

There Was No Couch: On Mental Illness and Creativity

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The psychiatrist held the door open for me, and my first thought as I entered the room was, “Where is the couch?”

Instead of the expected leather couch, I saw a patient lying down on a flat operation table surrounded by monitors, devices, electrodes, and a team of physicians and nurses. The psychiatrist had asked me if I wanted to join him during an “*ECT*” for a patient with severe depression. It was the first day of my psychiatry rotation at the VA (Veterans Affairs Medical Center) in San Diego, and as a German medical student I was not yet used to the acronymophilia of American physicians. I nodded without admitting that I had no clue what “*ECT*” stood for, hoping that it would become apparent once I sat down with the psychiatrist and the depressed patient.

I had big expectations for this clinical rotation. German medical schools allow students to perform their clinical rotations during their final year at academic medical centers overseas, and I had been fortunate enough to arrange for a psychiatry rotation in San Diego. The University of California (UCSD) and the VA in San Diego were known for their excellent psychiatry program, and there was the added bonus of living in San Diego. Prior to this rotation in 1995, most of my exposure to psychiatry had taken the form of medical school lectures and theoretical textbook knowledge with rather limited exposure to actual psychiatric patients. This may have been part of the reason why I had a rather naïve and romanticized view of psychiatry. I thought that the mental anguish of psychiatric patients would foster their creativity and that they were somehow plunging from one existentialist crisis into another. I was hoping to engage in some witty repartee with the creative patients and hoping that I would learn from their philosophical insights about the actual meaning of life. I imagined that interactions with psychiatric patients would be similar to those that I had seen in Woody Allen’s movies: A neurotic but intelligent artist or author would be sitting on a leather couch and sharing his dreams and anxieties with his psychiatrist.

I quietly stood in a corner of the *ECT* room, eavesdropping on the conversations between the psychiatrist, the patient, and the other physicians in the room. I gradually began to understand that that “*ECT*” stood for “[Electroconvulsive Therapy](#).” (1) The patient had severe depression and had failed to respond to multiple antidepressant medications. He was receiving *ECT* – commonly known as electroshock therapy – a measure that was reserved for only very severe cases of refractory mental illness. After the patient was sedated, the psychiatrist initiated the electrical charge that induced a small seizure in the patient. I watched the arms and legs of the patient jerk and shake. Instead of participating in a WoodyAllen-style discussion with a patient, I had ended up in a scene reminiscent of *One Flew Over the Cuckoo’s Nest*, a silent witness to a method that I thought was both antiquated and barbaric. The *ECT* procedure did not take very long, and we left the room to let the sedation wear off and give the patient some time to rest and recover. As I walked away from the room, I realized that my ridiculously glamorized image of mental illness was already beginning to fall apart on the first day of my rotation.

During the subsequent weeks, I received an eye-opening crash course in psychiatry. I became acquainted with *DSM-IV*, the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (2), which was the sacred scripture of American psychiatry that diagnosed and classified mental illnesses. I learned ECT was reserved for the most severe cases and that a typical patient was usually prescribed medications such as anti-psychotics, mood stabilizers, or anti-depressants. I was surprised to see that psychoanalysis had gone out of fashion. Depictions of the United States in German popular culture and Hollywood movies had led me to believe that many, if not most, Americans had their own personal psychoanalysts. My psychiatry rotation at the VA took place in the mid-1990s, the boom time for psychoactive medications such as Prozac and the concomitant demise of psychoanalysis.

I found it exceedingly difficult to work with the *DSM-IV* and to appropriately diagnose patients. The two biggest obstacles I encountered were: a) determining cause-effect relationships in mental illness and b) distinguishing between regular human emotions and true mental illness. The *DSM-IV* criteria for diagnosing a “Major Depressive Episode” included depressive symptoms such as sadness or guilt that were severe enough to “cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.” (3) I had seen a number of patients who were very sad and had lost their jobs, but I could not determine whether the sadness had impaired their “occupational functioning” or whether they had first lost their jobs and this had in turn caused profound sadness. Any determination of causality was based on the self-report of patients, and their memories of event sequences were highly subjective.

The distinction between “regular” human emotions and mental illness was another challenge for me, and the criteria in the *DSM-IV* manual seemed so broad that what I would have considered “sadness” was now being labeled as a Major Depression. A number of patients that I saw had severe mental illnesses such as depression, a condition so disabling that they could hardly eat, sleep, or work. The patient who had undergone ECT on my first day belonged to that category. However, the majority of patients exhibited only some impairment in their sleep or eating patterns and experienced a degree of sadness or anxiety that I had seen in myself or my friends. I had considered transient episodes of anxiety or unhappiness as part of the spectrum of human emotional experience. The problem I saw with the patients in my psychiatry rotation was these patients were not only being labeled with a diagnosis such as “Major Depression” but were then prescribed antidepressant medications without any clear plan to ever take them off the medications. By coincidence, that year I met the forensic psychiatrist Ansar Haroun, who was also on faculty at UCSD and was able to help me with my concerns. Due to his extensive work in the court system and his rigorous analysis of mental states for legal proceedings, Haroun was an expert on causality in psychiatry as well the definition of what constitutes a truly pathological mental state.

Regarding the issue of causality, Haroun explained to me the complexity of the mind and mental states makes it extremely difficult to clearly define cause and effect relationships in psychiatry. In infectious diseases, for example, specific bacteria can be identified by laboratory tests as causes of a fever. The fever normally does not precede the bacterial

infection nor does it cause the bacterial infection. The diagnosis of mental illnesses, on the other hand, rests on subjective assessments of patients and is further complicated by the fact that there are no clearly defined biological causes or even objective markers of most mental illnesses. Psychiatric diagnoses are therefore often based on patterns of symptoms and a *presumed causality*. If a patient exhibits symptoms of a depressed mood and has also lost his or her job during that same time period, psychiatrists then have to diagnose whether the depression was the cause of losing the job or whether the job loss caused depressive symptoms. In my limited experience with psychiatry and the many discussions I have had with practicing psychiatrists, it appears that the leeway given to psychiatrists to assess cause-effect relationships may result in an over-diagnosis of mental illnesses or an over-estimation of their impact.

I also learnt from Haroun that the question of how to address the distinction between the spectrum of “regular” human emotions and actual mental illness had resulted in a very active debate in the field of psychiatry. Haroun directed me toward the writings of Tom Szasz, who was a brilliant psychiatrist but also a critic of psychiatry, repeatedly pointing out the limited scientific evidence for diagnoses of mental illness. Szasz’ book, *The Myth of Mental Illness* (4), was first published in 1960 and challenged the foundations of modern psychiatry. One of his core criticisms of psychiatry was that his colleagues had begun to over-diagnose mental illnesses by blurring the boundaries between everyday emotions and true diseases. Every *dis-ease* (discomfort) was being turned into a *disease* that required a therapy. The reasons for this overreach by psychiatry were manifold, ranging from society and the state trying to regulate what was acceptable or normal behavior to psychiatrists and pharmaceutical companies that would benefit financially from the over-diagnosis of mental illness. An excellent overview of his essays can be found in his book *The Medicalization of Everyday Life*. (5) Even though Tom Szasz passed away in 2012, psychiatrists and researchers are now increasingly voicing their concerns about the direction that modern psychiatry has taken. Allan Horwitz and Jerome Wakefield, for example, have recently published *The Loss of Sadness: How Psychiatry Transformed Normal Sorrow into Depressive Disorder* (6) and *All We Have to Fear: Psychiatry's Transformation of Natural Anxieties into Mental Disorders*. (7) Unlike Szasz, who even went as far as denying the existence of mental illness, Horowitz and Wakefield have taken a more nuanced approach. They accept the existence of true mental illnesses, admit these illnesses can be disabling, and acknowledge the patients who are afflicted by mental illnesses do require psychiatric treatment. However, Horowitz and Wakefield criticize the massive over-diagnosis of mental illness and point out the need to distinguish true mental illnesses from normal sadness and anxiety.

Before I started my psychiatry rotation in San Diego, I had been convinced that mental illness fostered creativity. I had never really studied the question in much detail, but there were constant references in popular culture, movies, books, and TV shows to the creative minds of patients with mental illness. The supposed link between mental illness and creativity was so engrained in my mind that the word “psychotic” automatically evoked images of van Gogh’s paintings and thoughts of other geniuses whose creative minds were

fueled by the bizarreness of their thoughts. Once I began seeing psychiatric patients who truly suffered from severe disabling mental illnesses, it became very difficult for me to maintain this romanticized view of mental illness. People who truly suffered from severe depression had difficulties even getting out of bed, getting dressed, and meeting their basic needs. It was difficult to envision someone suffering from such a disabling condition to be able to write large volumes of poetry or to analyze the data from groundbreaking experiments. The brilliant book [*Creativity and Madness: New Findings and Old Stereotypes*](#) (8) by Albert Rothenberg helped me understand that the supposed link between creativity and mental illness was primarily based on myths, anecdotes, and a selection bias in which the creative accomplishments of patients with mental illness were glorified and attributed to the illness itself. Geniuses who suffered from schizophrenia or depression were not creative *because of* their mental illness but *in spite of* their mental illness.

I began to realize that the over-diagnosis of mental illness and the departure of causality that had become characteristic for contemporary psychiatry also helped foster the myth that mental illness enhances creativity. Many beautiful pieces of literature or art can be inspired by emotional states such as the sadness of unrequited love or the death of a loved one. Creativity is often a response to a state of discomfort or *dis-ease*, an attempt to seek out comfort. However, if definitions of mental illness are broadened to the extent that nearly every such *dis-ease* is considered a *disease*, one can easily fall into the trap of believing that mental illness indeed begets creativity. In respect to establishing causality, Rothenberg found, contrary to the prevailing myth, mental illness was actually a disabling condition that prevented creative minds from completing their artistic or scientific tasks. A few years ago, I came across [*Poets on Prozac: Mental Illness, Treatment, and the Creative Process*](#) (9), a collection of essays written by poets who suffer from mental illness. The personal accounts of most poets suggest that their mental illnesses did not help them write their poetry but actually acted as major hindrances. It was only when their illness was adequately treated and they were in a state of remission that they were able to write poems. A recent comprehensive analysis of studies that attempt to link creativity and mental illness can be found in the excellent textbook [*Explaining Creativity: The Science of Human Innovation*](#) (10) by Keith Sawyer, who concludes that there is no scientific evidence for the claim that mental illness promotes creativity. He also points to a possible origin of this myth:

The mental illness myth is based in cultural conceptions of creativity that date from the Romantic era, as a pure expression of inner inspiration, an isolated genius, unconstrained by reason and convention.

I assumed that the myth had finally been laid to rest, but, to my surprise, I came across the headline “[Creativity ‘closely entwined with mental illness’](#)” (11) on the BBC website in October 2012. The BBC story was referring to the large-scale Swedish study [*Mental illness, suicide and creativity: 40-Year prospective total population study*](#) (12) by Simon Kyaga and his colleagues at the Karolinska Institute, published online in the *Journal of Psychiatric Research*. The BBC news report stated, “Creativity is often part of a mental illness, with writers particularly susceptible, according to a study of more than a million people,” and continued:

Lead researcher Dr Simon Kyaga said the findings suggested disorders should be viewed in a new light and that certain traits might be beneficial or desirable.

For example, the restrictive and intense interests of someone with autism and the manic drive of a person with bipolar disorder might provide the necessary focus and determination for genius and creativity.

Similarly, the disordered thoughts associated with schizophrenia might spark the all-important originality element of a masterpiece.

These statements went against nearly all the recent scientific literature on the supposed link between creativity and mental illness and once again rehashed the tired, romanticized myth of the mentally ill genius. I was puzzled by these claims and decided to read the original paper. There was the additional benefit of learning more about the mental health of Swedes because my wife is a Swedish-American. It never hurts to know more about the mental health or the creative potential of one's spouse.

Kyaga's study did not measure creativity itself but merely assessed correlations between self-reported "creative professions" and the diagnoses of mental illness in the Swedish population. Creative professions included scientific professions (primarily scientists and university faculty members) as well as artistic professions, such as visual artists, authors, dancers, and musicians. The deeply flawed assumption of the study was that if an individual has a "creative profession," he or she has a higher likelihood of being a creative person. Accountants were used as a "control," implying that being an accountant does not involve much creativity. This may hold true for Sweden, but the creativity of accountants in the United States has been demonstrated by the recent plethora of financial scandals. The size of the Kyaga study was quite impressive, involving more than 1 million patients and collecting data on the relatives of patients. The fact that Sweden has a total population of about 9.5 million and that more than 1 million of its adult citizens are registered in a national database as having at least one mental illness is both remarkable and worrisome.

The main outcome was the likelihood that patients with certain mental illnesses such as depression, schizophrenia, or anxiety disorders were engaged in a "creative profession." The results of the study directly contradicted the BBC hyperbole:

We found no positive association between psychopathology and overall creative professions except for bipolar disorder. Rather, individuals holding creative professions had a significantly reduced likelihood of being diagnosed with schizophrenia, schizoaffective disorder, unipolar depression, anxiety disorders, alcohol abuse, drug abuse, autism, ADHD, or of committing suicide.

Not only did the researchers fail to find a positive correlation between creative professions and mental illnesses (with the exception of bipolar disorder), they actually found the opposite of what they had suspected: Patients with mental illnesses were less likely to engage in a creative profession.

Their findings do not come as a surprise to anyone who has been following the scientific literature on this topic. After all, the disabling features of mental illness make it very difficult to maintain a creative profession. Kyaga and colleagues also presented a contrived subgroup analysis to test whether there was any group within the “creative professions” that showed a positive correlation with mental illness. It appears contrived because they only break down the artistic professions but did not perform a similar analysis for the scientific professions. Among all these subgroup analyses, the researchers found a positive correlation between the self-reported profession of ‘author’ and a number of mental illnesses. However, they also found that other artistic professions did not show such a positive correlation.

How the results of this study gave rise to the blatant misinterpretation reported by the BBC that “the disordered thoughts associated with schizophrenia might spark the all-important originality element of a masterpiece” is a mystery in itself. It shows the power of the myth of the mad genius and how myths and convictions can tempt us to misinterpret data in a way that maintains the mythic narrative. The myth may also be an important component in the attempt to medicalize everyday emotions. The notion that mental illness fosters creativity could make the diagnosis more palatable. You may be mentally ill, but don’t worry, because it might inspire you to paint like van Gogh or write poems like Sylvia Plath.

A study of the prevalence of mental illness published in the *Archives of General Psychiatry* in 2005 (13) estimated that [roughly half of all Americans will be diagnosed with a mental illness by time they reach the age of 75](#). This estimate was based on the *DSM-IV* criteria for mental illness, but the newer *DSM-V* manual will be released in 2013 and is likely to further expand the diagnosis of mental illness. The *DSM-IV* criteria had made allowance for bereavement to avoid diagnosing people who were profoundly sad after the loss of a loved one with the mental illness depression. Since this bereavement exemption has been removed from the new *DSM-V* criteria, the diagnosis of major depression can be used even during the grieving period. The small group of patients who are afflicted with disabling mental illness do not find their suffering to be glamorous. There is a large number of patients who are experiencing normal sadness or anxiety and end up being inappropriately diagnosed with mental illness using broad and lax criteria of what constitutes an illness. Are these patients comforted by romanticized myths about mental illness? The continuing over-reach of psychiatry in its attempt to medicalize emotions, supported by the pharmaceutical industry that reaps large profits from this overreach, should be of great concern to all of society. We need to wade through the fog of pseudoscience and myths to consider the difference between dis-ease and disease and the cost of medicalizing human emotions.

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