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Art and Madness: The role of psychopathology in creativity

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Introduction: It has long been believed that a correlation exists between mental illness and artistic ability. This idea dates to antiquity, with Aristotle famously stating, “No great mind has existed without a touch of madness”. Recent studies suggest that writers and artists show a higher incidence of depressive disorders (DD) and bipolar disorder (BD) compared to the general population. However, we know that not all artists suffer from mental illness, and most individuals with mental illness are neither artists nor creative geniuses. Thus, numerous questions emerge regarding the true relationship between psychopathology and creativity.

Objectives: In this study, we sought to explore the correlation between psychopathology and creativity.

Methods: In this literature review, research articles on the relationship between creativity and psychopathology are presented.

Results: There is evidence that the genetic predisposition to BD, as well as milder forms of the disorder, is associated with increased creativity. A meta-analysis of 28 studies found a significant positive correlation between the risk of bipolar disorder and creativity ($r = 0.224$). Mild to moderate manifestations of the disorder can often serve as a source of inspiration, driving creative work. However, this creativity only flourishes when individuals are able to channel their emotional instability and cognitive disorganization into coherent and productive forms. In contrast, severe forms of the disorder tend to inhibit creativity, largely due to impaired concentration and disorganized thinking. Regarding DD, the research presents mixed findings. Some studies suggest a link between depression and lower creativity. A meta-analysis of 39 studies found a weak negative correlation between depressive mood and creativity ($r = -0.064$). However, other researchers argue that both positive and negative emotions can fuel artistic creativity. The Dual Pathway to Creativity Model supports this view, proposing that creativity—defined as the generation of original and valuable ideas—arises from cognitive flexibility and cognitive persistence. According to this model, dispositional or situational factors can influence creativity by enhancing either flexibility, persistence, or both. Negative mood states, for example, may enhance creativity by fostering persistence.

Conclusions: The relationship between psychopathology and creativity is complex. A genetic predisposition to BD, especially in milder forms, may enhance creativity, but severe cases often impair it due to cognitive difficulties. For DD, the link to creativity is more conflicted. While depression is generally associated with reduced creativity, some models suggest both positive and negative emotions, including those from depressive states, can foster creativity by affecting cognitive flexibility and persistence. In summary, the connection between psychopathology and creativity is multifaceted, with various contributing factors.

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EPV1312

Behavioral variant frontotemporal neurocognitive disorder or psychiatric disorder: a diagnostic challenge

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Introduction: The behavioral variant of frontotemporal neurocognitive disorder is the most common clinical syndrome within frontotemporal neurocognitive disorders and is primarily characterized by progressive changes in personality and behavior. Due to the heterogeneity of this condition and the lack of sensitive and specific complementary tests, patients are often misdiagnosed with a psychiatric disorder.

Objectives: To describe the clinical case of a patient with a long-standing history of psychiatric pathology who was admitted to the short-stay psychiatric unit due to newly emerged behavioral disturbances, and to conduct a brief review of the literature.

Methods: Case description and literature review.

Results: A 57-year-old male under psychiatric follow-up for Obsessive-Compulsive Disorder, impulse control disorder (kleptomania), and anxiety-depressive symptoms was voluntarily admitted to the short-stay psychiatric unit due to behavioral disturbances. During admission, the patient reported emotional dysregulation, experiencing irritability and difficulties with emotional containment and inhibition, noting feelings of impulsive discontrol and behavioral disinhibition. The family observed changes in the patient's personality over the past months, describing him as aggressive and inappropriate.

Basic complementary tests (blood analysis, urine analysis, and toxicology screening) showed no significant alterations. Brain MRI revealed subtle signs of cortico-subcortical atrophy, predominantly in the frontotemporal regions. Cognitive assessments, including the Mini Mental State Examination, Frontal Assessment Battery and Montreal Cognitive Assessment, indicated deficits suggestive of frontal impairment. The patient had been admitted one month prior due to possible hypomanic symptoms that resolved following pharmacological adjustment, leading to a proposed diagnosis of late-onset Bipolar Disorder Type II. However, after detailed history-taking with family members and additional testing, the diagnosis leaned more towards a frontal syndrome (possible behavioral variant of frontotemporal neurocognitive disorder).

Conclusions: The diagnosis of frontotemporal neurocognitive disorder remains a significant challenge, partly due to the limitations of complementary tests in the early stages of the disease, with diagnosis primarily based on clinical evaluation. Consequently, many patients with frontotemporal neurocognitive disorder initially receive a diagnosis of a psychiatric condition (more frequently if the patient has a personal history of psychiatric issues). Therefore, it is crucial to understand these differences, especially in the early phases of the disease, and to continue investigating new diagnostic modalities.

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