence were mentally ill, with an enlightenment rate of 90%. Out of 10,000 people suffering from schizophrenia, only five committed an act of violence. However, this contradicts the image of public opinion (ibid.).

7.8 Therapy of schizophrenia

The therapy consists of three building blocks: Psychopharmacology, psychotherapies and sociotherapeutic measures.

As Andrawis (2013) pointed out, psychopharmacology is at the forefront here. It should be noted that a combination of neuroleptics is only considered useful if it has a strong antipsychotic effect by mixing a non-sedating neuroleptic with a sedating benzodiazepine. In the stage of acute psychotic episodes an inpatient stay is absolutely necessary. The administration of a high dose of neuroleptics in the acute stage is important. This is then taken into account to ensure that the side effects are tolerated by the patient. When the acute stage is over and the patient feels stable enough, psychotherapy and sociotherapeutic measures follow. A check by a psychiatrist or outpatient specialist is required.

If after four to six weeks no treatment success is achieved, the neuroleptic clozapine is administered (Andrawis A, 2013).

Goal of the therapy:

The aim of modern psychopharmaceutical therapies, as the author has already described, is to stabilize the emotional state; thinking becomes clearer and ordered. Patients feel relieved and can master light activities again. The social therapeutic measures recommend orderly living conditions and clearly defined tasks in the professional field. Conflicts in the family should be avoided. Psychotherapies offer a further accompaniment on the path of life (ibid.).

7.8.1 Psychotherapies for schizophrenia

From a psychoanalytical point of view, many psychological problems are rooted in childhood. The aim is to make the personality structures visible by coming to terms with unresolved traumatic experiences in childhood, which are anchored in the unconscious. As Bondy emphasizes, a free association and interpretation of dreams is important for the therapy. Repressed traumas and conflicts are brought into consciousness in order to enable appropriate mental processing. The positive will of the patient is of great importance here.

I think it would be important to explain to the patient that defence and resistance in therapy are not effective. According to Freud, schizophrenic patients are not open to psychoanalysis,

which makes contact more difficult. The patient is over stimulated and the questioning after early childhood experiences brings even more confusion (Andrawis A, 2013).

7.8.2 Behavioural therapeutic approaches

Other psychotherapeutic measures include, as Möller already describes, Andrawis 2013), behavioural therapies at the cognitive level, as well as improvement of social skills and family therapies. The focus is on the spportive treatment, which awakens courage and hope. Information about the disease and treatment options should be considered, as well as the influencing factor of social conflict and stress. What is important is the motivation for the treatment (psychoeducation). Likewise, all problems of daily life must be discussed, especially all kinds of stress, as well as under-stimulation.

Exercise programme to promote cognitive and social coping strategies:

Three exercise sections, as already mentioned by Möller, on cognitive differentiation:

Focus attention on improving information processing and information reception. Promotion of conceptualisation and logical thinking.

Social perception: To cope with stress, cognitive planning and self-organisation are promoted.

Exercise training: Instrumental behaviours for coping with stressful situations are practised here.

Active relaxation as an additional technique: This is about the balance of harmony and disharmony for relaxation (ibid.).

For additional acoustic treatment:

As already mentioned by Bondy, the construction of dormitories, residential groups and "protective workshops" in recent years has contributed to a better return of the sick to everyday life. The population is often hostile to such measures. However, it would be better to develop an understanding for mentally ill people and show solidarity towards them. The aim is the tolerance and positive development of interpersonal relationships for an understanding, humane and positive psychiatry. This in turn would have positive effects on the patient (Andrawis A, 2018).

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