

Running Head: VAN GOGH'S ILLNESS

The Psychiatric Health of Vincent van Gogh: A Case Study

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Psychiatric History

Identification

Name	Vincent Willem van Gogh	Birthplace	Zundert, The Netherlands
Gender	Male	Ethnicity	Dutch
Date of birth	30 March 1853	Height	5 feet 7 inches

This patient, a 37-year-old, single, Dutch, male artist, the second-eldest of 6 siblings (wherein the first was a still-born), voluntarily admitted himself for the first time at Saint-Paul asylum in Saint Remy, France in 1889.

Chief Complaint

Patient: "I am having frightful ideas . . . I fear that God has abandoned me."

"I did not have to go out of my way very much in order to try to express sadness and extreme loneliness."

"Sometimes moods of indescribable anguish, sometimes moments when the veil of time and fatality of circumstances seemed to be torn apart for an instant."

"I put my heart and soul into my work, and have lost my mind in the process."

Paul Gaughin (friend): "His state is worse, he wants to sleep with the patients, chase the nurses, and washes himself in the coal bucket. That is to say, he continues the biblical mortifications." (Drunk & Zegers, 2006)

Theo (brother): "It is as if he were two persons: one marvelously gifted, tender and refined, the other egoistic and hard-hearted. They present themselves in turns, so that one hears him talk first in one way, then in the other, and always with arguments on both sides." (Sweetman, 1990)

History of Present Illness

The patient entered the city hospital at Brouwersgracht at The Hague, in the Netherlands in 1882 with a gonorrheal infection. he was admitted for 25 days. After 14 days, he complained by letter on of his "dreadful weakness" (2004).

At the time of his initial hospitalization, he has displayed suicidal acts, including the ingestion of turpentine, paint, and lamp oil (Blumer, 2002). These acts were carried out while he had a confused state of mind (2002), wherein he described his thoughts as increasingly becoming more muddled, to the point that 'the noise inside has become unbearable' (Stringer, Pollack, & Lipsedge, 2009). He claims of receiving divine 'communications' only he can understand but was not willing to explain how he has been able to receive them (2009). He reported losing the need for food and sleep, resulting into excessive fasting and sleeping only 2 to 3 hours a day. He finds the need to work continuously, in order to 'God's favor' through painting (2009).

On more than one occasion he was hospitalized, once admitting himself. He had several episodes of epileptic seizures about this time (Zuk & Zuk, 1998). He reported two previous episodes of depression, each lasting a few months. The first followed rejection by a girl in London in his 20s. The second followed dismissal from his post as an evangelist in Belgium when he was 25. He never saw a doctor for these. After both episodes, he reported periods of immense energy and productivity where he pursued his goals of religion and art with great intensity and had less need for sleep (2009). When he was institutionalized, treatment included developing better dietary habits, alcohol restriction, and bromide therapy (2004).

First indications of neuroses and psychoses occurred at age 27 (2004). On Christmas Eve of 1888, he became physically and emotionally exhausted because of opposing ideas and temperamental conflicts with fellow artist Paul Gauguin ("Vincent van Gogh", 2011). He reportedly chased Gauguin with a razor and cut off the lower half of his own left ear (2011).

His last psychotic episode before being admitted was experiencing terrifying hallucinations and severe agitation (2002).

Past psychiatric history

- (+) several episodes of epileptic seizures (1998)
- (+) two previous episodes of depression, each lasting a few months (Stringer et al, 2009)
- (+) visual and auditory hallucinations
- (+) suicide ideations
- (+) paranoid delusions

Medical history

- (+) acute intermittent porphyria, complicated by absinthe abuse (2002)
- (+) gastrointestinal irritability for long periods of time and at least one bout of constipation that required medical intervention (Arnold, 2004)
- (+) treated for gonorrhoea at age 29 (2009)
- (+) sliced off part of his ear in 1888, severing an artery (1998)
- (+) frequent bouts of fever (2004)
- (+) sexual impotence (2004)
- (+) temporal lobe epilepsy, triggered by use of absinthe causing a lesion in the limbic system (2002)
- (+) extreme fatigue, excitability, and irritability
- (+) keratitis

Family History. The patient had two younger brothers and three sisters. His younger brother Theo was his closest friend, although he described himself as being distant from his parents and other siblings. His brother Theo suffered from an affective disorder. His sister, Wilhelmina, spent many years in a psychiatric

institution. His youngest brother Cor both committed suicide, who is suspected of also having untreated bipolar I disorder (2009).

Personal history

Middle Childhood (3-11 years old). As a child, he was an insatiable reader, with wide-ranging interests, including religion.

Later Childhood (prepuberty to adolescence). He spent a great part of his fifteenth year of life engaging in solitary activities and long walks in the fields, which his sister noticed was the beginning of the struggles of an inner life (2009). At 16 he was apprenticed to The Hague branch of the art dealers Goupil and Co., of which his uncle was a partner (2011).

In 1873, at age 20, he traveled to London, fell in love with an English girl by whom he was rejected. Saddened and disillusioned, he resigned himself to a solitary life as a language teacher and a lay preacher in England (Hyams, 2003). From 1879 to 1880, he did missionary work in southwestern Belgium (2003). He had deep sympathy for the poor and unfortunate. He gave away all of his possessions and fell into despair and poverty. In his solitude, he began to draw. He also underwent a spiritual awakening and decided that his mission in life was to console humanity through art (2009).

Adulthood. In 1879, he became a missionary in a mining area in Belgium where he began to draw people in the community. During his mission, church authorities rejected his compassionate behavior, wherein he gave all his possessions, made his own shirts of old sack-cloth, slept in a wooden hut, spent his time feeding the poor, taking care of the sick, and donating money (as cited in de Leeuw, 1996). He consistently fed the hungry which led him to starve himself (2003).

Social History

Friendships. The patient described himself as a moody, solitary child, often disobedient and with few friends. His early interests were flowers, birds, and insects, but he preferred to play alone (2009).

Intimacy. He fell deeply in love with a cousin in 1881, but his affections were not returned. Afterwards, he began a relationship with an unmarried woman with a child who agreed to be his model. Their relationship lasted for a year (1998).

Upbringing. He had a profoundly religious and strict upbringing in the family, wherein he voluntarily attended private Bible study lessons in his hometown (1990). He was also gravely punished by his grandmother at one point.

Socioeconomic Status. At around 33 years of age, he was almost penniless in spite of his brother sending him some money every so often.

Religion. He displayed intense bouts of religiosity, manifested in his letters and his delusional experiences.

Education. Until the age of 12, the patient was taught at home by a governess. At 13 years old, he went to boarding school until he began middle school in Tilburg. It was in middle school when he learnt to draw. Attendance and marks were satisfactory, although he did not work particularly hard nor performed exceptionally well. He as well showed no special talent for art that time. At 25 years old, he took a theology degree, but dropped out in his first year (2009). In his early 20s, he planned to enter a theological school, but it was soon evident he was not intended for the orthodoxy in religious study and left the school. In 1879, he made a strong resolve to become an artist (1998).

Occupational History. He painted feverishly, at times to the point of physical and mental exhaustion (1998).

Drug, alcohol and tobacco history. The patient engaged in excessive alcoholism, constant smoking, and drinking coffee in excess (2007). Evidence shows that the patient nibbled at his paints, which may possibly be connected with his seizure around 1890 (2007). The patient admits to drinking alcohol daily to 'stun' himself when 'the storm inside gets too loud'. He noted that without alcohol he becomes shaky and sweaty—common withdrawal symptoms of alcoholism. He reported needing increasing amounts of alcohol, and resorted to drinking and 1.5 bottles of red wine a day (2009). More notably, he was reported to have drunk 8 glasses of absinth a day, an alcoholic drink made from wormwood, known for its hallucinogenic effects. Absinthe caused problems such as lesions of the brain and erratic behavior, which may be a primary factor in the patient's mental decline. He drank beer and wine in moderation since his late teens. He recognized a loss of control when drinking and blackouts when intoxicated.

Diet and Nutrition. The patient ate poorly, even fasting at times, resulting into malnutrition (2007).

Personal Values, Dreams and Ambitions. Art had become so important to him, and it became the center of his life. He had deep sympathy for the impoverished and unfortunate people.

Premorbid personality

Premorbid activities and interests. He had strong religious convictions. He believes passionately in social justice, particularly for the poor. This has shaped his life to the extent that he gave up most of his possessions to work with the poor in Belgium as an evangelist. As an artist, he claimed to have produced art 'for the people' (2009).

General mood and social patterns. As an adolescent he was prone to lengthy periods of low mood but 'not quite miserable'. He described himself as hardworking and a loner. Often feeling overwhelmed by setbacks, he struggled to get back on track afterwards. He enjoyed travel and frequently moved between cities (2009). He was distant from people and spent most of his time in solitude (2009).

Mental Status Examination

Appearance and behavior. The patient is a gaunt white man with red hair and beard. He was often dressed in a cap and coat. He appeared unwashed, with coal marks on his sallow-skinned face. He smelled of alcohol and was often seen smoking with his pipe. Maintaining eye contact was difficult for him. He was frequently distracted by objects. He whispers to himself, apparently responding to someone or something. Although he was not keen to engage in conversations with people, his behavior indicated no evidence of being aggressive.

Speech. When agitated, the volume of the patient's voice varied from whispers to shouts. His tone of speaking switched between irritable, gloomy, and excited. He complained he 'could not keep up' with his thoughts and found its speed distressing. He showed a consistent flight of ideas and changed the topic frequently when spoken to.

Emotional Expression. Mood. The patient stated that his mood changes as quickly as his thoughts. He was alternating between moods of calm and despair (2011). Affect. The patient had an unstable emotional state. He had uncontrollable temper and was highly emotional.

Thought content. Preoccupations and worries: Religious themes dominated his thoughts and worries, although it was difficult to determine what his specific beliefs are. He stated more than once that God had forsaken him and had been speaking to him through ordinary things. He once uttered, 'I am in the Garden of Gethsemane' (2009). Delusions: He expressed persecutory delusions towards Mr Gauguin, an artist whom he accused of conspiring against him, along with other artists from Paris (2009). Self-harm: In 1888, while having a fit of hallucinations and anguish, he cut off part of his left ear and sent it to a prostitute at a local brothel (2011).

Table 1. Mental Status Examination.

Criteria	Description
Thought form	(+) flight of ideas (+) circumstantiality
Perception	(+) auditory hallucinations* (2004) (+) visual hallucinations* (2004) *Mostly of the religious type
Alertness	He was able to paint for three days without sleep.
Orientation	(Information not available)
Concentration	The impressive productivity as shown in his artworks even during the onset of his illness displayed his ability to sustain attention over time.
Memory	The patient exhibited good recall of past and recent memories, as exhibited in the numerous letters he wrote throughout his life.
Calculations	(Information not available)

Fund of Knowledge	(Information not available)
Abstract Reasoning	His expertise as an artist displayed his aptitude for abstract reasoning.
Insight	He showed the third level of insight into his condition, wherein he is aware of being sick but insisted that the illness was a 'malady of the soul' inflicted upon him by God. He agreed to being admitted into asylum and to take medication, but suggested that medication was unlikely to work as 'they could not undo God's doing'.
Judgment	(Information not available)

Diagnosis

Salient Features

Table 2. Salient Features.

History	MSE
Epileptic attacks	Auditory and visual hallucinations
Altered sleep and energy patterns	Paranoid ideations and persecutory delusions
Visual and auditory hallucinations	Agitated speech
alcohol abuse (a common cause of gastrointestinal complaints)	Flight of ideas
Abuse of other substances (absinthe, nicotine, caffeine)	
Smoking addiction	
Aphasia	
Suicidal ideations	
Paranoid ideations	
Self-mutilation	

Core Symptoms. His ailment was characterized by episodes of acute mental derangement and disability, which were separated by intervals of lucidity and creativity (1991). The patient possessed an eccentric personality with frequent unstable moods. He suffered from recurrent psychotic episodes. Despite limited evidence, well over 150 physicians have ventured a perplexing variety of diagnoses of his illness. However, he had earlier suffered two distinct episodes of reactive depression, and there are clearly bipolar aspects to his history. Both episodes of depression were followed by sustained periods of increasingly high energy and enthusiasm, first as an evangelist and then as an artist.

Differential Diagnoses

Cyclothymic Disorder. The patient exhibits hypomanic symptoms characteristic of cyclothymic disorder, however his a history of mania, major depressive episodes, or mixed episodes eliminates cyclothymic disorder as a primary diagnosis.

Paranoid Schizophrenia. His paranoid ideations towards his colleagues in addition to positive symptoms of schizophrenia may point to a diagnosis of paranoid schizophrenia. His depressive episodes, however, lack the presence of negative symptoms required to make a diagnosis of schizophrenia (Carota, Iaria, Berney, & Bogousslavsky, 2005).

Schizoaffective Disorder, Bipolar Type. In schizoaffective disorder, as it is presently defined, psychosis must also occur during periods without mood symptoms. The patient, however, exhibited mood symptoms along with psychotic episodes.

Dissociation caused by Post-traumatic Stress Disorder (PTSD). It is also possible that his symptoms characterize dissociation caused by PTSD, wherein his trauma began the day he was born, the first anniversary of the death of his stillborn elder baby brother, who had the same name as his (2003). He exhibited symptoms of PTSD: insomnia, feelings of panic, anxiety, depression, self-doubt and fear. His parents' lack of empathy and understanding may also influence these symptoms.

Borderline Personality Disorder. The patient displayed symptoms consistent with a borderline personality disorder: impulsivity, variable moods, self-destructive behavior, unbalanced self-image, and complicated relationships. Being abandoned by his friend Gauguin may be a crucial element in the development of symptoms.

Adjustment disorder. Adjustment disorder is a classification especially for creative individuals experiencing emotional and cognitive difficulties. Unlike other diagnostic classifications applied to artists, this recognizes the creative individual's difficulty in adjusting to the society. This recognition emphasizes the fact that exceptional people who are exceedingly talented and creative and are original and valued in society are extraordinary, and should not be expected to fit in (2009). It is possible that the patient has adjustment disorder, but he has displayed many other symptoms that do not fit into the criteria of this disorder, including hallucinations, delusions, and suicidal ideations.

Bipolar I Disorder, most current episode Mixed, with psychotic features. The patient exhibited core symptoms required to make a diagnoses of bipolar disorder. The experienced two depressive episodes, followed by a prolonged period of hypomanic or manic behavior: first as evangelist to poor Belgian miners and then as quarrelsome and overly talkative in Paris.

Multiaxial Diagnosis

Table 3. Multiaxial Diagnosis.

	DSM-IV TR
Axis I	Bipolar I Disorder, most current episode Mixed, with psychotic features Polydrug Abuse (alcohol, nicotine, and caffeine)
Axis II	Paranoid Personality Disorder
Axis III	Acute intermittent porphyria, gastrointestinal irritability, gonorrhoea, temporal lobe epilepsy, sexual impotence

Axis IV	Poverty, parental conflicts, conflicts with his peers
Axis V	GAF: 30

Psychodynamic Formulation

Overview. Based on recent studies investigating the health of the patient, his prevailing signs and core symptoms strongly indicate him as having Bipolar I Disorder, with current mixed episodes with psychotic features.

Psychodynamic Theories.

Creativity and mania. A number of studies have shown that creative people such as poets, writers, composers, and artists are more affected by mania, depression, psychiatric hospitalization, psychosis, and suicide as compared to those immersed in other fields (Bartlett, 2009). Psychiatric abnormalities were found in 20% of painters (2009, as cited in Juda, 1949). Manic-depressive and artistic temperaments may overlap and may be causally related to one another (2009, as cited in Juda, 1949). There exist three hypotheses linking creativity and mania: (1) Artists are individual victims of mental illness, (2) Artists are often victims of mental illness with a genetic basis (2009, as cited in Jamison, 1993), and (3) Artists experience severe mood swings and occasional psychotic features, resulting from a maladaptive relationship to normal society (2009, as cited in Jamison, 1993).

Biological. The patient's abuse of and dependence to absinthe may also have precipitated his illness, wherein it was found that his seizures and his psychotic episodes have stopped once he abstained from it. In fact, absinthe was outlawed in the 20th century because of its psychotoxic effects. The alcoholic drink absinthe is made from oil of wormwood, which is primarily a toxic substance.

Psychological. The patient's conflicting personality traits may have contributed to the onset of bipolar disorder, wherein his compassionate, sensitive, and spiritual traits contrasted sharply with his disposition towards deep anger, a conflict that have been considered to be the core issue in patients with heightened emotionality and mood disorders (2002).

Social. At 27, he wrote a letter to his Brother Theo, stating that, "My only anxiety is, how can I be of use in the world?" (2002). He displays extreme charitable behavior, socialist ideals, and religious views that created conflicts and tensions between him and the people around him. His work lacked the recognition he aspired for, which may be important factors in the development of his psychotic symptoms which could have arisen because of an unconscious need for him to be accepted by society (2002).

Brief Discussion of the Diagnosis

History. Formerly known as manic-depressive disorder, bipolar I disorder is known to be one of the most severe forms of mood disorders. Since the 2nd century, Soranus, a Greek physician from Ephesus

came up with the idea of a relationship between mania and melancholia. He described mania and melancholia as distinct diseases with separate etiologies.

Classification. Bipolar I Disorder is classified in the DSM-IV-TR as a mood disorder, one of the three recognized forms of bipolar disorders. The other two types of bipolar disorders are bipolar II disorder and cyclothymic disorder. These three types are differentiated by the duration of the episodes. Another type of Bipolar disorder Not Otherwise Specified, is included in the bipolar spectrum, also called as subthreshold bipolar disorder.

Bipolar I disorder is characterized by a single manic episode, or a single mixed episode during the patient's lifetime. There may also be episodes of hypomania or major depression.

An episode of mania is described as a distinctly elevated or irritable mood in concordance with three other manic symptoms, which may include an increase in goal directed activity or physical restlessness, unusual talkativeness, flight of ideas, decreased need for sleep, inflated self-esteem, distractibility, and excessive involvement in pleasurable activities that are likely to have undesirable consequences. These symptoms may last for at least a week or require hospitalization in addition to causing significant distress and impairment in normal functioning.

A hypomanic episode is diagnosed when symptoms of mania last at least four days and there are clear changes in functioning without marked impairment.

A mixed episode, on the other hand, is characterized by severe symptoms of mania and depression that occurred in the span of a week. It is important to note that even if the manic episode that lasted for a week has occurred years ago, the person is still diagnosed with bipolar I disorder.

Prevalence. Bipolar I disorder affects about 0.8% of the general population or roughly 250 million people worldwide, and is equally prevalent among men and women.

Comorbidity. Bipolar disorders in general are comorbid with a range of other medical and psychiatric conditions, such as cardiovascular disease, diabetes mellitus, obesity, and thyroid disease. There are also several possible comorbid psychiatric conditions, such as anxiety disorders, including post-traumatic stress disorder (PTSD); social phobia; and attention deficit hyperactivity disorder (ADHD). ADHD has symptoms that overlap with bipolar disorder, such as being easily distracted and restlessness.

Epidemiology. About 1% of the population will meet criteria for bipolar I disorder. Women will experience more depressive episodes than men. Most will meet criteria for anxiety disorders as well.

Course. About 50 percent of people with bipolar I disorder will experience four or more manic or mixed episodes. Those hospitalized for bipolar I disorder are twice as likely to die from medical illnesses as compared to those without mood disorders

Prognosis. Bipolar disorder has a high risk of being under-diagnosed or misdiagnosed.

Modes of Onset. Symptoms of bipolar disorder usually emerges in late adolescence or early adulthood.

Review of Literature

Etiology

Neurobiological factors

Genetic. Bipolar disorder is one of the most heritable of psychiatric disorders, evidence of which can be found mostly from longitudinal studies of twins. However, genetic models do not play a role in the timing of symptoms, which hint to the consideration of other factors.

Neurotransmitters. Three neurotransmitters have been found to play a role in the onset of mood disorders, which includes norepinephrine, dopamine, and serotonin. Manic and depressive symptoms were linked to too high or too low levels of serotonin. Serotonin regulates the amount of norepinephrine and dopamine released by the presynaptic neuron.

Social and psychological factors

Depression in bipolar disorder. Depressive episodes in bipolar disorder and major depressive episodes have similar triggers, including the experience of a traumatic or distressing life event, lack of social support, neuroticism, and expressed emotion (2009).

Mania. Life events that include the attainment of goal and gaining acceptance, as well as the attraction to extrinsic rewards may trigger manic symptoms among patients with bipolar disorder (2009).

Symptoms

Table 4. Symptoms of Bipolar Disorder.

Manic Phase (High Phase) usually followed by 2 to 4 depressive episodes	Depressive Phase (Low Phase) Found in both bipolar I & bipolar II disorder
Easily distracted	Melancholia
Reckless behavior and lack of self-control (e.g. binge eating and drinking, substance use, promiscuity)	Difficulty concentrating, remembering, or making decisions
Poor judgment	Eating problems leading to weight gain or loss
Elevated mood (Hyperactivity, increased energy, flight of ideas, loquaciousness)	Fatigue
Little need for sleep	Feelings of worthlessness, hopelessness, or guilt
High involvement in activities	Anhedonia
Feelings of self-importance	Low self-esteem
High levels of agitation	Suicidal ideations
Poor temper control	Sleep problems

Table 5. Psychotic Features

Catatonia	abnormality of movement and behavior arising from a disturbed mental state
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Delusion of Reference	the belief that random events, objects, others' behaviors, have a particular significance to oneself
Delusions	firmly held false beliefs
Hallucinations	an experience involving the apparent perception of something not present
Negativism	the tendency to be negative or skeptical in attitude while failing to offer positive views.
Paranoia	delusions of persecution, unwarranted jealousy, or exaggerated self-importance

Sometimes, manic and depressive symptoms may occur together or immediately one after the other. A person with bipolar disorder may totally be unaware of being in the manic phase or vice versa. The frequency of the episode with bipolar disorder varies from patient to patient. Due to the nature of the condition, there is usually markedly impaired social and occupational functioning.

Rapid cycling. Episodes of depression may occur more regularly than episodes of mania (or vice versa). These are sometimes punctuated by periods of 'normal' mood. However, some people with bipolar disorder can immediately change from a high to low phase without having a stable period in between, which is called rapid cycling.

Treatment issues. Psychological treatments, when administered to the patient together with medication, may be most helpful in relieving symptoms of bipolar disorder (Kring, Davison, Neale, & Johnson, 2009). Electroconvulsive therapy on the other hand, has been found to be effective in patients who do not respond to medication.

Treatment Recommendations

Psychological Treatment

Psychoeducational approaches. Informing the patient in great detail about his condition may be considerably helpful in treating it, which includes educating the patient about the onset and course of his illness, encouraging consistent compliance with intake of medication, as well as informing him about the importance of regular sleep patterns and eating habits.

Psychotherapies. Interpersonal psychotherapy and cognitive therapy have been found to be effective in reducing symptoms of bipolar disorder.

Biological Treatment

Electroconvulsive therapy (ECT)

Medications

- a. Mood stabilizers: Lithium carbonate (requires regular monitoring)
- b. Anticonvulsants (anti-seizure): divalproex sodium (Depakote)
- c. Antipsychotics: olanzapine (Zyprexa), quetiapine, risperidone, or aripiprazole
- d. Anticonvulsants: sodium valproate, carbamazepine or lamotrigine

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