Creativity and Bipolar Disorder: Igniting a Dialogue

Sheri L. Johnson1, Michelle Moezpoor1, Greg Murray2, Rachelle Hole3, Steven J. Barnes4, CREST.BD5, and Erin E. Michalak4

Abstract

Bipolar disorder (BD) has been related to heightened creativity, yet core questions remain unaddressed about this association. We used qualitative methods to investigate how highly creative individuals with BD understand the role of symptoms and treatment in their creativity, and possible mechanisms underpinning this link. Twenty-two individuals self-identified as highly creative and living with BD took part in focus groups and completed quantitative measures of symptoms, quality of life (QoL), and creativity. Using thematic analysis, five themes emerged: the pros and cons of mania for creativity, benefits of altered thinking, the relationship between creativity and medication, creativity as central to one’s identity, and creativity’s importance in stigma reduction and treatment. Despite reliance on a small sample who self-identified as having BD, findings shed light on previously mixed results regarding the influence of mania and treatment and suggest new directions for the study of mechanisms driving the creative advantage in BD.

Keywords

bipolar disorder; qualitative

The idea that bipolar disorder (BD) and associated traits are tied to creativity has a long history (Andreasen 2008; Goodwin & Jamison, 2007). Evidence connecting BD to creativity is important for its potential to decrease stigma (Johnson et al., 2012). The aim of this project was to enhance understanding of several issues in the link of BD with creativity using rigorous qualitative methods. We begin with an overview of evidence linking BD to creativity (see Johnson et al., 2012; Murray & Johnson, 2010, for more comprehensive reviews) and then turn to the questions regarding this link that we aimed to address.

Biographical analyses suggest that many prominent artists might meet criteria for a diagnosis of BD, including luminaries such as Hemingway, Faulkner, Fitzgerald, Dickens, Handel, Tchaikovsky, Mingus, Plath, Gauguin, O’Keefe, and Rothko (Jamison, 1993). Indeed, biographical studies consistently find high rates of BD among eminently creative persons. For example, compared with the population prevalence of about 1%, Ludwig, in a biographical review of 1,005 eminent individuals, found that about 8.2% of those in creative professions appeared to have experienced mania (Ludwig, 1992). These studies also suggest that it is less severe forms of the BD spectrum (BD II and cyclothymic disorder) that are particularly prevalent among prominent artists (Goodwin & Jamison, 2007; Jamison, 1989, 1993; Wills, 2003).

Parallel findings have been obtained using standardized assessments of BD. For example, elevated prevalence of BD has been observed among samples of highly eminent authors (Andreasen, 1987; Czeizel, 2001; Jamison, 1989; Ludwig, 1992) and musicians (H. S. Akiskal & Akiskal, 1994; Wills 2003). Richards and colleagues found that peak lifetime ratings of creative accomplishment were higher among those with BD than among healthy controls. Consistent with biographical findings, creative accomplishments were elevated for those with less severe forms of the disorder and for unaffected family members but not for those with bipolar I disorder (K. K. Akiskal, Savino, & Akiskal, 2005; Juda, 1949; R. L. Richards, Kinney, Lunde, Benet, & Merzel, 1988).

Despite criticisms of studies of eminence (Rothenberg, 2001), findings do not appear to just reflect the ability to...
achieve fame. Large-scale population-based studies indicate that persons diagnosed with BD and their family members are more likely to choose artistic occupations (Kyaga et al., 2013; Kyaga et al., 2011; Tremblay, Grosskopf, & Yang, 2010). In these representative samples, BD was uniquely related to creativity compared with depression, schizophrenia, or other psychological disorders (Kyaga et al., 2011).

Creativity also appears to be subjectively valued by people on the bipolar spectrum (Jamison, Gerner, Hammen, & Padesky, 1980; Lobban, Taylor, Murray, & Jones, 2012), and people at risk for mania have been consistently shown to describe themselves as more creative (Furnham, Batey, Anand, & Manfield, 2008; Schuldberg, 2001; Shapiro & Weisberg, 1999), although the effect was not observed in a diagnosed sample (Santosa et al., 2007). In common with highly creative individuals, samples from across the bipolar spectrum demonstrate an aesthetic preference for novel and complex geometric figures over simpler figures (Santosa et al., 2007; Simeonova, Chang, Strong, & Ketter, 2005), and this is also true for the offspring of those with BD (Rawlings & Georgiou, 2004; Schuldberg, 2001; Simeonova et al., 2005).

In sum, a range of evidence supports the idea that BD and related traits are associated with creativity, whether operationalized as creative accomplishments and fame, creative occupations, subjective importance of creativity, or aesthetic preferences. Despite the evidence for this link, however, fundamental questions remain unanswered. First, existing literature is ambiguous about the impact of manic symptoms on creativity. Previous studies have suggested that more severe diagnoses of BD, characterized by more pronounced manic symptoms, are tied to lessened creativity than those observed among persons with subsyndromal symptoms or those at risk by virtue of family history (Richards et al., 1988). In contrast, persons diagnosed with BD sometimes report that mania supports creative accomplishments (Jamison et al., 1980). This type of inconsistency in the literature suggests the need to more carefully understand individual differences that might predict creative accomplishment.

Second, there is controversy concerning the role of mood-stabilizing medications in creativity. On one hand, severe manic symptoms appear related to poor lifetime creative accomplishment (Richards et al., 1988), lithium appears to be protective of long-term cognitive function (Forlenza, De-Paula, & Diniz, 2014), and some case reports indicate that lithium enhances creative work (Schou, 1979). Conversely, lithium might also have negative cognitive effects (Judd, Hubbard, Janowsky, Huey, & Takahashi, 1977), and some case reports suggest that it might diminish creativity (Kocsis et al., 1993; Shaw, Mann, Stokes, & Manevitz, 1986). Not surprisingly, people with BD describe perceived creativity-dampening effects as a barrier to medication adherence (Johnson & Fulford, 2008). Drawing on the current literature, it remains difficult to reach conclusions about the effects of medications on creativity.

Third, it has been difficult to identify the mechanisms that foster creativity in BD. Multiple qualities related to BD have been hypothesized to drive creativity, including divergent thinking, impulsivity, ambitiousness, and positive affectivity (Johnson et al., 2012; Srivastava & Ketter, 2010). None of these proposed mechanisms have received consistent support. Indeed, substantial research suggests that many of the cognitive variables tied to creative accomplishment, such as attentional set-shifting, fluidity, and reactivity flexibility, are compromised among those with BD (Clark, Sarna, & Goodwin, 2005) and divergent thinking has not been shown to be consistently elevated among those with BD (Johnson, Tharp, & Holmes, in press; Santosa et al., 2007).

In short, despite a consistently documented link between BD and creativity, little is known about the mechanisms driving the effect, the role of symptoms, or whether standard treatments for BD support or diminish creativity. Our ignorance in this area is not trivial: Clinicians and people living with BD require an understanding of creativity to protect and maximize this valuable and meaningful resource. Accordingly, our goal was to provide a more solid foundation for potential insights into BD and creativity, by asking creative people with BD about their creative process. Employing rigorous qualitative methods in a carefully selected sample, we sought to inform future research by developing a novel phenomenological understanding of how BD, its mood states and its treatments relate to creativity.

Method
Community-based participatory research (CBPR) is an orientation to scientific inquiry that values the experience of those who have direct involvement and personal knowledge about the issue under study (e.g., in this case, individuals living with BD; Roche, 2008). By creating knowledge of direct relevance to community members, the aim of CBPR is to bridge the gap between theory, research, and practice (Fredland, 2010; Israel, Schultz, Parker, & Becker, 1998). Thus, substantial community input is sought throughout the entire research process (Chen, Diaz, Lucas, & Rosenthal, 2010; Israel et al., 1998). This research project was conducted by the Collaborative RESearch team to study psychosocial issues in Bipolar Disorder (CREST.BD), a Canadian network that specializes in the application of CBPR in BD research and knowledge exchange (Michalak et al., 2014, in press).
We conducted this research as part of a CREST.BD “community engagement day” focused on creativity and BD. The university ethics board granted ethics approval. We designed a poster for the event to recruit “creative people (e.g., musicians, artists, writers, performers, designers) living with BD,” and distributed it through CREST.BD newsletters, networking, posters in art galleries and other art venues, websites such as Craigslist, and social media. Inclusion criteria were a self-disclosed diagnosis of BD, engagement in a creative profession, and public display of their work (e.g., work on display in a public gallery or equivalent). The community engagement event included brief presentations on creativity and BD, information about community services and ongoing research, and opportunities for networking and contributing to future research and knowledge exchange.

Participants

Creative individuals attending the community engagement day who self-reported a diagnosis of BD were invited to participate in focus groups following provision of written informed consent. Participants \( (n = 22) \) were musicians (4), authors (5), film makers and editors (3), visual artists (8), and other performers (2); 17 were women; mean age = 42.05 years \((SD = 12.73 \text{ years})\).

Five participants declined to provide employment information, 4 reported being on disability and/or unemployed, 4 were employed in a teaching capacity, 2 in mental health, 4 were self-employed (1 as a freelance writer), 1 event coordinator, and 1 in antique sales. One person was enrolled in school full-time and two were enrolled part-time. Six had completed some university education, 1 person had graduated college, and the remaining 15 had completed education beyond college. Eight were living alone, 2 with parents, 8 with a partner, and 4 with other relatives or roommates. Seven reported earning less than Can$11,000, 4 reported Can$11,000 to Can$25,000, 6 reported Can$26,000 to Can$50,000, and 1 more than Can$50,000 (4 declined to state their income). Nineteen described White European Canadian backgrounds, 2 described aboriginal Canadian background, and I described a Filipino-Chinese ethnic background. Eleven reported a diagnosis of BD I, 4 reported BD II, 1 reported an unspecified milder form with mixed states and rapid cycling, 1 reported rapid cycling, 1 reported receiving BD I and BD II diagnoses, and 4 declined to respond. Participants reported that they had been living with BD for a mean of 26.6 years \((\text{median } = 30, SD = 15.7 \text{ years})\), but diagnosed for a mean of 11.5 years \((\text{median } = 9, SD = 10.0 \text{ years})\).

Focus Groups

We chose to form focus groups because they encourage dialogue among participants and offer safety to those who might find individual interviews intimidating (Salvatori, Tremblay, & Tryssenaar, 2003). Treatment providers with expertise in BD facilitated each of the four groups (one treatment provider per group). To avoid biasing the responses, we held focus groups before the other events of the day. Treatment providers and participants in each group discussed the following questions:

1. How does BD enhance/add to creativity? (More specific probes were used to clarify this question, such as “Is it via helping you to see things in a different way?” or “Is it via increased activity levels?”)
2. Do different mood states have different impacts on creativity?
3. How does creativity relate to treatment?
4. Are there aspects of creativity that might impact treatment?
5. Do medications for BD help or hinder creativity?
6. Are there ways of tailoring BD treatments that could help with creative expression?

We audio recorded all focus groups, and each focus group lasted approximately 90 minutes.

Qualitative Data Management and Analysis

Although a note taker was present in each group, we transcribed audio recordings verbatim. We analyzed the qualitative data using thematic analysis (Braun & Clarke, 2006), a form of pattern recognition that involves identifying themes through careful reading and re-reading of the transcripts (Fereday & Muir-Cochrane, 2006). Through this iterative process, we manually coded, organized, and re-coded the data several times leading to the development of nine preliminary categories. Researchers M.M., R.H., and S.J. reviewed and discussed emerging patterns and examined the relations between and within the categories leading to the synthesis of the categories and concepts into themes. To address the analytic validity of the identified themes, we held regular meetings to discuss and monitor coding consistency and to ensure that the findings were confirmed by the data (L. Richards & Morse, 2013; Smith, 1996). To enable readers to evaluate the interpretations, we support the findings reported below with direct quotes from participants.

Measures

To characterize symptom, quality of life (QoL), and creativity levels, we administered several quantitative scales.

Seven-up Seven-down. The Seven-up Seven-down scale was developed as a brief screener for lifetime manic and depressive symptoms (Youngstrom, Murray, Johnson, &
Findling, 2013). Items were drawn from the General Behavior Inventory (GBI), a well-validated scale that has been shown to correlate with and predict the onset of bipolar spectrum diagnoses (Danielson, Youngstrom, Findling, & Calabrese, 2003; Depue, Krauss, Spoont, & Arbisi, 1989). Seven items reflecting manic symptoms and seven reflecting depression were selected using factor analytic techniques, and confirmatory analyses were conducted in a second sample. Construct validity was indicated by robust correlations with scales that have been shown to correlate with BD, including creative behavior scales. Internal consistency was high in the present sample, Seven-up alpha = .93, Seven-down alpha = .96. Normative data for comparison here were drawn from an original validation sample of 1,729 healthy young adults.

**Brief Quality of Life in Bipolar Disorder (QoL.BD).** To examine whether the highly creative sample was comparable with a general BD sample, participants completed the QoL.BD Scale (Michalak & Murray, 2010), which has adequate 1-week test–retest reliability (.69), and demonstrates large correlations with established QoL measures. In this sample, internal reliability was good (α = .86). We drew normative data for this scale from the original validation sample of 224 participants with BD.

**Creative Achievement Questionnaire (CAQ).** The CAQ (Carson, Peterson, & Higgins, 2005) is a self-report measure designed to assess lifetime creative accomplishments across 10 domains: visual arts, music, creative writing, dance, drama, architecture, humor, scientific discovery, invention, and culinary arts. Participants completed a checklist for each domain with options ranging from no training or recognized talent in this area (0 points) through exceptional levels of recognition (e.g., My choreography has been critiqued by a national publication, 7 points). Total scores reflect the sum of each accomplishment for each domain (range in this sample was 0–70). CAQ scores have been found to correlate with laboratory indices of creativity (Carson et al., 2005). We drew normative data from a previous study of a community sample of 62 persons diagnosed with BD I, assessed during a euthymic period, and a well-matched control group of 50 persons with no lifetime history of mood disorders (Johnson et al., in press).

**Results**

**Qualitative Analyses**

Five main themes emerged from qualitative data analyses: a pros and cons of manic energy, benefits of altered thinking, the relationship between creativity and medication, creativity as central to one’s identity with BD, and the importance of creativity in reducing stigma and improving treatment.

**Pros and cons of manic energy.** The most salient theme pertaining to the perceived benefits and costs of manic energy: 17 participants (across all four groups) spoke to this theme. These individuals described experiences of mania as a double-edged sword, having extremely positive and negative impacts on their creativity. Specifically, participants shared that mania can be associated with creative intensity and brilliant levels of energy while also being a hindrance to efficient creative output. On the positive side, individuals described experiencing increased motivation and obsessive energy directed toward their creative projects during mania. For example, one participant described how mania “is all about just the phenomenal amount of energy that is, can be for some, very creative.” Others explained how such energy “motivates our drive” and the energy acts as a “spark” that generates “an idea, or many at once” leading to a burst of creative inspiration compelling them to act and to create.

Participants also depicted the energy during mania as intense and often uncontrollable: Individuals described having no control and feeling almost forced into whatever project they become fixated on while in a manic state. For example, one participant stated,

I want to talk briefly about, briefly, about obsession and how the mood, there’s some element of the, of being driven to . . . better or for worse . . . I had no choice but to be there, doing what I was doing. I could, could not have been doing anything else.

This dangerous obsessiveness often led to negligence of other responsibilities such as family and self-care; one participant stated that “the emotions are so overwhelming that it’s hard to have focus [on anything] else.” Despite the compulsion to work on a project, many participants questioned the quality of the product. That is, while experiencing mania, some individuals believed their work to be brilliant and of high worth when it was not, or not to the extent they had believed. One participant expressed, “I think sometimes [the work is] inspired, [but] sometimes it’s way off the beaten path.” One participant portrayed this as a “delusional” state of mind: “[The mania], it’s a delusional creative state. I think I’m being creative, but I’m not particularly, or at least, I may be creative but the quality is not helpful at all.”

Another challenge of mania was the “stop-start” phenomenon of creative inspiration, making it difficult to finish projects that they start as a result of their initial surge of energy: “that’s what I’ve experienced, the stop, go, stop, go.” Participants shared that distractions and an
unfocused mind sometimes contributed to an inability to complete the task. For example, one participant stated, “So, I think it does contribute to not finishing things, because I have just a huge jumble of ideas, but I don’t follow through with them.” Finally, one participant shared, “You can be very busy without doing actual creative, productive work,” implying an inability to harness the intense creative drive and obsessiveness to efficiently create.

**Benefits of altered thinking.** More than half of the participants (across all four focus groups) described unusual states of creative thinking that were perceived as advantageous to their creative work. Participants spoke of having a special or “magical” source of creativity that allowed for unlimited creative thinking. One interviewee described this as “not just a linear way of thinking, you’ve got this thought and it can be expanded in all these different directions because of the way your mind is.” This way of thinking was also described as “out-of-the-box.” Participants indicated that this non-linear, multi-dimensional state of thinking bolsters creativity and allows them to create and imagine in a unique and expansive way compared with those without BD.

In addition, participants described a sensation of “connectivity” or “super-connectedness” of thoughts that grants them creative insights. The ability to connect diverse ideas and channel creative energy into art gave participants peace of mind and focus when creating work.

Many individuals reported instances of channeling creative energy. For example, one participant stated, “When I’m in that creative zone that I, I feel like I channel something . . . it’s not something I try to harness, I don’t try to do something with it, it just is.” This “channeling” of creative energy was for some transcendental, a state to which participants attributed not only the elevation of their creative work but also the centering of their creative and mental energy.

**Medication: Finding the balance that supports creativity.** Nine participants (from three focus groups) highlighted both positive and negative effects of medication on their creative work. Some described their creative work as being of good quality (“wonderful”) while taking medication, and considered that to be more important than the negative side effects of medication. For example, one individual shared, “I found a very creative medication . . . gave me lots of room to play with creativity. So, I think that the payoff was so great for that particular medication health-wise.” That said, most participants commented on the potentially negative effects of medication on creativity: “When I first was being medicated and diagnosed bipolar, they really heavily medicated me, and like, way over the top. And it put out my fire and turned me into a zombie.” Individuals stated that their medication diminishes creative energy and limits the experience of emotional connectedness—something that many consider to be a crucial aspect of their creative work. As such, individuals emphasized that being prescribed the right medication at the right levels was most critical. For example, one participant stated,

... if I’m on the wrong medication, it’ll dampen my thinking, it’ll dampen my energy, it’ll dampen my initiative, but when I’m not on meds at all, I’m all over the place or stagnant. But when I’ve got that sweet spot and the right medication and I’m doing all the other treatments, it makes a perfect creative storm.

Participants also underscored the importance of a medication “sweet spot,” where disruptive symptoms of BD are minimized without impairing creative freedom and practice.

**Creativity as central to one’s identity with BD.** In describing their experiences of living with BD, more than half of the participants focused on creativity as being strongly associated with their personhood. They viewed creativity as being intertwined with experience of the condition and considered it to be intrinsic to the person: “directly related to [one’s] chemistry.” Participants described creativity as a means of shaping the way they see themselves both as a person with BD as well as an individual beyond their illness. Many described creativity as essential to the lives of individuals with BD. One participant clearly conveyed this when stating, “Creativity has saved my life more times than I can count. The ability to write has got me through so much and I credit it with, with everything, with my continued recovery and who I am as a person.”

Many considered creativity to be a means of validating one’s life and adding purpose into one’s experience with BD. Participants highlighted the importance of creativity as an essential emotional outlet and method of communication that drastically improved the rate and quality of their recovery. As a result, participants explained, their illness becomes an accepted and even essential aspect of their identity; one participant stated that they would “be afraid not to have it, if that makes any sense / Well, it’s like, who would you be without it?” A synergistic relationship between BD and creativity was also viewed as problematizing the whole idea of “illness.” For example, one participant passionately explained, “I really feel like my creativity is expanded so exponentially, inexorably by, by my illness, what is described as an illness, but I consider it a gift.”

**The importance of creativity in reducing stigma and improving treatment.** Ten participants commented extensively on the stigmatization of BD by healthcare providers and
discussed one-sample t tests of lifetime manic and depressive symptoms as compared with the healthy normative sample, Seven-up: *t*(21) = 5.83, *p* < .0005, mean (M) creative sample = 10.64, normative M = 3.98; Seven-down: *t*(21) = 6.59, *p* < .0005, M creative sample = 13.86, normative M = 5.77. The highly creative sample endorsed a similar QoL level to the normative BD sample, *t*(21) = .32, *p* = .75, M creative sample = 40.82, normative M = 40.25.

To confirm that the present sample had high creative accomplishment levels, we conducted a *t* test to compare CAQ scores with a normative sample of those with BD. The current sample endorsed higher creative accomplishment, M = 27.45, SD = 19.30 compared with a BD normative sample, M = 14.10, *t*(21) = 3.25, *p* = .004, and a normative community sample with no mood disorder, M = 9.06, *t*(21) = 4.47, *p* < .0005.

**Discussion**

Although creativity is a highly valued domain in BD, researchers have struggled to understand the forces driving this link. Our current study provides the first rigorous qualitative examination of how highly creative people with BD understand this link. Using CBPR principles and practices, we invited artists with BD to take part in focus groups to discuss questions regarding the link between creativity and BD. Recruitment was successful, in that participants endorsed significantly elevated levels of manic and depressive symptoms during their lifetime, as well as QoL levels comparable with other diagnosed samples. They also reported creative accomplishment levels significantly higher than normative BD or control samples.

Five clear themes emerged through thematic analysis. First, manic states cannot be construed simply as helpful or unhelpful for creativity. Rather, participants described certain facets of mania as being constructive (e.g., motivation and energy), whereas others can be unproductive (e.g., uncontrollable, skewed judgment, “delusional”). Second, in parallel with the dialectical qualities of mania, medication was often viewed as useful, but this perspective was qualified by negative experiences such as excessive sedation. This complexity in participants’ experience of mania and medication treatment might help explain existing mixed findings about the link between BD and creativity, as previous publications have provided conflicting evidence regarding the benefits or costs of both mania and medication for creative outcomes (Johnson et al., 2012). For practitioners, the present findings for mania and for treatment highlight the importance of developing an individualized understanding of how mood states and treatments interface with creativity. This may involve more systematically monitoring how medications influence creativity, while understanding that depending on the individual, such effects might be either positive or negative until the correct balance is identified. Creativity monitoring could be
one more approach to identifying the “sweet spot” of medication dosage to quell symptoms without excessive sedation or side effects.

The findings regarding the third theme point toward future directions for quantitative research on creativity in this population, in that many participants described aspects of their cognitive style as beneficial to creativity, noting the advantages of a non-linear and non-conventional style of thinking. Although quantitative studies have considered some aspects of thought style, such as verbal fluency, that line of pursuit has not been particularly successful (Johnson et al., 2012), and it would seem fruitful for researchers to consider a broader range of constructs to quantify non-linearity or non-conventionality. Possible directions would include examining use of more unconventional reference points, mind-wandering (Baird et al., 2012), schizotypal, and other unusual thought styles that have been shown to benefit creativity (Folley & Park, 2005), and imagery (Ng, Krans, & Holmes, 2013). On the whole, researchers need new paradigms for considering the cognitive features that promote creativity within BD.

In the fourth theme, participants noted the importance of creativity to a positive sense of identity. This dovetailed with the fifth theme, in which participants were eager to see their creativity taken into account within treatment as a way to help foster more positive communication and to combat the stigma that they all too often experience (see Murray & Johnson, 2010, for more discussion). As such, creativity appears to be a positive focus for promoting growth and wellness, and for reducing stigma.

The study had a number of limitations. First, the sample size was small, although sufficient to derive strong qualitative themes. Second, we based recruitment on self-identification of BD diagnosis and creativity (although quantitative data provide some confidence that the sampling strategy was effective). Finally, our findings are based on the views of a highly motivated, highly creative sample, and as such, may not generalize to all of those with BD.

Despite limitations, current findings highlight the fruitfulness of using qualitative CBPR methods to enhance ongoing research and treatment. By listening to those with lived experience, new directions for research and treatment have emerged. We hope these findings provide insights for both the research and the clinical community to foster and protect creativity among people with BD.

Declaration of Conflicting Interests
The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding
The authors disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: CIHR RN117262-248227 provided support for the community engagement day.

References


Author Biographies

**Sheri L. Johnson**, PhD, is a professor and director of the Cal Mania (CALM) program at the University of California, Berkeley, and a fellow at the Center for Advanced Study of the Behavioral Sciences (CASBS), Stanford University.

**Michelle Moezpoor** is an undergraduate student at the University of California Berkeley.

**Greg Murray**, PhD, is a professor at the Swinburne University of Technology.

**Rachelle Hole**, PhD, is an associate professor at the University of British Columbia.

**Steven J. Barnes**, PhD, is a tenure-track instructor at the University of British Columbia.

**CREST.BD** is a multidisciplinary collaborative network of researchers, healthcare providers, and community members (people living with bipolar disorder, their family members, and supports) dedicated to researching and exchanging knowledge about psychological and social factors in bipolar disorder.

**Erin E. Michalak**, PhD, is the team leader of CREST.BD and an associate professor at University of British Columbia.