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Creative debate misses the point

The debate rages between Schlesinger (2004) and Wills (2004) over the evidence for a link between mental illness and creativity, but I believe that their focus is wrong.

Most studies to date have either focused on anecdotal (biographical) evidence or have been methodologically flawed retrospective cohort studies, and all would rate low on the hierarchy of evidence. Whatever the outcome of Schlesinger's and Wills' arguments, the question will remain unanswered until better controlled, masked, prospective and replicable randomised studies are carried out.

What is not in question is that mental illness is at least as prevalent in the creative community as in the general population and there are even examples of how some artists, including Dali and Munch, have used their mental illness to feed into the creative process (Saloman, 1996; Rothenberg, 2001). Given the hefty side-effect profiles of most psychiatric treatments, surely the emphasis should be on how best to treat such exceptional patients – indeed all patients – in a way that minimises their symptoms without rendering them incapable of practising their trade. That is, after all (at the risk of sounding naïve), what we are here for.

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Comedians: fun and dysfunctionality

The astonishing levels of drug- and alcohol-related morbidity in the history of jazz and popular music is well described by Wills (2003). After reading his paper I reflected on another group of my heroes, comedians, about whom popular biographies also abound. As I thought of a list of comedy greats, the well-published problems of many – indeed, almost all – of them was striking. Here follows an unresearched short list of some of my favourite great comedians, who manifest a range of neuroses, affective disorders, psychoses and substance problems: Caroline Aherne, Woody Allen, Lenny Bruce, Graham Chapman, John Cleese, Peter Cook, Tommy Cooper, Tony Hancock, Spike Milligan, Dudley Moore, Richard Pryor, Victoria Wood.

The thought of a 2-minute after-dinner speech, let alone three shows per night at the Glasgow Empire, illustrates how unusual any group of comedians must be. There may be a need for somewhat hypomanic thinking to improvise comedy. There is possibly some mileage in the 'bullied at school' manic defence explanation for becoming a clown. Such factors suggest the possible preselection of high-risk people to enter the comedy field. Once selected, the factors suggested by Plant (1981) to explain why some occupations have a high risk of drinking, and by extension drug use, all seem applicable: availability; social pressure to use; separation from normal social or sexual relationships; freedom from supervision; very high or very low income; collusion by colleagues; and strains, stresses and hazards.

The popular 'myth' that, beneath the motley, clowns are distressed, may account for some over-reporting of comedians' problems, but perhaps some truisms are just that.

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One hundred years ago

The mental state in myxoedema. By H. Wolseley-Lewis, MD Brux., FRCS Eng., Senior Assistant Medical Officer at Banstead Asylum

HAVING recently had some cases of myxoedema under my care I have had an opportunity of making the following analysis of their mental state. These patients are commonly sent to asylums as cases of dementia or melancholia. They present, however, few of the characteristics of either condition. Their memory for remote events is generally good and their impairment of memory for recent ones is slight and confined to a period coincident with the duration of their disorder. Their apprehension is fair, their coherence of thought is good, their reasoning power is sound, and their consciousness is clear. What depression they exhibit arises rather from a consciousness of their condition than from any more fundamental affection of the emotions . . . I submit then that the changes in the mental condition of those suffering from myxoedema are almost confined to the sphere of action. It seems necessary to suppose that either some toxin in the plasma surrounding the motor cells inhibits the chemical processes which originate a motor impulse or that the absence of some substance from the blood interferes with the discharge. This toxin is neutralised or this essential substance is supplied by the administration of thyroid extract; the patients get well and keep so

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as long as they continue to take thyroid. I have observed that the simultaneous exhibition of syrupus ferri iodidi appears to assist its action. We see this class of patients described by such terms as dull, listless, apathetic, taking a long time to comprehend and to answer questions, of sluggish ideation, of sluggish mentation, demented, depressed, moping, lethargic, suspicious, of impaired memory, sleepy, torpid, contented, and irritable. I suggest that this proves on careful inquiry to be but part of the truth and that the majority of these cases are sent to an asylum in error and could be as well treated outside one.

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Researched by Henry Rollin, Emeritus Consultant Psychiatrist, Horton Hospital, Epsom, Surrey

Corrigenda

Computer-aided self-help for phobia/panic via internet at home: a pilot study. *BJP*, **184**, 448–449. The authorship for this paper should read: Mark Kenwright, Isaac Marks, Lina Gega and David Mataix-Cols. The online version of this paper has been corrected accordingly.

Global burden of depressive disorders in the year 2000. *BJP*, **184**, 386–392. The third sentence under 'Comparison of GBD 1990 and GBD 2000' (p. 390), col. 2) should read: The first was that the epidemiological data used as input for the original GBD study to calculate the burden due to depressive disorders remain debatable: episode incidence was modelled as 2927 per 100 000 per year for women, and 1676 per 100 000 per year for men. The tenth sentence (p. 390, col. 3) should read: In the GBD 2000 the incidence estimates used were higher (4930 per 100 000 per year for women and 3199 per 100 000 per year for men) and with incident cases of depressive episodes appearing at younger ages than in the GBD 1990.

Global burden of depressive disorders: the issue of duration. *BJP*, **181**, 181–183. The penultimate sentence of the fourth paragraph under 'Scientific studies of duration' (p. 181, col. 3) should read: The GBD 1996 results were generally accepted, but calculations for depressive disorders remained debatable: episode incidence was modelled for women as 0.29‰ and for men 0.16‰; episode average age at onset was 37.1 years, with an average episode duration of 6 months (Murray & Lopez, 1996: pp. 601–606).

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