## *Selection procedure or training—which is at fault?*

DEAR SIRS

It has recently come to my attention that a number of Consultant Advisory Appointment Committees fail to select a candidate after interviewing those who have been short-listed. The reasons given appear to be diverse, including 'inadequate experience'. The situation, therefore, would suggest either anomalies in the short-listing system or fundamental flaws in training.

If, at the end of seven years of supervised learning, junior doctors are not regarded as suitable for a consultant post, the system must leave a lot to be desired. Either those selected for training are inappropriate or their experience is inadequate. Possibly the Selection Committee has an unrealistic opinion regarding the appeal of the post they are offering.

It might be pertinent if this, apparently common practice, was scrutinized, not only for the benefit of junior doctors, but also for the provision of an adequate service.

ANON.

*(Name and address supplied.)*

## *Creativity and depression*

DEAR SIRS

The long-held belief in the relationship between creativity and insanity has been modified recently. Schizophrenia in its florid form is no longer believed to be conducive to creative production. Schizophrenic artists, it is said, create in spite, not because, of their illness. However, a recent trend has been to promote the idea that depression and manic-depressive illness may have a facilitatory role in creativity. An American psychologist, Dr Kay Jamison, carried out a survey (*The Guardian*, 24 September 1984) on British painters, sculptors, playwrights, poets and novelists, and found that half the poets had received some form of treatment for depression or mania, and was led to conclude that, overall, artists and writers are 35 times more likely to receive treatment for mood disorders than the general population.

Noll and Davis[1] quote from a recent review of the lives of 400 eminent people of the 20th century: 'there are many references to periods of acute depression in the biographies and autobiographies of eminent men and women'. They also remark that in the follow-up to the Stanford University study of gifted children, by the average age of 50, 22 of the original 1,500 had died of suicide.

This implied relationship between creativity and depression has, however, been questioned. Trethowan[2] quotes the Wittkowers, whose investigation of the character and conduct of artists up to the time of the French Revolution was able to identify only a few who had suffered from melancholia. Slater,[3] in a study of 27 German musicians, found only one, Robert Schumann, who seemed to have had recurrent depressive illnesses.

A pervasive problem in studies such as these is that the term depression is used in so many different senses, not all necessarily to be equated with the diagnostic term. Furthermore, such are the diagnostic differences between countries, cultures and across centuries that firmer evidence needs to be forthcoming before the relationship between depressive illness and creativity can be considered established.

Depressive illness is only one vehicle for dysthymic affect. Another is the 'cyclothymic tendency' which Slater[3] believed was positively associated with creativity. His prime example was Schumann—others were Hugo Wolf, Handel, Schubert and Johann Strauss—who had ups and downs of mood for which no external cause could be found.

Cyclothymia—like manic-depressive illness—has two phases, a 'low' and a 'high', corresponding to psychomotor slowing, lack of vitality, life lived in slow motion and the opposite phase of quickening of psychic and physical activity and a release of energy. It is easy enough to understand that in a state of heightened mood, ideas can flow and be captured on paper or canvas. The question is, does the depressive phase bring advantages? It is possible that the germ of an idea is incubated during this phase in the same way as when a problem is solved after a night's sleep, sometimes even in a dream, following a day's fruitless thought. The 'low' phase of cyclothymia and manic-depressive illness is, perhaps, an equivalent of sleeping and dreaming. The dream-like experiences in REM or 'dream' sleep and the more prosaic experiences of non-REM sleep hint at possible creative activity. Thus the apparent slowness in psychic activity in the 'low' phase should not be construed as reflecting the total lack of creative activity—genius is still at work but on a different wavelength. The other point to be made in this regard is that the rapid swing of mood from 'low' to 'high' may itself be conducive to creativity. The whole basis of creative activity is originality, seeing ideas in a new light, tangentially and from unusual points of view. A rapidly changing mood state may help achieve this in the same way that the perception of objects in a dark room is changed when it is lit up. Those of a more equable affect are, perhaps, confined to an unchanging view of things.

One must also consider the possibility that the depressed mood actually influences the process of creation. Depression brings about a highly coloured (usually black) view of things and matters. It may not be a coincidence that a large number of artistic works are to do with solemn and sombre themes.

Another point which many (even ordinary) individuals make is that they work in order to keep 'depression' at bay. Entertainers are particularly prone to this confession. Here a person with depressive tendencies creates in order not to become depressed. When he does not create he is depressed, a different causal direction to that we have been considering.

Creative individuals are unusual and, by definition, abnormal. Few, it would seem, have succeeded in divorcing the abnormality in their art from their private lives. The inability to relate to people, except on their own terms, often leads to unhappiness, feelings of futility, even despair. In this instance the 'depression' is a result of the abnormalities of personal relationships and inappropriate responses to events and situations, the art being a parallel result of an abnormal

view of life, events and objects.

There is some affinity between creativity in depression and in what might be termed the 'schizoid state'. While florid schizophrenia may not be facilitatory of creative expression, as suggested by Kinnell,[4] elements of the schizophrenic process, such as loosening of association, may help the creative artist. The relatives of schizophrenics reportedly often have above-normal creative ability. Noll and Davis[1] have quoted work by Cohler and his colleagues regarding the gifted children of 'better prognosis' schizophrenia. It may therefore be permissible to suggest that a study of creative individuals may help in illuminating the grey area between schizophrenia and manic-depressive illness. Robert Schumann had manic-depressive illness. But he was also a schizoid personality and for nearly a century it was thought he had had schizophrenia. As in ordinary practice, the study of highly creative individuals is likely to be bedevilled by diagnostic doubt and speculation needs to be tempered with caution and scepticism.

B. MAHENDRA

*St Lawrence's Hospital,*
*Bodmin, Cornwall*

REFERENCES

[1]NOLL, K. & DAVIS, J. M. (1984) Depression. In *The Encyclopaedia of Medical Ignorance* (eds R. Duncan and M. Weston-Smith). Oxford: Pergamon Press.

[2]TRETHOWAN, W. H. (1979) *The Art of Madness*. Smith Kline and French Laboratories Ltd.

[3]SLATER, E. (1979) The creative personality. In *Psychiatry, Genetics and Pathology* (eds M. Roth and V. Cowie). London: Royal College of Psychiatrists, Gaskell Press.

[4]KINNELL, H. G. (1983) Insanity and genius. *Bulletin of the Royal College of Psychiatrists*, **7**, 188–89.

## *Novel ideas*

DEAR SIRS

It is not new to say that there is a creative dimension to psychiatry. It is new, however, to suggest that this creative side should be both promoted and examined by the College. In our view a good psychiatrist has a broad humanitarian attitude and an education which includes the study of some fictional literature would serve to engender this.

In addition to entertaining, fiction instructs us, particularly in the mechanisms of the inner world. Many of the problems and illnesses encountered by psychiatrists are described vividly in English language works and in translations of European and other literature. 'Othello syndrome' is a term reminding us of a debt to Shakespeare, for example; and Hamlet's complaint against 'The slings and arrows of outrageous fortune' is nicely evocative when compared with the equivalent: 'undesirable life-events of an independent nature'.

The Introduction to the current College Reading List states: 'It is a common complaint of medical students that, unlike general medicine, psychiatry is nebulous and confusing. We are aware, therefore, of the need to make our subject comprehensible . . .' Salinger's book, *The Catcher in the Rye*, provides a fine introduction to the psychology of adolescent turmoil. Dostoyevsky's novel, *The Idiot*, outlines the problems of an epileptic (The Prince) in love with a woman of disordered personality (Natasia), other characters including an alcoholic with probable Korsakoff's syndrome (Ivolgin), and a man (Hippolyte) who repeatedly threatens suicide. Nobel prize-winner Saul Bellow's book, *Herzog*, describes and clarifies for us the narcissistic personality. Textbook summaries, in our view, can only be enhanced by such accounts. Students of psychiatry wishing to grasp the subjective experiences of persons suffering some kind of paranoid disorder will hardly do better than read the book, *The Ordeal of Gilbert Pinfold*, by Evelyn Waugh. This is the sort of thing which helps to clarify whatever may be 'nebulous and confusing' about our subject, and reading general literature has the additional benefit of fostering a receptive, critical and compassionate mind.

Creative writers and psychiatrists are both called upon to select aspects of experience, facets of personality and recurrent themes within the life-cycle of individuals in order to bring understanding and improvement to suffering and disorder. Each has their own methods, yet the parallel is clear. We hope our colleagues will accept the idea that there is much to be learned from selected fiction, and propose that the College sanction a specific list of about twenty books (see Appendix I) all of which will have been read by candidates for an additional, *optional*, 'Literature and Psychiatry' paper to be taken at the time of the final Membership examination. It will consist of a single, two-hour essay (see Appendix II for a specimen paper). Results will not contribute towards pass or fail in the Membership examination, but grades of A (special merit), B (merit) and U (unclassified) will be awarded. These may then be recorded on an individual's curriculum vitae, presumably thereafter to his or her advantage.

We have avoided works of poetry, drama, religion and philosophy in the attempt to keep the syllabus pleasing and manageable. We would like to state firmly that it is not our intention to detract in any way from the major and traditional examination syllabus. (We both consider ourselves to be scientific, as well as artistic, psychiatrists!) The proposal we offer is a serious one and we await the response of others with considerable anticipation.

LARRY CULLIFORD

*Epsom District Hospital,*
*Surrey*

DENIS MURPHY

*Bethlem Royal Hospital,*
*Beckenham, Kent*

APPENDIX I: SUGGESTED BOOK LIST

*The Catcher in the Rye:* J. D. Salinger; *The Idiot:* Fyodor Dostoyevsky; *Herzog:* Saul Bellow: *The Ordeal of Gilbert Pinfold:* Evelyn Waugh; *Doctor Faustus:* Thomas Mann; *Lord of the Flies:* William Golding; *Doctor Jekyll and Mr Hyde:* R. L. Stevenson; *To Kill a Mockingbird:* Harper Lee; *Madame Bovary:* Gustave Flaubert; *The Solid Mandala:* Patrick White; *The Trial:* Franz Kafka; *Emma:* Jane Austen; *Oliver Twist:* Charles Dickens; *Sons and Lovers:* D. H. Lawrence; *A Study in Scarlet:* Sir Arthur Conan