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AN ANALYSIS INTO THE COMPLEX DISORDER OF SCHIZOPHRENIA

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Abstract

The aim of this study is to explore the mental illness of Schizophrenia providing a brief history on the move from the term dementia praecox and also referring to key area such as symptoms and causes in an attempt to gain a better understanding of the problems associated with this disorder. In order to view these symptoms in a more effective way we shall explore Freud’s famous case study on the memoirs of Daniel Paul Schreber demonstrating how patients lives can be affected by the symptoms related to schizophrenia and also how disruptive this can be not only to their own lives but also in relation to the lives of their family and friends due to extreme pressure and stigma associated with mental illness within society. This thesis will thereafter explore treatment options in terms of medication and psychotherapy in an effort to determine whether or not they are more beneficial when used alone or together to achieve the best results possible. In doing so much of the evidence has backed up the lasting theory that both medicine and psychotherapy should be combined to provide the patient with the best chance of success and also to reduce the likelihood of a relapse occurring in the future.
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Introduction

Modern research on Schizophrenia began in the late 1800’s this concept was first formulated by a psychiatrist called Emil Kraepelin although back in 1898 Kraepelin referred to Schizophrenia as dementia praecox. Even though Kraepelin was aware that the symptoms for this mental illness were diverse he believed that the term Dementia Praecox mirrored what he saw as an “early onset (praecox) and a progressive, inevitable intellectual deterioration (dementia)” (Kring et al, 2012, P.258). This meant that he believed the illness could only occur in young people and that in time it would result in the mental deterioration of that person. The term used today for this mental illness, „Schizophrenia“ was introduced in the early 1900’s by a psychiatrist by the name of Eugen Bleuler. This term was derived from the Greek words Skhizein – to split and phren – mind (Kring et al, 2010, P.258). Bleuler believed that these were the core elements of this mental illness. The mental splitting that is referred to here is a disorganisation of emotions, behaviour and mental processes; it does not refer to a split personality as is commonly believed (Perrotto & Culkin, 1993). Bleuler disagreed with Kraepelin on two matters, firstly that an early onset of schizophrenia was not essential to the illness and secondly that the illness did not eventually progress into a state of dementia for the patient but that it caused the patient to experience “a heightened consciousness of memories and experiences” (Burton, 2012).

Bleuler himself stated:

For the sake of further discussion I wish to emphasize that in Kraepelin’s dementia praecox it is neither a question of an essential dementia nor of a necessary precociousness. For this reason, and because from the expression dementia praecox one cannot form further adjectives nor substantives, I am taking the liberty of employing the word schizophrenia for revising the Kraepelinian concept. In my opinion the breaking up or splitting of psychic functioning is an excellent symptom of the whole group (Kuhn, 2004 P. 167).

A major issue with Schizophrenia is the wide variety of symptoms associated with the illness, which we will explore in more detail later in the text along with their causes in an attempt to grasp a better understanding of this mental illness. As a result of this variation in relation to symptoms associated with schizophrenia Bleuler created
his metaphorical concept called „braking associative threads”. He proposed that these threads joined words and thoughts making goal directed, efficient thinking and communication possible for a person. If these associative structures were disturbed a person could be said to be suffering from schizophrenia. This would also explain the range of symptoms involved in different patients. Bleuler also came up with four main features associated with Schizophrenia commonly known as the four A’s, disturbances of affect or emotions, ambivalence in feeling and attitudes, irrational mental associations and autism, a self-absorbed withdrawal. Although Kraepelin was the first to academically investigate this mental illness it can be dated back much further than this, in 1550BC in Egypt reports were made of an illness very similar to Schizophrenia. Archaeological digs also discovered skulls from the stone age with burr holes drilled into them which were believed to release evil spirits, this is also believed to be a form of schizophrenia. This can be seen in Irish methodology through the tale of Buile Shuibhne (the madness of Suibhne). Suibhne who was the legendary king of Dál nAraidi in Ulster was seen as a disorderly man with an awful temper (Crosbie, 1914). This evidence shows that schizophrenia is a lot older than first anticipated even though people at the time were unaware of it as being a mental illness.

The oxford dictionary describes Schizophrenia as a long-term mental disorder of a type involving a breakdown in the relation between thought, emotion, and behaviour, leading to faulty perception, inappropriate actions and feelings, withdrawal from reality and personal relationships into fantasy and delusion, and a sense of mental fragmentation. In addition to this we can include faulty perception and attention, the lack of emotional expressiveness or inappropriate expressions and disturbances in movement and behavior (Kring et al, 2010). The combination of these two definitions gives us a more accurate description of a mental illness that can differ from patient to patient as the symptoms of this illness are not as clear-cut as they may be in other illnesses. Schizophrenia can be one disorder or many disorders with different causes affecting anyone regardless of social class, creed, age, gender or race (Irishhealth.ie). The essential features of schizophrenia are a mixture of characteristic signs and symptoms, both positive and negative that have been present for a significant portion of time during a 1-month period (or for a shorter time if successfully treated) with some signs of the disorder persisting for at least 6 months. (DSM-IV-TR, 2000, P.298)
Now that we are more familiar with the background of schizophrenia and how this term came to be used in the place of dementia praecox we will attempt to look at other key areas in order to gain a better understanding of this mental illness. This study will explore the mental illness of schizophrenia, firstly by looking at the symptoms and their causes. In order to do this more effectively we shall explore Freud’s famous case study on the memoirs of Daniel Paul Schreber to demonstrate how patients lives can be affected by the symptoms related to schizophrenia and also how disruptive this can be not only to their own lives but also in relation to the lives of their family and friends. This thesis will therefore explore treatment options in terms of medication and psychotherapy in an effort to determine whether or not they are more beneficial when used alone or together to achieve the best results possible.

*Symptoms associated with schizophrenia*

The symptoms of Schizophrenia can be divided into positive, negative and dis-organized. **Positive** symptoms include hallucinations and delusions these are the most common symptoms in acute episodes of schizophrenia. Delusions are seen as disorders of thought, this means the person experiences beliefs, which are false, and this would indicate an abnormality in the affected person's thinking process.

**Delusions** are common symptoms of schizophrenia. This is when a patient can have false beliefs that are firmly held even when disconfirming evidence is presented. As a result of these delusions schizophrenics may engage in bizarre or aggressive behaviours (Perrotto & Culkin, 1993). They may experience false feelings of hate from other people or feel that they are being looked at or laughed at. Also that people are listening to their private conversations in order to plot against them in some way, this could eventually lead to them firmly believing that close friends are also against them. Freud’s notes on the case study of Daniel Paul Schreber show the effects of this kind of symptom as the patient suffered from delusions of soul murder, which we will refer to in more detail later in the text. In addition to this Lacan’s case of Aimée describes a woman of thirty-eight who attempted to stab an actress by the name of Huguette Duflos. Aimée seemed to suffer from "almost the full gamut of paranoid themes" including feelings of persecution, jealousy and prejudice (Lacan, 1932, p.158).

**Hallucinations** can be the most dramatic alteration in perception as they can cause individuals to have sensory experiences without any real stimulation form the surrounding environment. These delusions are more commonly auditory than visual.
and a study done in 1974 reported that 74% of people with schizophrenia had suffered auditory hallucinations (Kring et al, 2010). Many people who have suffered from these hallucinations describe hearing their own thoughts but they are spoken in another voice. Other people can report hearing voices that argue or comment on their behaviour. Hallucinations can be frequent and unpleasant for people who suffer from schizophrenia and they can make it difficult to separate reality from the imaginary for them. Schreber suffered from both visual and auditory hallucinations during his illness. With this in mind it is important to note that hallucinations are not exclusive to schizophrenic patients, in fact hallucinations can be experienced by any person during the course of their lives during times of extreme stress, illness, fatigue, intoxication and so on. Therefore it is a combination of symptoms over a certain period of time that would lead to a diagnosis of schizophrenia and experiencing hallucinations does not mean that the person is necessarily suffering from schizophrenia.

Negative symptoms focus on behavioural deficits like *avolition* meaning they would have a lack of motivation or would be unable to take part in everyday activities like working or social commitments. *Anhedonia* is the loss of interest in gaining pleasure either consummatory pleasure (in the moment) or anticipatory pleasure (gained from future events). *Blunted affect*, the absence of expression of emotions; a person suffering from this may answer questions in flat tones, have little facial movement and make little eye contact. *Asociality* refers to impairment in social relationships; meaning they would have no desire for close relationships, have very few friends and poor social skills and abgia would cause the person to reduce the amount of speech they produce, questions may be answered using one word but the individual would not have a tendency to elaborate even if asked to do so. These symptoms tend to have a more profound effect, as oppose to other symptoms, on the lives of people who suffer from schizophrenia.

Disorganised symptoms consist of disorganised speech, which is also referred to as formal thought disorder. This can cause the person issues in organising their thoughts and speech making it difficult for the listener to understand what the individual is trying to get across, this is due to a disconnection between images and fragments of thoughts. This can also cause loose associations meaning they can communicate but find it difficult to stick to a particular topic. Another disorganised symptom is disorganised behaviour this would cause the person to suffer from
agitation, dress unusually, behave childlike or act in a silly manor. They would find it extremely difficult to act in a way that would be acceptable to society. Schizophrenia is an episodic disorder, with periods of acute problems frequently separated by periods of remission (Bennett, 2003). This is evident in the Schreber case as he experienced three different episodes of illness but carried on working in between these episodes.

According to the DSM-IV-TR to be diagnosed with the mental illness schizophrenia two or more of the following symptoms must be present for a considerable amount of time over a 1-month period.

(1) Delusions
(2) Hallucinations
(3) Disorganized speech
(4) Grossly disorganized or catatonic behaviour
(5) Negative symptoms (flattened mood, alogia, avolition)

Only one of these symptoms is required if the delusions are bizarre or the hallucinations comprise a voice keeping up a running commentary on the persons behaviour or thoughts, or involve two or more voices conversing with each other. As well as this there must also be a dysfunction in work, interpersonal relations or self-care.

Some theorists do not agree with the DSM (diagnostic and statistical manual) classification of schizophrenia and argue that it lacks the notion of a disorder having one underlying mechanism making it one of the most difficult mental illnesses to define due to the diversity in symptoms, meaning that every patient can present different experiences or problems and be diagnosed with this illness. Bentall (1993) - noted that, „we are inevitably drawn to an important conclusion: “schizophrenia” appears to be a disease which has no particular symptoms, which has no particular course, and which responds to no particular treatment” (Pg 227) even though Bentall himself dismissed the concept of schizophrenia as a useless “label for anything that is coherently identifiable for the purposes of scientific study and clinical treatment” (Claridge, 1993 P.168). Although there may be controversy over the term Schizophrenia and the problem associated with it, it is still a “chronic illness that affects approximately 1% of the Irish population” at first glance this may seem like a low rate of diagnosis but it means that 1 out of every 100 people within the Irish population suffer from this illness (Irishhealth, 2013). It is also important to emphasis
that people who have been diagnosed with schizophrenia are not the only people who suffer from the negative effects of the illness as the families and caregivers of those individual are also forced to endure the negative social and financial burdens associated with this disorder (Zafar et al, 2008).
Chapter One

Etiology of Schizophrenia

Schizophrenia is such a complex disorder that even the nature of defining it and setting the relevant criteria evokes debate amongst people within the profession, consequently identifying the correct and acceptable cause of this illness has been difficult for researcher in this area of study and despite the extensive research that has been carried out in an effort to pin point the cause of this mental disorder no clear-cut solution has been identified. If we are to fully understand schizophrenia and what the best possible choice for treatment would be it is imperative that we first grasp what could possibly cause its onset. The famous Irish play writer and poet James Joyce stated that Schizophrenia was “One of the most elusive disease known to man and unknown to medicine” after his daughter Lucia had been diagnosed with the disorder (Canavan, 2000). It has become widely accepted that Psychiatric disorders are not triggered as a result of one simple factor but rather “a complex interplay between genetic and environmental factors is usually responsible” (Bucher, Mineka & Hooley, 2010). Here we will look at the main causes associated with schizophrenia and show how all factors must be taken into consideration as no single factor can be attributed as the sole cause of this mental disorder.

Genetic Factors

It is well known that Schizophrenia and known subtypes of this disorder tend to „run in families“ as the available evidence for high levels of schizophrenia amongst biological relatives of index cases proves to be overwhelming (Butcher et al, 2010). This means that there is a strong correlation between the type of blood relationship and the possibility of developing the illness. A study done supporting this claim showed that the prevalence of schizophrenia among first-degree relatives, for instance parents, siblings and children, of index cases with the disorder is around 10 percent (Gottesman, 1991). Although this does not necessarily make the condition specifically genetic as a condition can run in families for non-genetic reasons. While looking at genes we must also take into account the environment in which these genes express themselves. Although this does not necessarily make the condition specifically genetic as a condition can run in families for non-genetic reasons. While looking at
genes we must also take into account the environment in which these genes express themselves. Many researchers now agree that a single dominant gene is unlikely to account for the causation of schizophrenia. In saying that there have been major developments in the areas of family and twin studies in relation to the influence of genetics. Family studies have produced solid evidence in support for genetic inheritance. One such study of Irish families discovered that the risk of schizophrenia was thirteen times more likely for close relatives of people suffering from schizophrenia that among a control group with no schizophrenic relatives (Kendall & Hammen, 1998). Twin studies have been hugely important in this area, as concordance rates in twin pairings are useful in identifying any heritability associated with Schizophrenia. Concordance rates are found to be significantly higher in identical (monozygotic) twins than for fraternal (dizygotic) twins. The most famous case of concordance for schizophrenia is the Genain quadruplets who were identical sisters all diagnosed with a form of schizophrenia. E. Fuller Torrey and his colleagues (1994) found that pairwise among twins the concordance rate is 28 percent in monozygotic twins and 6 percent in dizygotic twins suggesting that the reduction of shared genes from 100 percent to 50 percent reduces the overall risk of schizophrenia by almost 80 percent. This can be viewed on two ways firstly that genes definitely play an important role in causing schizophrenia or secondly that genes alone are not the complete picture (Butcher et al, 2010).

Even though genetics alone cannot provide us with the answer here it is clear that they are in some way involved. Whether or not a genotype is articulated can depend on a biological or environmental trigger in the prenatal environment such as viral infections, early nutritional deficiencies and perinatal birth complications. The risk of schizophrenia seems to be at its highest when the mother contracts the flu in the fourth to seventh months of pregnancy (Butcher et al, 2010). It is clear that genetic factors are very influential in the development of schizophrenia but it is also clear that this is not the only possible cause. In order to fully understand what is currently known about the development of schizophrenia other factors must be taken into consideration.

Neurodevelopmental aspects

In past years studies done on abnormalities within the brains of schizophrenic patients heavily depended on autopsy studies that did not control for factors such as
age, physical health or medications. However thanks to recent technological developments such as CT and MRI scanning we can now view the living brain in ways that were inhibited by autopsy and the use of older x-ray systems. There have been huge developments in research supporting the concept of schizophrenia as a neurodevelopmental disorder and key areas of interest have been identified as possible causes of this illness. It is commonly seen that a vulnerability to schizophrenia is created due to a static lesion that occurs during fetal brain development (Murray and Lewis, 1987). This lesion remains dormant until the brain is matured and the problem created by this lesion becomes evident, this generally occurs late in the second decade of the person’s life (Clonklin & Iacono, 2002; Weinberger, 1987). As the development of the brain is still seen as a highly complex process it is not yet fully clear what goes wrong to cause these lesions. Assumptions have been made relating to this issue and it is thought that there might be a disturbance during cell migration meaning that several cells fail to reach their destination and hence disrupting the internal connectivity of the brain (Butcher et al, 2010). An interesting finding of studies done involving schizophrenic patients is that brain scans show them to have enlarged cerebral ventricles and decreased cortical volume mainly in the areas of the temporal and frontal lobes in comparison to scans done on patients who are not suffering from a schizophrenic disorder (Bennett, 2010). Enlarged ventricles are a good indicator of a shortage in brain tissue and can endue many symptoms associated with this disorder. It is important however to point out that these enlarged brain ventricles are not present in all cases of schizophrenia and are also not specific to the disorder as they have also been identified in patients suffering from Alzheimer’s and other illnesses.

The most important neurotransmitter associated with schizophrenia is dopamine. The dopamine hypothesis involves neurons mediated by dopamine that are found in the limbic system with known links to the thalamus, hippocampus, the frontal cortex and also the substantia nigra. This hypothesis poses that the symptoms experienced by schizophrenic patients occur due to an excess amount of dopamine created or as a result of the receptors being sensitive to the normal amounts of dopamine. This Dopamine hypothesis was developed as a result of three main observations. Firstly there was the use of the drug chlorpromazine in the treatment of schizophrenia as it blocked dopamine receptors and proved to be extremely helpful to sufferers of the illness. Secondly, Amphetamines are drugs that increase excess levels
of dopamine producing a psychotic state, which pose positive symptoms similar to those seen in schizophrenia. These symptoms may not go away when amphetamine use is stopped in fact they can continue for extended periods of time (Lieberman et al, 1990). The last piece of evidence that is used to link dopamine levels to schizophrenia has derived from clinical studies that were carried out on patients. This involved treating patients with drugs that would increase the levels of dopamine present in the brain. This resulted in an induced psychotic state for the patients (Butcher et al, 2010).

Other neurotransmitters that present research is examining in an effort to understand the developmental process of schizophrenia are Glutamate and serotonin. Glutamate that is widespread in the brain and postmortem studies on schizophrenic patients have detected low levels of the enzyme required to create glutamate (Tsai et al, 1995). PCP is known to block glutamate receptors and induce positive and negative symptoms that resemble those present in schizophrenic patients. In addition to this when PCP is given to schizophrenic patients their symptoms become worse (Butcher et al, 2010). Along with PCP, ketamine, which is an antiseptic that also blocks glutamate receptors. When ketamine is given to adults it produces positive and negative symptoms similar to those seen in schizophrenic patients (Krystal et al, 2005). Ketamine research is particularly important because amazing its use has no effect on children and so it is still administered to them. This revelation suggests to us that factors such as age and also maturation of the brain play a key role in the ability of ketamine to induce psychotic symptoms

Social Factors

In the past parents were accused of being the cause of the development of schizophrenia resulting from hostility toward the child, rejection or parental incompetence. Mothers in particular were criticized and were thought to act in a cold and distant manner in regards to their children. This perception within society made life more difficult for these families not only did they have to support and care for the sufferer but they also had to bare the blame for causing the illness and were highly criticized by professionals within the field. Although present research dismisses these claims as Onwumere and colleagues (2010) stating that families do not cause schizophrenia. They do however play an important role in helping to improving our understanding of psychosis and they can also facilitate optimal outcomes, for patients
and the careers themselves. As schizophrenia is a chronic disorder there may be times when symptoms become particularly worse, this is most likely to occur during times of relapse. A study done by George Brown and colleagues (1958) showed that patients returning home from care to live with their parents or a spouse were at a higher risk of relapsing than patients returned from care to live with siblings or even alone. The reason behind this could be that emotional environments could induce excess stress that would not be helpful in maintaining the patients wellbeing.

In the past it has been a common finding that first generation immigrants and their children have a higher rate of schizophrenia than people who remain in their native country mainly due to social stressors. Recent studies have found that immigrants, especially from social minorities, as suggested by the social defeat-hypothesis, are at a higher risk of suffering from schizophrenia. (Werbeloff, Levine, & Rabinowitz, 2012). As well as immigrants people who have spent their lives living in urban areas seem to have a higher risk of developing schizophrenia than those who live in rural areas. A study carried out in Denmark found that it was 2.75 times more probable that children who had spent 15 years living within an urban environment would develop schizophrenia in adulthood in comparison to those who had lived in rural areas (Pederson & Mortenson, 2001). It is not yet fully clear how this link between urban life and schizophrenia has developed although this does lead us to believe that schizophrenia may have environmental causes that we are not yet certain of.

It is well known that people suffering from schizophrenia are twice as likely to use cannabis than people within the general population (van Os et al., 2002). Due to this many researchers have attempted to find a possible link between the abuse of cannabis and the development of this illness. A recent study on males with schizophrenia has found that cannabis status has minimal effects on cognition abilities, although cumulative cannabis exposure significantly impairs cognition in current, but not former users, this suggests that the state dependent negative effects of cannabis may be reversed through sustained abstinence (Rabin, Zakzanis, Daskalakis, & George, 2013). Further studies into this area would provide a better understanding of the effects of cannabis use among schizophrenic patients.

A huge amount of research has been carried-out in an effort to find a key area that could be identified as the cause of schizophrenia. Due to this we have focused on the main areas of concern here and those, which have produced the most reliable
information to back up the theories presented. There have been other areas of social life, neurodevelopment, genetic inheritance and cognitive functioning that have found other factors that could also be considered here that would however be an extensive piece of work. It is now widely accepted that a combination of factors are most likely to cause the onset of schizophrenia and in order to fully comprehend the effects of this mental disorder it is severely important that we look at how this can affect an individual within society. In order to do this we will now look at the commonly known case of Daniel Paul Schreber, an extraordinary man within society who documented his battle with mental illness displaying how he managed his life as a result. In doing this we will also look at Freud’s interpretations of this case and how his analysis provided us with a better understanding in relation to psychosis.
Chapter Two
The Schreber case

Daniel Paul Schreber was born on July 25, 1842 in Leipzig Germany. Schreber was the subject of Freud’s most significant work on the psychoanalytic exploration of psychotic illness (Niederland, 1984). He has also since become “the most frequently quoted patient” within the world of modern psychiatry as a result of the memoirs he had written about his illness (Macalpine & Hunter, 1955). Schreber was a well-established German judge who suffered from what was then call dementia praecox. Within these memoirs he wrote:

“I have suffered twice from nervous disorders.... And each time as a result of mental overstrain. This was due on the first occasion to my standing as a candidate for election to the Reichstag while I was Landgerichtsdirektor at Chemnitz, and on the second occasion to the very heavy burden of work that fell upon my shoulders when I entered on my new duties as Senatspräsident in the Oberlandesgericht in Dresden” (Freud, 1911, P.12)

Dr. Schreber was forty-two years of age and a presiding judge of a lower court when his first illness broke out in the autumn of 1884 in the form of depressive hypochondriasis not long after he was defeated in an election to the Reichstag. During this time he spend six months in the care of professor Paul Emil Flechsig’s clinic and recovered by the end of 1885. Flechsig was a highly regarded psychiatrist and neuro-anatomist within the profession and it was him who discovered the dorsal spinocerebellar fasciculas, which later became known as, Flechsig's fasciculus in remembrance of his discovery. In a report that had been drawn up regarding the patient Flechsig described the illness as an “attack of severe hypochondria” After his time in Flechsig’s clinic Schreber completely recovered by January 1886 and returned to work taking up the new post of director of the district court in Leipzig, to which he had been transferred while still In the psychiatric clinic.

The onset of the second illness was not until October 1893, Schreber was now age fifty-three and it was not long after he had been promoted to the high-powered post of President of the Appeal Court in Saxony. During this illness he experienced anxiety dreams about his first illness returning and had a fantasy about what a woman might feel during intercourse. By fall he had a dramatic explosion of symptoms including insomnia,
agitation, hypochondriacal and nihilistic delusions and also attempts at suicide. He voluntarily returned to the Psychiatric Hospital of Leipzig University and was under Flechsig once again. Months after his admission, his agitated depression evolved into a syndrome that involved prosecutor hallucinations and delusions of sexual abuse and hostile human and divine influences, which Schreber described as soul murder. Schreber attributed these influences to Flechsig and he would repeatedly chant „little Flechsig” (Freud, 1911). Schreber was treated in this clinic for seven months before he was transferred to Dresden where he remained under the supervision of Dr. Weber for eight years until he secured his own release in 1902. Schreber wrote his *Memoirs of my Nervous Illness* as support for his application to the courts for release from the psychiatric institution. These memoirs outlined the progression of his illness and included accounts of delusions and hallucinations he had experienced, his intention was to show that he was socially stable and capable of reintegrating himself into society. Schreber successfully secured his freedom but the presiding judge still felt he was insane although believed that he was no longer a threat to himself or to others within society (Quinodoz, 2005). When Daniel Paul Schreber was released he lived in Dresden with his wife and their adopted daughter until he relapsed five years later. Schreber was then admitted to the psychiatric asylum in Leipzip and remained there until his death in November 1911, this also happened to be the year that Freud published his case study.

Technically this was never one of Freud’s case histories even though this mistake could easily be made In fact it would be more accurately classified a psychoanalytic interpretation of Daniel Paul Schreber’s 1903 book *Memoirs of my Nervous Illness* (Thwaites, 2007). Freud spent many years researching neurosis focusing particularly on hysterical neurosis, making use of the Anna O case and obsessional neurosis in the form of the Rat Man case. Freud then decided to turn his attention towards psychosis and began to make an attempt at finding a specific mechanism that might be key to understanding this mental state. He shortly began considering possible connections between paranoia and dementia praecox, which is now known as schizophrenia when Abraham and C. G. Jung introduced him to the memoirs written by Daniel Paul Schreber referring to his illness that were published in 1903. (Quinodoz, 2005). Freud subsequently developed a case study based on the autobiography written by the patient without ever meeting Schreber himself, this case study remained Freud’s only in-depth analysis of a case of psychosis.
Chapter Three

Freud’s Analysis of Daniel Paul Schreber’s Memoirs

Freud’s analysis of Daniel Paul Schreber’s memoirs, a man who Freud considers to be of a “high level of…intelligence”, consists of five parts including: Introduction, Case History, Attempts at Interpretation, Mechanisms of Paranoia and Postscript (Freud, 1911, P.35). This analysis is a significant piece of work that continues to have substantial value among psychoanalysts who continue to critically review Freud’s work to this day.

This analysis begins with a description of the key element associated with the case and a history referring to the development of both of Schreber’s illnesses. At its most severe stage Schreber’s paranoid and hallucinatory delusion was for the most part an anxiety provoked persecutory delusion. In the beginning this involved his emasculation, as he was to take to form of a woman, it seemed to Schreber that this sexual punishment was unavoidable. As was mentioned earlier Professor Flechsig was the initial source of persecution for Schreber, which he deemed „soul murder”, believing that Flechsig was conspiring against him in an effort to transform him into a woman. Schreber maintained this belief of persecution until he began to relate his emasculation to the holy redeemer and a sense of redemption. Schreber himself described in his own words how he came to realize that God himself was an instigator in his emasculation:

*It was very natural…. That I should view Professor Flechsig or his soul as my only true enemy…. And that I should see in God my personal ally… It was not until very much later that the idea entered my mind that God himself has been my accomplice, if not the instigator of the plot by which my soul was to be murdered and my body used like that of a whore… (Schreber, 1903).*

The new fantasy that came to light was one of god and himself fulfilling a divine mission as follows: Schreber strongly felt he had a mission that required him to redeem the world and return it to a state of bliss. In order to do so he believed that two factors were crucial to the success of this mission, firstly he must bare the identity of a woman and secondly the world was to be demolished. Now Schreber, in the form of a woman must become Gods mate in order to create a more worthy and healthy human race. Schreber becomes obsessed with him delusion and how he believes he is perceived by God. Freud himself states that the transformation into “the delusional formation, which we take to be the pathological product, is in reality an attempt at recovery, a process of reconstruction” (Freud, 1911 P.71).
Freud believed that as the illness had begun with persecution the key source of this persecution was with out a doubt Professor Flechsig as he had been Schrebers primary seducer throughout his illness. Freud then argued that it was as a result of the admiration and gratitude Schreber felt towards Flechsig that caused him to become the persecutor as it is those who are loved and admired in a strong sense that then become the persecutor. Feelings of love are transformed into hate and this is precisely what Freud argues for this case. Schreber fantasized about being with such a man as Flechsig making the statement that “it must be nice to be a woman submitting to the act of copulation” (Freud, 1911, P. 42). Freud then attributed the underlying reason for Schreber’s illness as being the result of a homosexual drive stating that, “the basis of Schreber’s illness was the outburst of a homosexual impulse” (Freud, 1911, P.45). In order for this homosexual fantasy to be acceptable to Schreber the source of persecution needed to be altered, therefore God was identified as the new persecutor. Schreber was more willing to accept these homosexual feelings as the fantasy was now part of a higher cause and a divine mission needed to be completed. “By this means an outlet was provided which would satisfy both of the contending forces. His ego found compensation in his megalomania, while his feminine wishful fantasy made its way through and became acceptable” (Freud, 1911, P.48). Freud goes on to develop the source of Schreber’s feelings towards Flechsig, deciding that they are displaced feelings of deep love for his father or perhaps his older brother which he had subsequently transferred onto Flechsig as “the patient was reminded of his brother or father by the figure of the doctor” (Freud, 1911, P. 47). At this time Freud made this prognosis based on the assumption that the if Schreber felt such an intense love towards either his brother or father it was most likely that the person in question was dead, in fact in the years that followed it was found that this assumption had been correct.

It is important to note that Freud had made this assumption without any knowledge of the patients family life as he only had access to the memoirs dispite attempts made to retrieve more background information. This brings us on to Freud’s next point, which involves the “father complex” (Freud, 1911, P. 55). Freud ascribes the conflict Schreber feels in relation to the professor and God to an infantile conflict that occurred in connection to his father. Freud proposed that Schreber’s father might not have been very gentle with him as a young boy, instead suggesting that he was a harsh man who would often use the threat of castration against his son. As a result of this “his fathers most dreaded threat, castration, actually provided the material for his wishful phantasy (at first rejected but later accepted) of being transform into a woman (Freud, 1911, P.56). In other
words it was the Schreber’s fear of his fathers threat of castration that caused the formation of his delusion of becoming a woman and adopt a homosexual disposition based on feelings of both obedience and defiance. Freud points out that this homosexual wish and the father complex are not the causing factors of paranoia but he does stress the importance of distinguishing the role a homosexual wish plays in the development of paranoia as Schreber’s phantasy was of an “unmistakably homosexual nature” (Freud, 1911, P.60). The persecution that the patient endured was as a result of his failure to keep this homosexual wish repressed within his unconscious.

Freud describes how he believes a homosexual disposition is created between the stages of autoeroticism and object-love opposed a heterosexual one. This stage is called narcissism and Freud describes what occurs during this stage:

*There comes a time in the development of the individual at which he unifies his sexual instincts (which had hitherto been engaged in auto-erotic activities) in order to obtain a love-object; and he begins by taking himself, his own body, as his love-object, and only subsequently proceeds from this to the choice of some person other than himself as his object (Freud, 1911, P.60-61).*

As a result of this event in ones infantile development homosexual tendencies do not just disappear and features of this stage can be carried over into later stages of the persons development. The person will then attach these feelings to social drives and impulses, which form the basis of future friendships although the “the object of their choice must posse genitals like their own” (Freud, 1911, P.61). In cases were people have not freed themselves from the stage of narcissism and who are exposed to some “unusually intense wave of libido” they may not sexualise social instincts causing regression to occur (Freud, 1911, P. 62). A consequence of this would be a heightened sensitivity to paranoia and may be prone to persecutory anxiety. Freud proposes that the feeling of love felt towards a mate “I (a man) love him (a man)” is transformed into “I do not love him- I hate him” if these feelings are rejected by their conscious thoughts, as in the case of Daniel Paul Schreber. Hereafter this feeling of hate is repressed into the unconscious by the person and is then transferred onto another source within the social world. The person’s feeling of hate then becomes “he hates (persecutes) me, which will justify me in hating him” (Freud, 1911, P.63). Even though persecution becomes the delusion Freud believes that this person who is accused of being the persecutor was once loved by the individual being persecuted. In conclusion to this paper Freud he applies this theory to
many different types of delusion falling under the heading of paranoia in order to prove his hypothesis. These include: persecutory delusions, erotomamia, and delusions of jealousy in men and women and also megalomania.

When Daniel Paul Schreber’s memoirs were translated into English in 1955 it allowed many more psychoanalysts the opportunity to explore the text used by Freud for his famous case study. As this text was now available to a wider audience many people re-examined Freud’s work and began to challenge his hypothesis with theories of their own. Some psychoanalysts disagreed with Freud’s idea that psychosis was the result of repressed homosexual desires. In rejection to this followers of leading psychoanalyst Melanie Klein known as Kleinian psychoanalysts, thought that far too much emphasis was placed on what Freud deemed as the father complex in Schreber’s case as they were of the belief that they were more concerned with the child’s early interactions with the mother instead. Klein made the argument that the features that contribute to the creation of a psychotic illness during adult life stem from early stages of the individuals normal growth (Likierman, 2001). Klein herself was responsible for the discovery of concepts such as the paranoid-schizophrenic and depressive dispositions along with differentiating between primitive defence mechanisms that are associated with psychosis and more radical mechanism, which are seen within neuroses. A huge difference in views between Freud and Klein is that unlike Freud, Klein believed that psychotic patients did form a relationship involving transference that could be analysed.

In 1955 Lacan also got the chance to explore the text and came up with his own ideas on the origins of psychosis. This included two concepts firstly of foreclosure and secondly of the Name-of-the-Father. Lacan noted that foreclosure was a primary rejection of an essential signifier out of the symbolic order. As this cannot be accepted back into the unconscious it is therefore taken in the form of a hallucination. The individual cannot form a suitable structure as the father is needed to preform the symbolic role of a parent this means handing down his name so that the child can form an identity. The name of the father is significant as it is a crucial element in the development of the child for Lacan. Many other post Freudians also analysed the text but Klein and Lacan are among the most respected theorists who followed after Freud.

This case study provides us with great insight into the life of someone suffering from a mental illness and who has given their own account on the events that occurred throughout the prolonged periods of suffering. Daniel Paul Schreber was a well-respected man within society and had obtained a high-powered job that required
dedication and hard work. Even though the onset of his illness had occurred relatively late in his life considering the average time of onset is during early adulthood, Schreber’s illness was no less severe than someone who had been burdened with it for a longer period of time. Schreber was a married man and these periods of illness caused stress on their relationship as they longed for the birth of a child eventually leading to the adoption of their daughter during the time between the first and second illness. Schreber had spent a significant amount of time in psychiatric care during his later years of life meaning that he didn’t get to experience an ideal family life with his wife and daughter as they had hoped for. It is obvious from this case study that Schreber’s life had been extremely disturbed as a result of this mental illness as he made neurmorous attempts at ending his own life during times of turmoil. It is also clear that you are never safe from relapsing as Schreber had been living in relatively good health for five years before his third and final illness was triggered. People who suffer from schizophrenia are at high risk of relapse due to a number of factors and in the next section we will see how a stressful family life could trigger such a relapse. In addition to this schizophrenia is an illness that not only affects the patient but also the familt unit and we will now gain some insight into how they are affected along with treatment options that are available for this mental illness.
Chapter Four
Living with Schizophrenia

The symptoms associated with schizophrenia generally begin to appear when the individual is an adolescence or young adult. As a result of this the person’s life will change forever along with the lives of their close family members. Family members have often suffered for extended periods of time before a diagnosis has been made and have more than likely struggled to understand and assist their loved one. Family members who stand by their loved one going through this situation may become frustrated if treatment doesn’t seem to be accomplishing much progress or if they fail to follow through with the treatment altogether. As a result of the effects this can have on the family their patience fade and some families my sever contact with their schizophrenic relative. Although this is not the case with all patients this condition, along with other mental illnesses, can test the emotional support loved ones are capable of providing and the strength of the relationships between family members. Friends also tend to lose interest in the person suffering as they are unsure how to respond to schizophrenic experiences. Family members can be left feeling burdened by the care they are expected to provide and embarrassed by the symptoms associated with the illness, this can be due the stigma associated with mental illness within society. People suffering from mental illness may also be reluctant to talk about their problems due to the negative attitude of many people within society (Mental Health Ireland, 2013). Due to the eminence pressure that is placed upon family member they should not be the only form of support available to patients. Support should also be sought out in other areas such as lasting friendships, professional caregivers, churches or synagogues and so on. The family unit is crucial in the treatment of schizophrenic patients as they provide essential information about the illness and its consequences, they can identify any side effects of medications and also detect signs of a relapse.

Treatment options

Research has not yet found any cure, neither biological nor psychological, for the mental illness schizophrenia. Having said that there has been major progress made in this area that has enhanced our ability to diagnose this illness and provide the
individuals with a better quality of life than in previous years. Before any treatment is provided a medical examination is usually carried out in order to exclude any other illness from the prognosis that would induce or worsen psychotic symptoms and also to determine weather or not the individual poses a risk towards others or indeed themselves. Certain factors must be taken into consideration when setting a treatment plan which would provide the most benefits for the patient these would include: the persons living situation (are they homeless or not), their readiness to accept treatment, any history of treatment, financial situation (including health care, family and social support). These factors are all crucial in the selection of treatment types, However in order for this treatment to be most successful potential patients should be urged to speak about their preferred options, thoughts on medication and the possible concerns about side effects relating to these medications. There are four steps in the treatment of schizophrenia today that are crucial in targeting different problem areas.

Step one: Reduce positive symptoms when patient is actively psychotic.
Step two: Reduce negative symptoms.
Step three: Increase neurocognitive functioning.
Step four: Increase the ability to function within society (Rosenberg & Kosslyn, 2011).

These steps are challenging objectives, however they are need in order to provide the best possible outcome for schizophrenic patients.

Medication

Medication has been used since the 1950’s to treat the symptoms of schizophrenia when antipsychotics such as Thorazine were developed. Various types of antipsychotic medications have been developed since with two general types being used widely. The first of these are Traditional Antipsychotics and second are Atypical Antipsychotics.

A commonly used traditional antipsychotic is thorazine, which is also known as chlorpromazine, is an antipsychotic that work by blocking dopamine receptors causing positive symptoms (hallucinations and delusions) of schizophrenia to be significantly reduced. Antipsychotics were the first steps taken in treating schizophrenia and have been successful in reducing the risk of relapse in patients (Rosenberg et al, 2011). This type of antipsychotic poses sedating properties, which
affect individuals quite quickly in comparison to the five days to six weeks they take to improve psychotic symptoms. Similar to most other medications antipsychotics can cause patients to experience side effects when taken frequently over a prolonged period of time. A common side effect of traditional antipsychotics that can develop is *tardive dyskinesia*, this condition causes patients to involuntarily smack their lips together, and to make odd facial expressions along with other movement linked symptoms. This is a long lasting side effect and is unlikely to cease even when traditional antipsychotics have stopped being consumed another type of medication is needed to reduce symptoms associated with tardive dyskinesia. Traditional antipsychotics can also cause other side effects such as tremors, weight gain, and physical restlessness.

The second type of antipsychotic medication that are widely used are Atypical Antipsychotics otherwise known as second generation antipsychotics. This type of medication works as they affect the dopamine and serotonin levels in the brain but cause as much disruption to motor functioning areas of the brain as opposed to traditional antipsychotics. Some examples of these medications are Risperdal, Zyprexa, and Seroquel, if used over an extended they appear to reduce positive and negative symptoms associated with schizophrenia and also show a reduction in cognitive deficits (Rosenberg et al, 2011). Studies have found that in some cases the use of traditional antipsychotics works just as well as atypical antipsychotics as long as patients are able to endure the side effects that they can cause. Having said that there are a number of benefits associated with using atypical antipsychotics opposed to traditional antipsychotics; as far as we know they do not cause tardive dyskinesia, can reduce anxiety and depression, and they also improve the individuals daily functioning. Antipsychotics are a hugely effective in the treatment of schizophrenia as they reduce the chances of relapse by at least a year. Side effects of such antipsychotics can be harsh on the body so must be carefully weighed up against the possible benefits. The main area of concern id the change in metabolism that may cause weight gain and the increased risk of heart problems meaning that certain people should not continue to use these medications (McElroy et al., 2007). For this reason antipsychotics should be started at a low dosage and gradually increased over time (Gelder, Mayou & Geddes, 2005).
Both of these antipsychotic medications are thought to be successful for patients when they reduce symptoms in significant proportions and the subsequent side effects are bearable for the individual.

*Psychotherapy*

Within psychoanalysis there are a wide variety of treatment options from which patients can avail. Therapists divide the methods into two large categories, each with specific goals. Investigative Psychotherapy aims to alleviate emotional difficulties as well as symptoms. The author Wayne Fenton (2000) describes how this is achieved through the “scrutiny of the patient’s life history, reviewing in close detail the realities of the patient’s current relationships and life situation and understanding the historical roots and current ramifications of maladaptive interpersonal patterns as reflected in the doctor-patient relationship and in daily life”. This form of treatment is expected to assist the individual in the growth of personality and to also provide better ability in the area of communication and functioning with other people within society. Another huge area is Supportive Psychotherapy, which accepts schizophrenia as a biologically based disorder, gaining much respect from clinicians. This form of psychotherapy aims for different results than Investigative psychotherapy including: providing relief from the current crisis or direct reduction of acute disequilibrium, the removal of symptoms to premorbid levels, restoration of psychic homeostasis by strengthening the individuals defenses, closing psychotic experiences and conflicts, the circumscribed fostering of adaptation, and to mobilize the healthy features of the individual in order to enable best possible functioning and to minimize the impact of continuing deficits (LeVine, 2009).

Cognitive-Behaviour Therapy is commonly used among professionals within this field. This is a generally one-on-one based therapy that focuses on the patient’s symptoms and the suffering that they can cause. It is essential for patients to comprehend and control symptoms. This is achieved by learning to differentiate hallucinatory voices from people speaking, realizing the importance of effective medication, to highlight any issues that hinder obedience with compliance and to develop successful coping strategies. CBT does not aim to provide a cure for schizophrenia but instead helps patients to create rational thoughts and views relating to their delusions and hallucinations, hopefully providing them with the skills needed to keep a firm grip on reality while dealing with their illness. CBT has shown
considerable improvements in relation to positive symptoms, and symptoms overall, although no significant improvements were noted in relation to negative symptoms, depression, or social functioning. CBT is not recommended in all cases, as there is a considerable drop out rate among more severe patients.

Discussion

When exploring the best possible treatment of schizophrenia it is important that we do not assume that we must choose one over the other. We should instead remain open to the possibility of combining different pharmacologic agents with a non-somatic treatment, which could be the most fitting option in an effort to produce optimum results. This idea is supported by a meta-analysis, which was conducted in 1994 of over 320 studies, spanning from 1895 to 1992. This analysis found that only an estimated 1/3 of patients who were suffering from schizophrenia had a favorable outcome based on the use of medication alone (Roberts, 2006). Due to the sometimes, horrific side effects associated with all antipsychotics compliance can become a huge issue. It has been noted however that patients who regularly attend psychological treatment are more likely to continue taking their medication as prescribed and are therefore not as prone to relapse or indeed be hospitalized (National Institute of Mental Health, 2013). Many schizophrenic patients therefore opt to use antipsychotic medication but to also attend psychotherapy in order to help them deal with the side effects and overcome remaining issues in relation to forgoing symptoms, family situation, social interactions and so on.
Conclusion

Schizophrenia is a life altering illness that can affect an individual through areas such as thought, emotion, behaviour, perception, and feelings, turning the events of everyday life upside down and for some people making the thought of living a task not worthy of the battle against hallucinations and delusions. As demonstrated in the case study by Freud on the memoirs of Daniel Paul Schreber, this can be an all consuming illness that causes patients to not only consider suicide but to make several attempts at ending their own lives as a result of how events and the actions of others are perceived by these people who are mentally ill. Family members are therefore placed under extra pressure not only having to deal with the illness itself but they also have to worry about the welfare and stability of the individual in order to prevent a suicide occurring. Mental illness is a serious matter that effects a huge percentage of the Irish population, it should therefore be taken more seriously by society as the stigma associated with illnesses such as schizophrenia prevent people from coming forward and seeking out the help that is needed in order to support them and their families in moving forward with their lives in the best way possible. However it is essential to point out that help is available thanks to the work of organizations such as Shine Ireland and Heads up who provide helplines for people suffering from this disorder in an effort to provide professional help and support to ensure the wellbeing of people who suffer from schizophrenia. It has been made clear that although medication does provide benefits when used alone the best course of action may indeed be to integrate this with psychotherapy in order to avoid the unwelcome occurrence of a relapse. Research into the cause and effects are still being carried out and it is clear that this is needed, as schizophrenia still remains a mysterious illness that is relatively unpredictable.
References


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