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Pepperdine University
Graduate School of Education and Psychology

THE DEVELOPMENT OF THERAPY SUGGESTIONS FOR ADDRESSING ISSUES OF
CREATIVITY IN INDIVIDUALS DIAGNOSED WITH BIPOLAR DISORDER

A dissertation submitted in partial satisfaction
of the requirements for the degree of
Doctor of Psychology

by

Sean Agopian

February, 2017

Stephanie Woo, Ph.D. – Dissertation Chairperson

This clinical dissertation, written by

Sean Agopian

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

Doctoral Committee:

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TABLE OF CONTENTS

	Page
DEDICATION.....	vi
ACKNOWLEDGEMENTS.....	vii
VITA.....	viii
ABSTRACT.....	xii
Chapter 1: Introduction.....	1
Typical Features of Bipolar Disorder.....	2
Historical Views on Mental Illness and Creativity.....	4
Client Perceptions on the Relationship Between Illness and Creativity.....	9
Empirical Studies Examining the Relationship Between Mood States and Creativity.....	11
Other Aspects of Bipolar Disorder That May Impact Creativity.....	13
Effect of Bipolar Disorder Medications and Treatment on Creativity.....	15
Psychotherapy for Bipolar Disorder.....	19
Cultural Factors Related to the Treatment of Bipolar Disorder.....	22
Summary.....	23
Chapter 2: Methods.....	25
Rationale.....	25
General Procedure.....	26
Literature Review and Analysis Procedures.....	26
Identification of source material and study selection.....	26
Search strategies.....	27
Development of the program content.....	28
Chapter 3: Results.....	31
The Need for Psychosocial Treatments in the Treatment of Bipolar Disorder.....	31
Modifying Therapies for Use with the Creative Bipolar Client.....	31
Challenges Faced by the Clinician Working with the Creative Bipolar Client.....	36
General Considerations for Intake, Diagnosis, and Treatment Planning.....	37
Intake.....	37
Diagnosis.....	38
Treatment planning.....	41
Specific Psychotherapy Treatments for Bipolar Disorder.....	43
Psychoeducation.....	44

Family interventions.....	49
Interpersonal social rhythm therapy.....	50
Cognitive-behavioral therapy.....	55
Increasing Medication Adherence in the CPBD.....	59
Systematic/chronic care models.....	63
Assessment and care planning.....	63
Structured monthly telephone calls.....	64
Feedback to the mental health treatment team.....	64
Structured group psychoeducational program.....	65
As-needed support, education and care coordination.....	66
Chapter 4: Discussion.....	67
Strengths, Limitations and Future Directions.....	68
REFERENCES.....	71
APPENDIX A: Resource of Treatment Suggestions for Working with Creative Persons with Bipolar Disorder.....	90
APPENDIX B: IRB Exemption.....	112

DEDICATION

I dedicate my research to my mother, Sadie Agopian, and father, Melkon Agopian, for their unending support and encouragement throughout my doctoral program.

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To Dr. Woo, my dissertation committee chair, I thank you for all of your support and guidance throughout the time I have worked on this dissertation. You undoubtedly spent hours poring over this document and your dedication and attention to detail is greatly appreciated.

To Dr. Ingram, my committee member, I thank you for helping me to better myself as a therapist through your teaching at Pepperdine University, and for the support you gave me throughout the dissertation process.

To Dr. Ortiz, my committee member and clinical supervisor, I thank you for the tireless work you do at Kedren Community Health Center and for the clinical supervision you provided while I was a practicum student there.

To Araceli Almanza, for all the love and support you have provided me throughout my time as a doctoral student in Psychology.

VITA

EDUCATION

Doctor of Psychology in Clinical Psychology *October 2016*
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 Dean's List

Master of Arts in Psychology *May 2010*
 Pepperdine University, Graduate School of Education and Psychology Los Angeles, CA
 Dean's List

Bachelor of Science in Marketing *May 2000*
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 Dean's List

RELEVANT EXPERIENCE**Pre-Doctoral Internship**

Oregon State Hospital Psychology Internship Program (OSH-PIP) *Salem, OR*
Clinical Psychology Intern August 2015 – September 2016

- First Major Rotation (August 2015-March 2016): Pathways, admissions program.
- Clinical Supervisor: Jennifer Snyder, Ph.D.
- Completed a 6-month major rotation within the Pathways program, an admissions program where services are provided to patients with severe and persistent major mental illness found Guilty Except for Insanity. Focus was on identifying and ameliorating patients' barriers to discharge, psychiatric and behavioral stabilization, and treatment engagement in preparation to move forward within the hospital setting.
- Duties included clinical interviewing, individual therapy, group therapy co-facilitation, focused psychological assessments and consultation to and participation with the interdisciplinary treatment team.
- First Minor Rotation (August 2015-March 2016): Dialectical Behavior Therapy (DBT).
- Clinical Supervisor: Andrew Weitzman, Psy.D.
- Completed 6-month minor rotation within Dialectical Behavior Therapy program. Patient population includes individuals with diagnosed with borderline personality disorder, as well as other diagnoses that cause them to experience difficulty with emotion regulation, distress tolerance, interpersonal effectiveness, non-suicidal self-injurious behavior, and/or suicidal ideation and attempts.

- Duties focused on provision of individual therapy, co-facilitation of group therapy, and participation with the interdisciplinary treatment team.
- Second Major Rotation (March-September 2016): Archways, admissions program.
- Clinical Supervisor: Kimberly McCollum, Psy.D.
- Completed a 6-month major rotation within the Archways program, an admissions program where services are provided to patients found unable to aid and assist in court. Patient population included individuals with acute symptoms of mental illness, cognitive impairments, personality disorders, substance use disorders, and response style issues.
 - Duties focused on identifying patients' barriers to competency and otherwise aiding in their restoration process. Responsibilities include clinical interviewing and psychological assessment, individual teaching of legal skills, short-term crisis therapy, group therapy co-facilitation, co-facilitation of supervision of practicum students, participation with the interdisciplinary treatment team, consultation throughout hospital, and development and implementation of behavioral management plans.
- Second Minor Rotation (March-September 2016): Risk Assessment
- Clinical Supervisor: Stephen James, Ph.D.
- Completed a 6-month minor rotation within the Risk Assessment program that focused on assessment of risk for violence, formulation of violence risk factors, and providing recommendations of risk management strategies.
- Duties included clinical interviewing, administering relevant assessment measures/tools (e.g., HCR-20 V3), and writing violence risk assessment reports.

Practica

VA Long Beach Healthcare System

Psychology Practicum Trainee

Long Beach, CA

August 2014 – August 2015

- Conducted comprehensive clinical interview and mental status examinations with patients in the Substance Abuse Treatment Clinic to provide diagnostic clarification and inform treatment planning.
- Facilitated group and individual therapy with patients in the Substance Abuse Treatment Clinic in order to maintain patients' abstinence from drugs and alcohol.
- Conducted group and individual therapy with patients in the PTSD and Mindfulness clinic in order to ameliorate patients' symptoms.
- Wrote diagnostic summaries and formulated treatment plans.

Pepperdine University Community Clinic*Psychology Practicum Trainee*Los Angeles, CA
July 2012 – August 2015

- Conducted clinical interviews with clinic patients to collect background information and to assess severity of the presenting problem.
- Provided individual therapy with a focus on integrating psychodynamic, humanistic-existential and cognitive-behavioral techniques to clients with various diagnoses, including mood, anxiety, and personality disorders.
- Maintained progress notes for all clients to ensure proper documentation of session content and interventions.

Kedren Community Mental Health Center*Psychology Practicum Trainee*Los Angeles, CA
September 2013 – August 2014

- Conducted comprehensive clinical interview and mental status examinations with patients in an acute psychiatric hospital setting to provide diagnostic clarification and inform treatment planning.
- Administered cognitive, personality, and diagnostic assessments to hospital patients
- Scored and interpreted psychological tests and integrating all data to produce assessment reports.
- Presented findings of psychological testing to a multi-disciplinary treatment team in order to assist with treatment planning and patient care.

Metro State Hospital*Psychology Practicum Trainee*Norwalk, CA
September 2012 – August 2013

- Conducted clinical interviews with hospital patients in both the forensic and civil commitment units.
- Administered cognitive, personality, diagnostic, and suicide risk assessments to patients in all hospital divisions.
- Wrote assessment reports to aid in treatment planning and diagnostic clarification.
- Collaborated with hospital psychologists, physicians and staff for the purpose of treatment planning and risk reduction for patients.
- Facilitated therapy groups to help foster patients' social and daily living skills.

Wiseburn School District*Psychology Practicum Trainee*Torrance, CA
September 2011 – May 2012

- Conducted clinical interviews with students and students' parents to assess issues the students were facing at home and in school.
- Provided individual therapy with children and adolescents to address emotional, behavioral and academic problems.
- Facilitated skills groups in order to develop students' interpersonal and social abilities.
- Communicated with parents and school personnel, including the school psychologists, principals and teachers, to monitor students' progress.

ManagedMed, Inc.

Psychologist's Assistant

Los Angeles, CA
August 2010 – May 2012

- Provided cognitive-behavioral therapy to injured workers in order to manage pain and ease distress associated with emotional and physical injuries.
- Conducted clinical intake interviews that would later be used in the supervising psychologists' reports sent to courts.
- Administered, scored and interpreted personality and cognitive tests including the MMPI-II, WAIS-IV, and Bender-Gestalt tests.

University of California Los Angeles, Cognitive Psychology Dept.

Research Assistant

Los Angeles, CA
October 2009 – April 2010

- Assisted in Dr. Ladan Shams' Visual and Multisensory Perception Lab by scheduling and administering computerized experiments to research volunteers.
- Gathered and compiled test data to present to the research team.
- Tested and critiqued computer programs that were to be used in future experiments.

ABSTRACT

The aim of the present study was to generate a set of therapy suggestions specifically for use in the treatment of creative individuals diagnosed with bipolar disorder. In order to achieve this end, the author collected information from bodies of literature that focused on three general research areas: (a) the relationship between bipolar illness and creativity, (b) the treatment of bipolar individuals, and (c) psychotherapy treatment of creative individuals. The information gleaned from these three areas was synthesized and used to inform the general treatment suggestions. This study examined several of the existing approaches to the treatment of bipolar disorder and provided suggestions for ways in which those treatments could be tailored for use with creative clients who are diagnosed with bipolar disorder. Effective psychiatric and psychological (i.e., psychotherapeutic) interventions have been developed for the treatment of individuals diagnosed with bipolar disorder, though additional research can be conducted to better understand how these interventions can be adapted to improve outcomes with certain clinical subgroups. Creative individuals with bipolar disorder reflect one such subgroup, and it is hoped that the suggestions for therapeutic adaptations contained within this dissertation begin to draw more attention to an under-researched group.

Chapter 1: Introduction

For the past several decades, many psychologists have wondered about the correlation between creative achievement and symptoms of mental illness, especially bipolar disorder (Anderegg & Gartner, 2001). Since ancient times, the constructs of creativity, artistic accomplishment, genius, and madness have been linked by philosophers, such as Aristotle who stated, “no great genius has ever been without some madness” (Eysenck, 1995, p. 12). Furthermore, in the Latin language, there is no difference between the words for *madness* and *inspiration* (Eysenck, 1995).

Although there has commonly been a fascination with the connection between mental illness and creativity throughout history, Jamison (2011) contends, “no one would argue that there is a straightforward relationship between psychopathology and creativity. Most people who are creative do not have mental illness and most people who are mentally ill are not unusually creative” (p. 352). Rather, she states, “there is a disproportionate rate of psychopathology, especially bipolar disorder, in highly creative individuals” (Jamison, 2011, p. 352). Certain symptoms of mania or hypomania, including flight of ideas, lowered inhibitions and heightened sensitivity and productivity, may enhance artistic creativity in individuals diagnosed with bipolar disorder (Sadre & Brock, 2008). Indeed, throughout the history of psychiatry and psychology, several psychoanalysts, psychiatrists, and psychologists have written about certain benefits associated with bipolar disorder, such as a disproportionate rate of artistic ability and professional success, increased productivity, wittiness, talkativeness, and liveliness (Jamison, Gerner, Hammen, & Padesky, 1980). Psychologists who study the link between mental illness and creativity today find value in their work as they have encountered evidence that the previously mentioned symptoms of

bipolar disorder may confer advantages for creative accomplishments which would help improve public conceptualizations and remove stigma from the disorder (Johnson et al., 2012). However, it is also important to recognize that a diagnosis of bipolar disorder is frequently accompanied by significant functional impairment.

Typical Features of Bipolar Disorder

Bipolar disorder has been identified by the World Health Organization as the sixth leading cause of disability among individuals between the ages of 15 and 44 (Berk et al., 2010). Bipolar disorder is a highly recurrent illness, with 73% of individuals relapsing within a 5-year period (Proudfoot et al., 2009), and it is associated with elevated mortality risk (e.g., 25-50% of individuals with the disorder attempt suicide; Berk et al., 2010).

Bipolar disorder is characterized by symptoms of mania, including elevated or irritable mood, distractibility, pressured speech, decreased need for sleep, flight of ideas, increase in goal-oriented activity, and engagement in high-risk behavior, and symptoms of depression, including depressed mood, insomnia or hypersomnia, weight loss or decrease in appetite, feelings of worthlessness, diminished interest in most or all activities, psychomotor agitation, fatigue or decreased energy, diminished concentration, and recurrent suicidal ideation (American Psychiatric Association, 2013). Individuals diagnosed with bipolar disorder often have comorbid psychiatric diagnoses, including personality disorders, substance use disorders, and anxiety disorders (Altindag, Yanik, & Nebioglu, 2006; McIntyre & Keck, 2006). Additionally, comorbid medical conditions are often found in individuals diagnosed with bipolar disorder, including coronary heart disease, hypertension, hyperthyroidism, diabetes, dyslipidemias, hepatitis, and obesity, and these medical conditions may exacerbate the stress and depression associated with bipolar

disorder (Fenn et al., 2005). Furthermore, individuals diagnosed with bipolar disorder often experience greater difficulties with occupational functioning, financial well-being, and relationship stability (Leahy, 2007).

The average age of onset for bipolar I disorder is 18 years old, although late life first onset has been noted in individuals in their 60s or 70s (American Psychiatric Association, 2013). The lifetime course of bipolar disorder is typically cyclical and recurrent and episodes of depression are twice as likely to occur as episodes of mania (Leahy, 2007; Perlis et al., 2006). Studies indicate that, even when individuals are being treated with medication, approximately 40% relapse within 1 year, 60% within two years, and 73% within 5 years (Gitlin, Swendsen, Heller, & Hammen, 1995). Lifetime rates for completed suicide attempts among clients diagnosed with bipolar disorder are 60 times higher than that of the general population (Baldessarini, Pompili, & Tondo, 2006).

Given these observations, there is value in considering how potential connections between bipolar disorder symptomatology and creativity could be addressed in psychotherapy of those with this disorder. For example, creative clients with bipolar disorder may be reluctant to take medication for the illness if they perceive it will adversely impact mood states (e.g., hypomania) that they associate with enhanced creativity. Similarly, if a client identifies aspects of their creative life as inextricably tied to their mood episodes, helping the client to reconsider the role of the disorder in their life (e.g., "What is me? What is my illness?") takes on added complexity. This dissertation provides a critical evaluation of the literature in order to provide a set of treatment recommendations in addressing issues of creativity in the management of bipolar disorder. For the purposes of this dissertation, creative individuals are defined as individuals who

are involved in a creative occupation or a creative field of study. The acronym CPBD (i.e., creative persons with bipolar disorder) will be used throughout the document to refer to creative individuals who have been diagnosed with bipolar disorder.

In order to provide the reader with a contextual understanding of the potential links between creativity and bipolar disorder, a review of relevant literature on this topic follows. This includes: (a) the history of the connection between mental illness and creativity, (b) the subjective experience of clients diagnosed with bipolar disorder, (c) aspects of bipolar disorder that may contribute to creativity, (d) the potential effect of bipolar medications and treatment on creativity. This is followed by a brief review of medication adherence in clients diagnosed with bipolar disorder since pharmacotherapy is an important element of the management of bipolar disorder and enhancing medication adherence is frequently a key component of psychotherapy for the illness. Given that some individuals with bipolar disorder may view aspects of their illness (e.g., hypomania, mania) as facilitating their creativity and/or may view medication as potentially adversely affecting creativity, addressing how a creative life can be maintained while still managing symptoms of the illness (including through use of medication) seems an important clinical endeavor.

Historical Views on Mental Illness and Creativity

Dating back to Ancient Greek times, great thinkers have linked the distress related to melancholia or “madness” with artistic creativity (Akiskal & Akiskal, 2007). While his teacher, Plato, believed that creativity signified inspiration from “madness of divine origin,” Aristotle questioned whether creativity originated from the “indistinct boundary between melancholia and its temperaments” (Akiskal & Akiskal, 2007, p. 2). Pies (2007) argues that

Aristotle was the first to describe bipolar illness by associating melancholy and frenzy as related mood states and notes that Aristotle begins his book *Problemata XXX* with the quote “Why is it that all men who have become outstanding in philosophy, statesmanship, poetry, or the arts are melancholic...?” (p. 9).

Becker (2001) describes that during the following Roman era and Middle Ages, interest and fascination in exceptionally creative persons diminished. However, during the subsequent Italian Renaissance, a renewed curiosity in those with extraordinary creative ability was commenced, and the name *genio* was bestowed upon such individuals. Comparable to the descriptions of Greek poets and philosophers, the characteristics of the Renaissance *genio* were explained in terms of melancholy and *passia*, or madness. However, such descriptions of “madness” were not meant to communicate a perception of insanity; rather, the term suggested characteristics related to a melancholic disposition, such as unconventionality, sensitivity, moodiness, and solitariness (Becker, 2001). However, Wittkower and Wittkower (1963) note that these were not considered negative attributes and imitating these demonstrations of melancholic behavior became fashionable in 16th century Europe (as cited in Becker, 2001).

The term *genius* was introduced during the 18th century Enlightenment, and the prevailing conception of the creative individual shifted once again (Becker, 2001). The new Enlightenment view established judgment, reason, taste, and sensibility as primary components of creativity (Becker, 2001). This emphasis on judgment, Becker (2001) notes, made insanity unlikely for the genius of the Enlightenment period. Wittkower (1973) observes that during the Enlightenment, “artists, known since antiquity for their

propensity for eccentric behavior, complied with an image of the conforming artist” (as cited in Becker, 2001, p. 47).

In the late 18th and early 19th centuries, the prevailing perception of a creative genius was again modified during the Romantic movement: “The romantic artists and men of letters, in particular, revived the classical notion of divine mania or inspiration and established it as a defining mark of the extraordinary individual” (Becker, 2001, p. 48). Again, the concept that mania endowed the genius with a supernatural and unexplainable inspiration that distinguished him from the normal or merely talented man became the prominent idea of the time (Becker, 2001). Consequently, madness, or at least some degree of it, became desirable among poets of the time (Becker, 2001).

Emil Kraepelin (as cited in Jamison et al., 1980), often considered the father of modern psychiatric nosology, noted that the symptoms of bipolar disorder may also provide benefits to individuals in their day-to-day lives, when he stated:

The volitional excitement which accompanies the disease may under certain circumstances set free powers which otherwise are constrained by all kinds of inhibition. Artistic activity namely may, by the untroubled surrender to momentary fancies or moods, and especially poetical activity by the facilitation of linguistic experience, experience a certain furtherance. (p. 198)

Consistent with this observation, Jamison (1996) has written widely on the topic of the relationship between psychopathology and creativity and has found that many prominent, deceased poets, artists, composers, and writers were believed/known to have suffered from bipolar and unipolar depression, such as Emily Dickinson, T.S. Eliot, Sylvia Plath, Ernest Hemingway, and Virginia Woolf. In addition, Jamison also found high

prevalence rates of institutionalizations, suicide attempts, and successful suicides in the sample of creative individuals she examined (Jamison, 1996). Studies of creative individuals indicate that there is also a higher rate of both creativity and affective disorder in their first-degree relatives, suggesting that these traits are genetic and run together in families (Andreasen, 1987, 2011). Andreasen (2011) notes that both James Joyce and Albert Einstein had children with schizophrenia and schizotypal traits.

Becker (2001) proposes that there is a certain *expectation* of “madness” in the contemporary professional belief of what it means to be exceptionally creative, which is rooted in the Greek ideas mentioned previously. Given this assumption, Becker (2001) states that it is not unrealistic to imagine that modern artists and writers, rather than denying an association with “madness,” may actually invite it and unintentionally provide supportive data in psychological and diagnostic examinations. In fact, Becker (2001) points out one of the limitations of the studies conducted by Jamison is that she relied heavily on personal accounts and letters written by the artists she posthumously diagnosed and further noted:

Treating such self-admissions as essentially reliable descriptions of mental illness ... tends to overlook one critical fact: These pronouncements on the part of the creative individuals may involve self-serving descriptions and projections of images that were made in the context of cultural assumptions often quite different from those of contemporary society. In light of these facts, it remains unclear what meaning should be attached to the tendency on the part of many poets and other creative persons to admit to a “touch” of madness. (p. 51)

Becker (2001) theorizes that the association of creativity and madness can be viewed as a role expectation suitable for creative individuals that has its origin in ancient Greece and was reinforced through the Romantics' descriptions of the characteristics of genius. In the same manner that modern scientists, engineers, and accountants are often presumed to be objective, reasonable, and emotionally stable, thus so are artists, writers, and poets expected to display fanciful imaginations, sensitivity, temperament, and emotional expressiveness (Becker, 2001). Some researchers have proposed that individuals diagnosed with bipolar disorder commonly encounter difficulties in finding and maintaining jobs, so that the greater representation in artistic occupations might be a result of social drift to less structured and demanding professions rather than solely a personal creative ability (Vellante et al., 2011).

The evidence offered in support of a correlation between creativity and bipolar disorder is often limited to biographical accounts of eminent individuals, case studies, or other small samples such as distinguished musicians, visual artists and poets and, as previously noted, there are inherent limitations in posthumously diagnosing these individuals with bipolar disorder. In contrast, there may be value in examining the experiences of individuals who have been formally diagnosed and who have received treatment for bipolar disorder to discern the subjective connection they perceive between their creative productivity and phases of their illness. There may be conditions that are inherent in the experience of bipolar clients that push many of them to pursuing careers in the arts.

Client Perceptions of the Relationship Between Illness and Creativity

Though there is a general lack of research in this particular area, the following paragraphs summarize the findings of the relatively few studies that address this specific topic.

Hershman and Lieb (1988) theorize that mild forms of mania and depression are necessary for creativity (as cited in Montgomery, Hodges, & Kaufman, 2004). Hypomania, they argue, assists creative ability by supplying the energy necessary to create, while mild depression assists creative ability by providing the needed critical evaluation for creative output. It follows that there may be value in examining clients' subjective perceptions regarding the relationship between various mood states and their own creativity.

A study by McCraw, Parker, Fletcher, and Friend (2013) focused on self-reports of individuals with bipolar disorder from the general population (i.e., not necessarily creative individuals) regarding their creative experiences. Specifically, the study explored how clients felt when engaging in creative activities, including painting, drawing, writing, music, craft and textiles, business/work ideas, other art activities, life plans/ideas, and home design (the study did not provide an explicit definition of creativity). These researchers found several subjectively experienced advantages and disadvantages related to creative pursuits when the participants were either manic or hypomanic. For instance, some individuals reported that they had an elevated feeling (e.g., "it's bliss for me," "I feel fantastic, on top of everything," "I always felt positive and good about myself during these times and confident that this would achieve my end"), were productive and gained results (e.g., "when I was at work I'd do 3-4 people's job and do all sorts of things, fast, efficient, and tireless," "finish projects, do a lot of things in a short period"), and had improved focus

and clarity. For example, “everything feels clearer and I can see what is wanting to be created,” “useful in ‘sorting out’ or ‘organizing’ my thoughts” (McCraw et al., 2013, pp. 833-834). These experiences may be aspects of bipolar disorder that contribute to increased creativity. Conversely, participants also reported illness-related disadvantages that may impede creativity or hinder creative pursuits, such as overspending money, quitting ideas before completion, experiencing depressed or irritable mood, neglecting other activities (e.g., work, sleep), and harming oneself or others (McCraw et al., 2013).

Parker, Paterson, Fletcher, Blanch, & Graham (2012) found that 14% of clients diagnosed with bipolar disorder (compared to 1% of clients diagnosed with unipolar depression) believed that having a mood disorder helped them be more creative and more successful in their creative pursuits. Interestingly, many of the clients with bipolar disorder observed that their creativity stemmed from low mood periods and was not specific to elevated mood (Parker et al., 2012). However, participants with bipolar disorder in this study wrote about episodes of improved productivity where they were able to achieve many things in a brief time period – but only during “highs.” Additionally, 8% of those with bipolar disorder identified increased productivity and 5% identified increased self-confidence as primary benefits of the condition, which may be related to creative output (Parker et al., 2012). Jamison et al. (1980) found that, in a sample of 61 patients from the UCLA Affective Disorders Clinic, those with bipolar disorder reported experiencing varying degrees of increases in creativity and productivity (along with increases in sensitivity, sexual intensity, social ease, and outgoingness) during hypomania.

Although mania, with its symptoms of flight of ideas, lowered inhibition and increased productivity, may enhance creative output, Andreasen and Glick (1988) argue

that manic and depressive episodes may not necessarily be causally related to creative work output. For example, respondents in their study assessing creative output indicated that they were unable to work during periods of depression and that output created during severe manic periods was of poor quality (Andreasen & Glick, 1988). In addition, work created during episodes of hypomania was also not useful since diminished concentration, distractibility, and increased sociability reduced creative drive (Andreasen & Glick, 1988). This is consistent with Jamison et al.'s (1980) observation that not all manic or hypomanic episodes are euphoric and productive, and that many are highly dysphoric, terrifying, fragmented, and chaotic, rather than gratifying.

Empirical Studies Examining the Relationship Between Mood States and Creativity

Although not directly related to the clinical population of individuals diagnosed with bipolar disorder, a meta-analysis conducted by Baas, De Dreu, & Nijstad (2008) indicates that there is an extensive body of literature studying the effect of mood (e.g., positive, neutral, or negative) on creative problem solving tasks among individuals drawn from non-clinical populations. These studies commonly used objective performance measures of creativity, including fluency (e.g., the amount of non-redundant, unique problem solutions or ideas that a participant produced), flexibility (e.g., the amount of different semantic categories that participants used, and success rates on the ability to change problem-solving methods), originality (e.g., measures of uniqueness or infrequency of produced ideas), insight tasks (e.g., problems that typically need restructuring of presented material to solve the task and have only one known solution), and creativity performance (e.g., ratings which were derived from another individual's evaluation and are not categorizable in the originality, fluency, flexibility, or insight categories; Baas, De Dreu, & Nijstad, 2008).

Mood induction procedures that were used in these studies included (a) imagery techniques (e.g., participants were coached to assume an intentional mood condition through imagination), (b) emotion-inducing materials (e.g., researchers presented study participants with emotional stimuli without the explicitly instructing the individuals to experience the implied mood condition), (c) emotional treatment (e.g., perceived or actual failure or success of performance on a task was controlled so that individuals experienced either negative or positive mood states), and (d) a combination of induction procedures (Baas et al., 2008).

The various aforementioned studies have produced contradictory findings. For example, Ashby, Isen, and Turken (1999) suggested that positive mood results in increased cognitive flexibility and improves creative problem solving. However, other studies in which researchers compared mood states to creative problem solving tasks have found that individuals in a positive mood state may be *less* creative than individuals in a neutral mood state (e.g., Anderson & Pratarelli, 1999) or that negative moods sometimes facilitate creativity to a larger degree than positive moods (e.g., Gasper, 2003). Baas et al. (2008) suggest that, generally, the association between creativity and mood conditions is still inadequately understood. It is essential to consider that the aforementioned studies may not generalize to individuals diagnosed with bipolar disorder, as mood-disordered individuals typically also experience changes in energy, concentration, and thought processes when experiencing periods of elevated or depressed mood, and these changes may not necessarily be experienced by normal individuals who undergo mood induction procedures as study participants. The variety of changes experienced by mood-disordered individuals could potentially impact creativity in various ways.

Other Aspects of Bipolar Disorder That May Impact Creativity

Individuals diagnosed with bipolar disorder demonstrate significant cognitive impairments and deficits in everyday functional outcomes (Wingo, Harvey, & Baldessarini, 2009). Between 30% and 50% of bipolar disordered individuals face substantial social disability that may be associated with persistent cognitive impairment (Dickerson et al., 2004; Zarate, Tohen, & Land, 2000). The severity of the mood symptoms experienced by these individuals is related to the severity of cognitive deficits, but deficits are distinctly still present in individuals who experience less severe mood symptoms (Harvey, 2011). In bipolar disorder, affective symptoms may impact daily functioning through a detrimental effect on the ability to execute critical functional skills, and depressive symptoms seem to affect the motivation to execute conceivably reinforcing behavior (e.g., engage in creative work), possibly through the induction of anhedonia (Harvey, 2011). Cognitive impairments are found in clients with affective disorders, and individuals diagnosed with depressive episodes have mild-to-moderate deficits in cognitive functioning compared with normal controls and compared with the moderate-to-severe deficits found in individuals diagnosed with schizophrenia (Wingo, Harvey, & Baldessarini, 2009). The general profile of cognitive deficits appears similar in schizophrenia, bipolar disorder, and, depression, particularly during periods where symptoms are present (Daban et al., 2006; Harvey, 2011). Deficits include impaired processing speed; impaired capacities for executive functioning, attention, and concentration; and impairments in the speed of learning new information, but not in delayed recall memory (Daban et al., 2006; Harvey, 2011). All of these deficits could potentially affect the creative output of an individual with bipolar disorder.

Furthermore, many clients with bipolar disorder who complain of these cognitive deficits

often attribute these problems to medications that are used to treat their affective symptoms, which in turn places them at a greater risk for medication non-adherence (Burdick, Endick, & Goldberg, 2005).

Considerable research suggests that residual cognitive impairments are also seen in clients who are partially recovered from depression and in a relatively euthymic/residual state, and this finding appears to be consistent cross-culturally (Robinson, Thompson, Gallagher, Goswami, Young, Ferrier, & Moore, 2006; Torres, Boudreau, & Yatham, 2007). These impairments include persistent deficits in processing speed, memory, and concentration, with many clients expressing that they simply do not feel as “sharp” as they had before the onset of their illness (Harvey, 2011; Martinez-Aran, Vieta, Colom, Torrent, Reinares, Goikolea, Benabarre, Comes, & Sanchez-Moreno, 2005; Wingo, Harvey, & Baldessarini, 2009). There are numerous influences that predict more severe impairments in cognitive performance in affective disorders, including a history of psychotic major depression and treatment-resistant depression (Harvey, 2011). In bipolar disorder specifically, the occurrence of mania, depression, and residual dysthymia are related to more serious cognitive deficits than estimations of pre-morbid cognitive performance seen during episodes of euthymia (Harvey 2011).

Depression is a critical factor for understanding functional impairments in individuals diagnosed with bipolar disorder (Harvey, 2011). Clients diagnosed with bipolar disorder experience depressive symptoms associated with increased disability, reduced productivity, adverse impacts on functionally skilled acts, and other indicators of impaired daily functioning (Harvey, 2011; Wingo, Harvey, & Baldessarini, 2009). Motivation is an important concept in regards to everyday functioning, as many daily acts are likely

performed because of their inherently reinforcing results, and depression is known to decrease the capacity to experience pleasure and may lessen the motivation to engage in otherwise reinforcing activities (including creative activities) because of interference with either the pleasure experienced from such activities or the anticipated pleasure that motivates a person to perform them (Harvey, 2011; Wingo, Harvey, & Baldessarini, 2009). The decreased motivation to engage in pleasurable activities experienced by individuals with bipolar disorder during depressive episodes could result in a decrease in creative work. Given that depressive episodes predominate over manic/hypomanic or cycling/mixed episodes in bipolar disorder, the decrease in creative work during depressive episodes can potentially be a significant issue for individuals with bipolar disorder (Judd, Akiskal, Schettler, Coryell, Maser, Rice, Solomon, & Keller, 2003).

Effect of Bipolar Disorder Medications and Treatment on Creativity

Pharmacotherapy is typically considered the first-line treatment for bipolar disorder and long-term maintenance therapy to prevent recurrence is commonly offered to the majority of those with the disorder (Scott, 2006; Smith et al., 2007). Goodwin (2009) provides detailed recommendations for the treatment of various presentations of bipolar disorder, but medication (including mood stabilizers, antipsychotics and antidepressants) remains the primary choice of intervention, supplemented by psychosocial treatments (e.g., psychotherapy). Research indicates that atypical antipsychotics and divalproex (i.e., Depakote) be considered as first-line treatment in bipolar mixed states with lithium and carbamazepine as second-line treatments; however, most individuals will require combination therapy for the treatment of mixed states (McIntyre & Yoon, 2012).

However, similar to other long-term conditions, medication non-adherence among clients with bipolar disorder is a major problem; these individuals are rarely totally adherent, and rates of non-adherence have not substantially improved since psychotropic medications were initially introduced in the 1950s (Crowe, Wilson, & Inder, 2011). Medication non-adherence is commonly defined as taking medications differently from the prescriber's recommendations – using symptomatically instead of prophylactically, reducing dosages and frequency, or temporary or full cessation of the medication regimen (Crowe et al., 2011).

Studies suggest that individuals with bipolar disorder have rates of medication non-adherence ranging from 35% to 65% and often discontinue their medications within the first year of treatment (Berk et al., 2010; Sajatovic, Valenstein, Blow, Ganoczy, & Ignacio, 2006; Scott & Tacchi, 2002). Additionally, as individuals with bipolar disorder age and potentially develop co-morbid illnesses, their medication treatments may become more complicated, increasing the risk for lapses in adherence to complex medication routines (Depp, Lebowitz, Patterson, Lacro, & Jeste, 2007). Medication non-adherence in clients with bipolar disorder is related to increased risk of suicide, higher rates of affective relapse and hospital admissions, and poorer quality of life (Clatworthy, Bowskill, Rank, Parham, & Horne, 2007). The reasons why bipolar clients are often not adherent to medication prescriptions are not well recognized by clinicians, who often assume that non-adherence is primarily related to the disorder itself (Crowe et al., 2011). Medication non-adherence has also traditionally been attributed to 'lack of insight' or 'denial' as a symptom of the illness, but this offers a limited explanation of the reasons related to medication non-

adherence (El-Mallakh, 2007; Keck, McElroy, Strakowski, Bourne, & West, 1997; Pollack, 1995; Yen, Chen, Ko, Yeh, Yang, Yen, Huang, & Wu, 2005).

Horne (2006, as cited in Crowe et al., 2011) suggests that most individuals do not thoughtlessly adhere to treatment recommendations even when trusted clinicians provide them; rather, they are inclined to assess whether the recommendations make sense in light of their personal perceptions and beliefs about the disorder. Many clients have strong negative views regarding medications, including that they are unnatural, harmful, and better avoided, and that clinicians are far too eager to provide prescriptions for psychotropic medications (Horne, Weinman, & Hankins, 1999). Such factors may be relevant to understanding why many individuals, including those with bipolar disorder, may exhibit medication non-adherence.

Despite the deleterious impact that hypomanic and manic states can potentially have, many individuals with bipolar disorder may feel that the high levels of energy and euphoria experienced during mood episodes facilitate creativity. Therefore, they may be reluctant to comply with medication treatment because they may feel that manic and hypomanic states are blunted by psychotropic medications (Andreasen, 2008). It has been noted that a frequent impediment for the use of mood stabilizers, such as lithium carbonate, in the treatment of bipolar disorder is the common belief on the part of the creative person that “tampering with or ameliorating their illness will damage their creative talent” (Rothenberg, 2001, p. 144). It has also been argued by some individuals that experiencing depression may increase their capacity for creativity (Andreasen, 2008). As a result, seeking treatment may be resisted, or once accepted, treatment non-adherence may become an issue (Rothenberg, 2001). Although the use of medication is indicated in

the treatment of bipolar disorder, Andreasen (2008) notes that little empirical work has been done on the subject of psychotropic medications and their effects on creativity.

Another treatment issue for the CPBD is the concern that otherwise effective treatment modalities will cause cognitive impairment, which may in turn affect their creative work (Rothenberg, 2001). It is believed that high levels of cognitive capacity are required for creative activities and there is evidence that treatments such as lithium carbonate or electroconvulsive therapy (ECT) may have deleterious effects upon certain aspects of cognition (Rothenberg, 2001). For instance, research conducted by Shaw, Mann, Stokes, and Manevitz (1986) suggested that the discontinuation of lithium carbonate improved the production of idiosyncratic associations (which may be linked to creative processes) and rate of cognitive processing in clients who had been maintaining a lithium carbonate treatment regimen for an average of 9.4 years. They noted that the restoration of lithium treatment significantly reversed both effects (Shaw et al., 1986). Similarly, ECT, which can be used with severely ill, treatment resistant, or pregnant clients with bipolar disorder, can cause memory loss and dysfunction, which are usually temporary but can become permanent in some cases (Rothenberg, 2001).

On the other hand, as alluded to earlier, contrary to the belief that suffering from mental illness increases the capacity for creativity, many individuals have given anecdotal accounts describing how mood disorders have been disruptive and counterproductive to their ability to create, suggesting that medication may actually assist individuals with bipolar disorder in improving their creativity (Andreasen, 2008). For example, the American poet, Robert Lowell, who suffered from severe bipolar disorder, was described by biographer Ian Hamilton as being more creative *after* being placed on lithium (as cited

in Andreasen, 2008, p. 254). Similarly, a study conducted by Andreasen and Canter (1974) showed that the creative output of writers who suffered from bipolar disorder improved after lithium treatment by lessening disturbances due to the symptoms of mood episode relapses (as cited in Murray & Johnson, 2010, p. 727). Schou (1979) conducted a similar study, and found the efficiency and output quality among 24 artists increased after treatment by lithium in 12 cases (50%), was unchanged in 6 cases (25%), and decreased in 6 cases (25%).

Vellante, et al. (2011) stress that although studies have found the cognitive impact of psychotropic medication on creativity to be small and the overall area is understudied, therapists should be aware of the potential effects psychotropic medication may have on creativity when treating clients involved in artistic, scientific, or otherwise creative professions.

Psychotherapy for Bipolar Disorder

Bipolar disorder is a chronic illness, and new mood episodes are common even in routinely followed clients who are receiving psychiatric treatment (Perlis et al., 2006). Perlis et al. (2006) found that 48.5% of recovered individuals with bipolar disorder (where recovery was defined as having two or fewer syndromal features of mania, hypomania, or depression for at least 8 weeks [consistent with DSM-IV criteria for partial or full remission]) experienced recurrences of depressed, manic, hypomanic or mixed episodes. Recurrence was defined as meeting the full DSM-IV criteria for a manic, hypomanic, mixed, or depressive episode during a follow-up visit (Perlis et al., 2006). Given this statistic, the development of specific psychotherapies for bipolar disorder appears to be a needed and appreciated development (Scott, 2006).

Scott (2006) conducted a systematic review of treatment outcome studies of psychotherapy for bipolar disorder and found that adjunctive psychological therapies reduce overall rates of relapse, but are more effective for preventing new depressive episodes than for new manic episodes. A recent study on the current state of research regarding psychosocial interventions for bipolar disorder found that psychoeducation, family therapies such as family focused therapy (FFT), cognitive-behavioral therapy (CBT), dialectical behavior therapy (DBT), interpersonal and social rhythm therapy (IPSRT), and mindfulness-based cognitive therapy (MBCT) are all effective in reducing symptoms of depression (Salcedo et al., 2016). Specifically, psychoeducational and cognitive-behavioral approaches were found to result in increased time to mood episode relapse or recurrence, and mindfulness-based cognitive therapy was found to be valuable in improving symptoms of anxiety and depression (Salcedo et al., 2016). Gonzalez-Pinto et al. (2003) found that psychoeducational and cognitive-behavioral approaches are effective in preventing new recurrences in clients diagnosed with bipolar disorder who are also receiving drug therapy. Interpersonal and social rhythm therapies, that emphasize the interpersonal events that may increase relapse risk (especially in terms of these events' impact on sleep/wake cycles), offer other approaches to the treatment of bipolar I disorder, especially with respect to prevention of new mood episodes (Frank et al., 2005).

Typical goals in psychotherapy for bipolar disorder include improving acute symptoms, improving psychosocial functioning, preventing relapse and recurrence, preventing rehospitalization, identifying prodromal states, increasing compliance with medical treatment, assisting clients in developing their capacities to deal with socio-occupational stressors and improving the lives of both clients and their families (Craighead

& Miklowitz, 2000; Huxley, Parikh, & Baldessarini, 2000; Scott, 2006). However, the goals for treatment of the CPBD may differ in some ways from the typical goals of psychotherapy with bipolar clients in that the creative person may be concerned with maintaining their subjective creative potential while engaging in psychotherapy and taking psychotropic medications to treat their disorder. However, creative individuals will likely find that many of their goals in therapy will be similar to the general goals of psychotherapy for bipolar disorder, such as preventing hospitalization and coping with socio-occupational stressors, among others. Furthermore, it has been argued that creativity is improved with psychotherapy rather than impeded, and creative individuals may choose to use psychotherapy as a facilitator for their creativity (Rothenberg, 2001). Substance abuse, especially alcohol abuse, is not unusual with CPBDs and also may be a focus for treatment (Rothenberg, 2001).

Artists, in general (i.e., not necessarily just those with bipolar disorder), in psychotherapy may have unique concerns. Rosen (1975) states that, “the artist who believes that his creativity is the result of his inner conflicts is fearful that he will lose his creative talents and drives by undergoing psychotherapy,” while “other artists sense strongly that there are inhibitors and blocks to their creative potential which they hope therapy might free” (p. 137). Rothenberg (2001) posits that one of the obstacles to the treatment of artists diagnosed with bipolar disorder is that creative clients often believe in a correlation between suffering and creativity, and therefore that ameliorating their illness will diminish their creative ability. Similar to the bipolar artist’s concerns that medication may dampen their creativity, so too may they be concerned that psychotherapy could

adversely affect their creative work. Addressing this concern may be an important part of psychotherapy with the CPBD.

Psychotherapy is likely to be an essential piece in the treatment of CPBDs. According to Rothenberg (2001), artists are independent-minded and generally value exploratory activity and would benefit from both the opportunity for self-exploration and the opportunity for change. Furthermore, psychotherapy may help to resolve the conflicts and anxiety connected with creative work, bipolar disorder, and everyday life; promote medication adherence; and may help to develop and maintain a creative identity and confidence in one's creative capacities (Rothenberg, 2001).

Cultural Factors Related to the Treatment of Bipolar Disorder

Cultural factors influence the epidemiology, phenomenology, outcome, and treatment of psychiatric disorders, including bipolar disorder (Viswanath & Chaturvedi, 2012). A number of studies have indicated that cultural background affects the presentation and diagnosis of bipolar disorder (Kirov & Murray, 1999; Strakowski, McElroy, & Keck, 1996). For example, a study by Strakowski et al. (1996) found African American individuals with bipolar disorder were more likely to present with more severe hallucinations and inappropriate sexual or social behavior while Caucasian bipolar patients were more likely to exhibit persecutory delusions. Kirov and Murray (1999) found that African individuals with bipolar disorder were more likely than whites to present with mainly manic symptoms, Afro-Caribbean bipolar individuals were more likely to exhibit mood-incongruent delusions, and Caucasian clients diagnosed with bipolar disorder were more likely to have suicidal ideas or actions. A study by Mackin, Targum, Kalali, Rom, &

Young (2006) suggested that the cultural background of the clinician treating the bipolar individual may also have a direct influence on the diagnosis of bipolar disorder.

In terms of treatment, Viswanath & Chaturvedi (2012) indicate that cultural variances affect the way psychotropic medications are prescribed, the way clients react to medications, and the way they are metabolized and excreted, and note that many of these differences are secondary to genetic mechanisms. Additionally, non-genetic factors such as medication adherence, drug availability and affordability, and explanatory models about psychiatric disorders also play an important role (Kuruvilla & Kuruvilla, 1995). In terms of psychological treatment, types of interventions, types and number of coping strategies utilized by clients, roles of family members in treatment, sociocultural beliefs regarding treatment, degree of stigma related to illness, and the nature of expressed emotion (a construct related to criticism and emotional overinvolvement in the family of the client) may differ cross-culturally (Viswanath & Chaturvedi, 2012). Furthermore, clients of diverse cultures may be more likely to seek out traditional healing practices rather than psychological interventions, and the Western-model of psychotherapy in its typical practice may not be suitable for varied cultures (Viswanath & Chaturvedi, 2012). Given these cross-cultural differences, it is important that mental health clinicians give sufficient attention to the role of cultural factors in the treatment of major mental illness, including bipolar disorder. It is notable that research that examines cultural issues in the context of creativity and bipolar disorder has been lacking.

Summary

The aim of the current project is to provide treatment recommendations for mental health professionals working with CPBDs in therapy. These recommendations will focus on

suggested ways to address issues and concerns related to the impact of bipolar disorder on creativity and medication adherence issues that may directly stem from client concerns related to effects on creativity.

This study is important to conduct as it may provide insight into some of the unique issues CPBDs face in dealing with their illness, and how potential connections between their illness and creativity can be used in psychotherapeutic treatment. The information gathered may potentially be used to understand and inform clinicians of possible obstacles or barriers to medication and psychotherapy adherence in bipolar individuals and address themes that clinicians can bring up with their clients in regards to the perceived relationship between medication, psychotherapy and creativity. The proposed study hopes to advise treatment providers who are prescribing medication and/or providing psychotherapy to CPBDs. To date, limited work has been conducted that proposes treatment recommendations for CPBDs specifically targeting the struggles they face in terms of understanding the impact illness symptoms have on their identity and work and how medication and psychotherapy can help them maintain a creative life. This study hopes to inform medical professionals with valuable treatment recommendations that may help to serve individuals suffering from bipolar disorder. It is the author's hope that clinicians will find value in having a set of suggestions to treat CPBDs.

Chapter 2: Methods

The present study involved a review of the existing literature to devise treatment recommendations for clinicians working with CPBDs. “Creative individuals” is defined in this study as: persons who are either involved in a creative industry (e.g., actively working, in a creative capacity, in the industries of creative writing, visual arts, music, etc.) or persons who are involved in the study of creative arts (e.g., completing university degrees in the areas of creative writing, visual arts, music, etc.). The formulation of treatment recommendations was achieved through systematic review and analysis of both empirical and theoretical writings in the overlapping areas of treatment of bipolar disorder, psychiatric medication/treatment adherence (primarily in the area of bipolar disorder, although literature about psychotropic medication adherence more generally was also utilized), and psychotherapeutic treatment of creative individuals.

This chapter is focused on describing the literature review synthesis strategies that were employed in the proposed dissertation.

Rationale

Although studies have examined the relationship between bipolar disorder and creativity, and other research has studied the rates and issues related to medication and therapy non-adherence in bipolar disorder, this author is aware of only one study (Murray & Johnson, 2010) that has provided specific treatment recommendations based upon both the CPBD’s experience in therapy (i.e., their motivations for commencing treatment, common concerns that arise in working with this population, and suggested interventions for this population, etc.) and experience with medication and psychotherapy compliance (i.e., concerns regarding medication use, their reasons for medication and therapy

compliance/non-compliance, and interventions that have shown to be effective in increasing rates of medication and therapy compliance with this population, etc.). The aforementioned areas were explored to develop a set of recommendations that clinicians can consider implementing in the treatment of CPBDs. It is beyond the scope of this dissertation to actually implement and evaluate the recommendations that are proposed. This limitation of the study will be addressed further in the Discussion section of this document.

General Procedure

First, a comprehensive review of the existing literature on approaches to the treatment of clients with bipolar disorder served to demonstrate what information is already available, and to highlight any gaps in the literature regarding providing treatment to CPBDs.

The second part of the dissertation involves the development of a specific set of treatment recommendations that clinicians can use in the treatment of CPBDs.

Literature Review and Analysis Procedures

Identification of source material and study selection. Three major bodies of literature were reviewed for the conceptualization and development of treatment recommendations. The first literature review was focused on addressing the relationship between the bipolar illness experience and creativity. Specifically, this literature review focused on the following domains: (a) the representation of creative individuals in the population of individuals with bipolar disorder, which provides context regarding the necessity for a set of specific treatment recommendations for this population, and (b) the subjective experiences of bipolar disordered individuals and how the illness potentially

facilitates and/or hampers the creative process in these individuals. Some of this literature had been reviewed in the Introduction of this proposal, to provide readers with background, context, and rationale for the current dissertation. Relevant information from the Introduction section of this document was integrated and reviewed with other literature in the Results section in informing the treatment recommendations.

The second body of work that was examined focused on the treatment of bipolar individuals, including (a) methods for engaging clients in treatment, (b) addressing concerns bipolar individuals have regarding psychotherapeutic and psychiatric treatment, and (c) addressing issues of medication and therapy adherence.

The final area of the literature review focused specifically on the treatment of creative individuals, including (a) literature which addresses specific concerns and issues that creative individuals have regarding psychotherapeutic and psychiatric treatment, (b) literature which identifies how potential connections between bipolar illness and creativity can be used in psychotherapeutic treatment, and (c) literature which proposes general treatment recommendations for creative individuals that can potentially be applied to creative bipolar individuals.

From a review and integration of the three aforementioned areas, a set of treatment recommendations for working with CPBDs was created.

Search strategies. Databases that were explored to gather the data necessary to devise treatment recommendations included search engines for scholarly work such as PubMed, PsycARTICLES, PsycINFO, Scopus, and Google Scholar for all years up to the present, although greater emphasis was placed on literature published within the last 20 years. To guide the literature research in a systematic way, various combinations of the

following keywords were entered into literature databases: *bipolar disorder, creativity, artists, musicians, arts, creative writing, music, visual arts, medication, medication adherence/non-adherence, treatment, therapy, psychotherapy, pharmacotherapy, and therapy*. Emphasis was placed on obtaining information from scholarly sources, such as peer-reviewed articles, and professional books and book chapters. Articles and other literature were examined critically to determine the applicability of the findings and to determine the quality of the findings based on methodology and data reporting. Data with questionable validity, such as data from studies with limited information about methods, or from unreliable sources (e.g., non-peer-reviewed journals, independent websites, etc.), was excluded from the literature review and analysis.

Development of the program content. Findings from the comprehensive literature review were systematically evaluated to inform a specific set of proposed treatment recommendations. Literature obtained from the above mentioned sources was reviewed multiple times to ascertain themes and to determine relevant findings. The author selected several of the most effective treatment recommendations based upon those strategies for which there is the strongest empirical support in the literature as the foundation for a specific set of treatment recommendations that will aid clinicians in the treatment of CPBDs. For example, recommendations emerging from studies employing a randomized controlled design were given more weight than findings from uncontrolled trials or from case studies. In cases where extensive empirical research has not been conducted (e.g., psychotherapy of creative individuals), the literature was analyzed for recurrent themes and commonalities that emerged across studies. As there may not be extensive recommendations for this specific population available in the literature, the

author also generated unique and original recommendations that were informed through analyzing and synthesizing information gathered from the different related bodies of literature. For example, any recommendations that emerged from a review of literature on psychotherapy with creative individuals was adapted to the unique issues/presentation of individuals with bipolar disorder.

Based upon the identification of critical treatment recommendations from the literature and the generation of unique and original treatment recommendations, a set of general recommendations and guidelines was developed which informs clinicians regarding the treatment of CPBDs. The model was written in the form of a booklet that can be delivered to clinicians treating this population. This pamphlet appears in Appendix A of this document. The proposed resource is organized as follows:

- The program opens with a brief description of the purpose and goals of the guidelines and recommendations.
- The next section describes critical background information regarding the intersection of creative individuals and bipolar disorder, including the psychological impact of bipolar disorder on individuals' creativity.
- Information about the lack of and need for specific recommendations for this population is highlighted.
- A plan is proposed regarding the treatment of CPBDs. It includes specific suggestions for the treatment of this population, including engaging creative individuals in treatment, addressing the relationship between illness and creativity, exploring concerns clients may have regarding psychotherapeutic and

psychiatric treatment, addressing the unique concerns and issues that CPBDs face, etc.

- A discussion of how to adapt to limitations of the proposed program with respect to diversity of the clients is provided. Specifically, recommendations for understanding cultural diversity factors in the context of psychological intervention are addressed.

Chapter 3: Results

The following section consists of information regarding the treatment of CPBDs, followed by a resource (i.e., booklet, Appendix A) that succinctly summarizes key suggestions and is formatted in a user-friendly design for distribution to clinicians.

The Need for Psychosocial Treatments in the Treatment of Bipolar Disorder

While the breakthrough of lithium carbonate as a medication for bipolar disorder had previously led clinicians to believe that the illness is a purely biological process responsive to treatment by medication alone, it has become evident in the past 25 years that pharmacotherapy alone is an insufficient treatment (Crowe et al., 2010; Frank, Swartz, & Kupfer, 2000). Even clients who receive optimal medication treatment are likely to have recurrent affective episodes, employment difficulties, and trouble maintaining relationships (Perlis et al., 2006). This points to the need for psychosocial interventions in the treatment of bipolar disorder. Indeed, a number of psychotherapies have either been developed or adapted for the treatment of bipolar disorder in response to the poor functional recovery and on-going sub-syndromal symptoms associated with this illness (Crowe et al., 2010).

Modifying Therapies for Use with the Creative Bipolar Client

Modifications may be necessary to adjunctive therapies for the treatment of the CPBD. For example, psychoeducation may include a component that focuses on the unique concerns and needs faced by the CPBD (Murray & Johnson, 2010). Some of these unique concerns and needs are discussed later in this chapter.

The presentation of information and therapeutic strategies chosen should be evaluated with consideration of the values and the sociocultural context of the CPBD

(Murray & Johnson, 2010). For example, it may be helpful to consider personality traits (e.g., Neuroticism, Expressiveness, and Openness, which are often seen in creative individuals), cognitive styles, and beliefs in the value of intense emotion (Murray & Johnson, 2010). Traits of Expressiveness may lead individuals to feel more comfortable with group therapy (Miller, 1991). Additionally, creative clients may prefer to be in a therapy group of people in the arts, as they can provide several different perspectives and empathize with an artist's unique struggles (Schoenewolf, 2002). Internet-based treatments, which provide accessibility across geography and time, may be beneficial for creative clients who travel often due to their work (Marks & Cavanagh, 2009; Murray & Johnson, 2010).

The American Psychological Association recommendations (2006) suggest that best research evidence is only one driver of evidence-based practice. Clinicians should also consider individual client attributes, ideals and context, and they should use clinical proficiency when developing treatment plans and conceptualizing case formulations (Murray & Johnson, 2010). Murray and Johnson (2010) posit that creativity may be a potential moderator and mediator of psychological treatment of certain clients with bipolar disorder (e.g., the creative client may be more apt to engage in psychological treatment and find greater treatment success if their creativity is valued in the therapeutic relationship and used as a treatment tool to bring about psychological change), and recognizing these connections can enhance the therapeutic relationship, case formulation, and treatment planning. Given that, compared to the general population incidence of approximately 1%, several research projects have suggested that 10% of artists experience symptoms of bipolar disorder (Goodwin & Jamison, 2007; Rothenberg, 2001) and about 8% of

individuals diagnosed with the illness may be described as creative (Akiskal & Akiskal, 2007), the use of creative activities in psychological treatment of creative individuals with bipolar disorder may be relevant and effective.

Creative activities have long been thought to be therapeutic. As Petrillo and Winner (2005) point out, Plato believed that music could “calm the soul,” while Aristotle believed that dramatic tragedy had cathartic effects. Furthermore, Freud viewed the arts as cathartic, and argued that creative works allow both the creative individual and the audience to expel unconscious instinctual wishes resulting in pleasure and relief from anxiety (Petrillo & Winner, 2005).

Hacking et al. (2008) found that clients with mental health needs who participated in creative activities (i.e., community art projects) experienced increased levels of empowerment and improvements in mental health difficulties and social inclusion. A study by Petrillo and Winner (2005) found that creative activities (i.e., drawing) could improve mood via catharsis or redirection (e.g., distraction) from rumination on negative feelings. In therapy, creative activities can promote therapeutic rapport (Dalley, 1984; Schaverien, 1995), afford clients a means of communicating unconscious feelings nonverbally (Carter, 1996), and allow clients to externalize and thereby resolve conflicting emotions (Bernstein, 1995; Kramer, 2000; Petrillo & Winner, 2005; Waller & Gilroy, 1992). Heenan (2006) found that creative activities used in a therapeutic context improve clients’ self-esteem and self-confidence and provide a safe space for reflection on mental health issues. Leckey (2011) found that creative activity could have a curative and protective effect on mental well-being, through promotion of relaxation, through a means of self-expression, and through reduction of blood pressure while simultaneously boosting the immune system and

reducing stress. As Petrillo & Winner (2005) point out, “if artmaking genuinely improves people’s moods on the dimension of pleasure, then it is no wonder that people choose to make art under dire circumstances, as testified by the art of concentration camp inmates” (p. 211). Furthermore, as Heenan (2006) posits, the significance of creativity as beneficial for healthy human development and healing from mental illness is widely recognized among international cultures.

In a study examining the psychotherapy participation rates of successful jazz musicians who were addicted to heroin, the researchers found that, compared to control patients (i.e., heroin-addicted jazz musicians who did not participate in psychotherapy), those individuals who remained active in their treatment bettered their standing in the music profession and secured better occupational opportunities; several of the individuals in treatment more than doubled their incomes. Additionally, those who were attending therapy for their addiction improved significantly in the areas of drug use cessation and social adjustment (Winick & Nyswander, 1961). When examining the differences between study participants who stayed in treatment and participants who stopped attending treatment, Winick and Nyswander (1961) found that the participants whose presenting problems were associated with varied severe life problems rather than with substance abuse had a better retention rate than those who presented with substance abuse as their main problem or indicated that they were referred to the clinic by an authority figure whom they wanted to please. Although this study is not directly related to the treatment of CPBDs, the findings are likely to be relevant since the study involved the treatment of creative individuals with serious mental health problems. Furthermore, Wills (2003) conducted a study of prominent jazz players and found high rates of mood and psychotic

disorders, along with substance abuse. Based on this research, clinicians may want to help clients identify major life difficulties or problems that could be a focus for therapeutic treatment rather than solely focusing on symptoms of their psychiatric illness. These life difficulties or problems may be specifically related to the client's creativity (e.g., writer's block), though they may also be unrelated to their creativity, such as relationship problems.

Winick and Nyswander (1961) noted that a number of the jazz musicians participating in their psychotherapy program had trouble communicating verbally with their therapists, preferring to "talk" through their musical instruments. This may be the case with other creative individuals who may find it easier to express themselves through their medium of choice (e.g., creative writing, visual art, etc.) and this may indicate that their creative outlet could potentially be used in therapy as a tool for self-expression and growth. Additionally, a study by Taylor, Fletcher, and Lobban (2015) found that creative activity could mediate mood symptoms and improve feelings of well-being, indicating that clients' creative talents can be used in psychotherapeutic work and also facilitate self-management of mood outside of therapy sessions. Likewise, Schoenewolf (2002), who was the director of The Living Center in New York City (a cooperative of therapists who specialize in working with people in the arts), suggests that art therapy interventions are effective with creative clients, and that therapy can use art as a way to access clients' underlying conflicts. Introducing art therapy interventions into sessions may be an effective way at getting past clients' defenses that may arise when solely communicating verbally (Schoenewolf, 2002). Schoenewolf's text (2002) focuses on ten case studies of creative individuals he treated.

Creative narrative writing has also been found to be an effective therapeutic intervention. Smyth (1998) found that written disclosure studies indicate that, generally, writing about emotional themes is connected to increases in positive mood and significant reductions in stress. As Pennebaker (1997) points out, “a process common to most therapies is labeling the problem and discussing its causes and consequences...the mere act of disclosure is a powerful therapeutic agent that may account for a substantial percentage of the variance in the healing process” (p. 162). Pennebaker (1997) suggests when people are provided the chance to divulge profoundly personal aspects of their lives through written disclosure, they willingly do so, and that the overwhelming majority of patients who partake in therapeutic writing indicate that the writing experience is valued and meaningful in their lives.

Another finding from the research by Winick and Nyswander (1961) was that those patients who had sufficient foreknowledge of what therapy was were more likely to continue in therapy; this indicates that psychoeducation about the nature and process of psychotherapy may be an important key in improving treatment adherence with creative clients.

Challenges Faced by the Clinician Working with the Creative Bipolar Client

Working with creative individuals can provide many challenges and opportunities. Creative ability is greatly regarded in western nations, and the clinician should therefore be cautious not to idealize the individual’s creative achievements and capacities. Although it is important to respect the importance the client may place on their own creative achievement and capacities, it is equally important to emphasize focus on the client’s recovery from bipolar disorder. Furthermore, the therapist must be careful to not endorse

the common notion that psychopathology is necessary for creativity (Murray & Johnson, 2010). Conversely, many correlates of bipolar disorder and creativity, including positive affect, a motivation to succeed, high energy levels, and an openness to experience, can be considered strengths and can all contribute to positive outcomes in the right context (Murray & Johnson, 2010).

Schoenewolf (2002) suggests that working with creative clients requires a special therapeutic approach. First, he states, the therapist must communicate an understanding of the importance of the arts, either by demonstrating that the therapist is an artist him/herself, or by showing an appreciation of the arts. Second, Schoenewolf (2002) recommends that the therapist must demonstrate an understanding of a special kind of sensitivity that most artists embody (which he terms “neurotic sensitivity,” p. 66), which makes them susceptible to emotional disorders. Finally, he indicates that the therapist must understand that creative clients must create, and they cannot be fulfilled unless they actualize their creativity in some way (Schoenewolf, 2002).

General Considerations for Intake, Diagnosis, and Treatment Planning

Intake. Creative persons may not be motivated by a medical-model of treatment as the path to mental health (Rothenberg, 2006). Impulsive expression of needs and emotions can be related to creative accomplishments in science and art, and creative clients may not want to feel constrained. Creative individuals may perceive defining and quantifying symptoms as being at odds with a Romantic perspective in which feeling is prized over reason (Murray & Johnson, 2010). During intake discussions, it is suggested that therapists openly consider goals of therapy, including a discussion of which parts of spontaneity the clients may want to retain (Murray & Johnson, 2010). In conceptualizing and planning

treatment, diverse aspects of the creative client such as environmental challenges, personality characteristics, and values should be considered (Murray & Johnson, 2010).

During this initial phase, it may be helpful for clinicians to initiate a discussion with the client regarding the structure of the intake and treatment to address any unique concerns the client may have. Although it is important to gather information regarding affective symptomatology and establish goals for treatment, CPBDs may prefer a high degree of flexibility throughout the intake process. The creative individual may want their “story to be heard” and might want to retain control over the direction of the interview. The clinician should weigh the importance of gathering relevant historical information against allowing the client greater free reign to tell his or her story. This issue is complicated by the fact that determination of a bipolar disorder diagnosis requires careful evaluation of the scope and duration of different mood episodes, which necessitates symptom-based and temporally-oriented questions (which could be viewed by the client as medically oriented). For these reasons, it may be necessary to extend the intake process and clinicians might want to plan to conduct the intake with the CPBD over the first few sessions.

Diagnosis. As previously noted, an accurate diagnosis of a bipolar disorder involves careful determination of whether the client has experienced specific constellations of symptoms and the severity and duration of such symptoms. Misdiagnosis of bipolar disorder as unipolar depression, for example, may delay treatment and worsen prognosis (Angst & Cassano, 2005). A study by Ghaemi, Boiman and Goodwin (2000) indicated that clinicians misdiagnose bipolar disorder as unipolar depression in 37% of clients visiting an outpatient clinic. Bipolar clients often come to the attention of clinicians when they are in a

depressive phase and seeking relief from their symptoms, and past symptoms of mania or hypomania may go undetected (Angst & Cassano, 2005). Furthermore, creative individuals may value certain symptoms of manic or hypomanic phases (e.g., decreased need for sleep, flight of ideas, elevated mood) that may be perceived as contributing to their creativity. As such, creative clients may be less likely to report these symptoms as being troublesome in their lives. A comprehensive psychosocial history must be obtained by clinicians to ensure that clients with bipolar disorder are not misdiagnosed as having unipolar depression.

When asking about client's symptoms, clinicians may want to obtain a history of symptomatology as related to creative work output. For example, asking clients if there were ever times when their creative work output was higher than normal or times they were feeling so low, unmotivated, or distractible that they were unable to produce creative work are possible ways of assessing for symptoms of mania or depression, respectively. It would also be relevant to inquire about the factors creative clients believe most benefit their artistic work as a way of assessing symptoms of bipolar disorder (e.g., does a client experience flight of ideas which might provide for multiple novel and unique artistic ideas?). This line of questioning may also help to reveal a client's perception of the relationship between his/her creative output and his/her bipolar disorder.

Clients diagnosed with bipolar disorder often experience some ambivalence towards treatment (Leahy, 2007). Acceptance of the diagnosis of bipolar disorder often takes time, and can be a process in which clients return to the question of whether to continue several times throughout the course of treatment (Newman, Leahy, Beck, Reilly-Harrington, & Gyulai, 2002). Given that hypomanic episodes seen in milder forms of the disorder (e.g., Bipolar II Disorder) may not markedly interfere with the client's functioning,

those with less severe symptoms of the disorder may value some of the advantages seen with the disorder, including boosted energy, sociability, and rapider thinking (Murray & Johnson, 2010). Therefore, some clients may be more hesitant to accept a diagnosis or may be less motivated to engage in treatment for their bipolar disorder. Furthermore, it has been suggested that some clients diagnosed with cyclothymia, characterized by more frequent, sometimes fairly persistent, mood fluctuations, may see their affective variations and sensitivity as an aspect of their individual character, rather than as symptoms of a clinical disorder (Akiskal & Akiskal, 2007). If creative ability is seen as part of one's self-identity, then psychotherapy may best be considered as a developmental process, in which identity and self-creation consolidate to moderate the course of the illness (Murray & Johnson, 2010; Rothenberg, 2006). During the course of therapy, the clinician and client may be faced with certain existential questions regarding the relationship between the client's creative identity and their illness; for example, how might the client view their own identity after a diagnosis of bipolar disorder? Which aspects of their personality might be part of and separate from the disorder and what meaning might this have for the client? What does it mean that we might be trying to treat the very symptoms that clients have found beneficial to their creativity?

Viswanath and Chaturvedi (2012) suggest that culture greatly impacts the way in which symptoms of depression are manifested. A 1983 study by the World Health Organization (as cited in Viswanath & Chaturvedi, 2012) indicates that patients assessed for core depressive symptoms from Basel, Montreal, Tehran, Nagasaki, and Tokyo all had several symptoms in common, including lack of interest and energy, anhedonia, sadness, impaired concentration, and ideas of worthlessness. However, feelings of guilt and suicidal

ideation were least common in patients assessed from Tehran (Viswanath & Chaturvedi, 2012). Other studies have indicated that guilt is less common in Indian patients than patients from western countries and that physical symptoms are a more common presenting problem for Indian patients who suffer from depression (Viswanath & Chaturvedi, 2012). Additionally, disorders of conduct and somatic complaints were more common in non-western societies in patients assessed for depression (Viswanath & Chaturvedi, 2012).

In regards to manic symptoms, research has found a higher rate of grandiose and persecutory delusions, delusions of reference, and delusions related to sexual or religious themes in Indian patients than those in the west (Viswanath & Chaturvedi, 2012). Additionally, hostile irritability is common among Indian manic patients and recurring episodes of mania are more common in India and tropical countries than it is in western societies (Viswanath & Chaturvedi, 2012). Such cultural differences should be considered when diagnosing clients of varied cultural backgrounds and are a reminder to clinicians that questions regarding mood and related symptoms should be broad and should not assume that the same constellation of symptoms are likely to characterize individuals with bipolar disorder.

Treatment planning. As Kogan (2002) points out, creative performers (e.g., musicians, singers, dancers, and actors) are often members of a team when executing their creative work and most performers function in a social context. Considering this, creative individuals may appreciate a collaborative approach to treatment planning where their ideas are welcomed and valued. Also, elements of psychoeducation (discussed in more detail later in this chapter) may be beneficial to discuss with the client at this stage.

Additionally, individual challenges that the CPBD faces must be assessed. Murray and Johnson (2010) suggest five features of creative professions that may pose significant challenges to the CPBD: substance misuse, occupational stress, reinforcement of emotionality, challenges to goal regulation, and irregular sleep and activity schedules. Although not universally seen in all creative professions, these features are common in many artistic lifestyles, and may be counterproductive for individuals diagnosed with bipolar disorder. Additional features that can pose challenges to the creative client are impulsivity, legal difficulties related to their illness, hospitalizations, and relationship problems. Effective treatment planning necessitates proper assessment to determine whether these variables are factors in the lives of CPBDs (Murray & Johnson, 2010).

Instillation of hope is an important activity for the mental health clinician to engage in at this stage of treatment. A discussion with the client of the prognosis of treatment and the idea that bipolar illness does not necessarily mean the individual will lead an unproductive or unsatisfying life can aid in the instillation of hope. A study conducted by Ettner, Frank, and Kessler (1997) found that, in a sample of 4,626 people from the National Comorbidity Survey, the employment rates of people with a current diagnosis of mania or depression range between 71-90% as compared to employment rates of 82%-93% of those with no psychiatric diagnosis; this indicates that employment rates for individuals diagnosed with bipolar disorder may not uniformly be worse than those for individuals with no diagnosis or diagnosed with other disorders. Encouragingly for the CPBD, Tremblay, Grosskopf, and Yang (2010) found that higher concentrations of individuals diagnosed with bipolar disorder are found in professional and managerial occupations, which include authors, musicians and artists, and that the likelihood of having a job that

involves creative activities is higher for individuals diagnosed with bipolar disorder than the normal population.

Clinicians should consider cross-cultural differences in standards of treatment. Viswanath and Chaturvedi (2012) indicate that physical treatments (e.g., electroconvulsive therapy) are more common in developing countries such as India. Additionally, clients of different cultures may choose to participate in traditional healing practices that can be used in conjunction with psychotherapy, and it is essential for clinicians to understand the ideas, classification, and management of other treatment modalities in order for the treating therapist to have effective liaisons with other treating health professionals (Viswanath & Chaturvedi, 2012). The therapist may want to consider other variables when planning treatment with clients of different cultures, including: (a) use of religion or spirituality, (b) family involvement (i.e., clients of non-western cultures may prefer more active family involvement), (c) lower emphasis on individual responsibility and autonomy (e.g., non-western cultures value collectivism and interdependence over individualism and autonomy), (d) the power differential between therapist and client (e.g., in Indian societies, the doctor is considered superior and the patient undertakes a passive role), (e) greater active participation by the therapist (e.g., therapists working with clients from developing countries may need to be more active and direct), and (f) single session therapy use for the poor and underprivileged (Viswanath & Chaturvedi, 2012).

Specific Psychotherapy Treatments for Bipolar Disorder

In a systematic review of psychosocial interventions for bipolar disorder, Crowe et al. (2010) divided the interventions into five categories: (a) individual or group psychoeducation, (b) family intervention, (c) interpersonal rhythm therapy, (d) cognitive-

behavioral therapy, and (e) intensive therapies. Particular features of these treatments may need to be adapted to improve therapeutic outcomes of CPBDs (Murray & Johnson, 2010). Though Salcedo et al. (2016) cover additional therapeutic modalities that may be beneficial in the treatment of bipolar disorder (i.e., DBT, MBCT), there are fewer studies examining these modalities compared to the treatments reviewed by Crowe et al. (2010).

Psychoeducation. Psychoeducation, which can be offered to clients in group or individual formats, may be a useful tool for strengthening the creative bipolar individual's commitment to treatment. Assuming that a CPBD's personal goals likely include improved creative output, one argument for strengthening client commitment to treatment could potentially be that clients with less severe symptoms of bipolar disorder may accomplish more creatively than those who are experiencing more severe symptoms. A study by Richards, Kinney, Lunde, Benet, & Merzel (1998) suggested that individuals with milder forms of bipolar disorder (e.g., bipolar II disorder, cyclothymia) have greater accomplishments than those with bipolar I disorder, and healthy relatives of individuals diagnosed with bipolar disorder had higher creative output than individuals with the illness. Likewise, in a study of prominent writers, more participants met criteria for bipolar II disorder (30%) than for bipolar I disorder (13%; Andreasen, 1987).

Furthermore, mood may be a mediating variable in strengthening client commitment to treatment (Murray & Johnson, 2010). Positive affect has been shown to be associated with increased fluency and originality, both considered to be related to creativity (Fredrickson, 2001; Mumford, 2003). Several studies have indicated that moderate positive affect supports creativity (as opposed to low or extreme states of emotion, which may hinder creativity; Davis, 2009; De Dreu et al., 2008). Furthermore, a

study by Schuldberg (2000) suggested that creativity was positively associated with hypomanic mood states and negatively correlated with depressive mood symptoms. This might suggest that the extreme positive affect seen in manic episodes and extreme negative affect seen in depressive episodes are counterproductive to creative output, while moderate levels of happiness (and possibly even moderate levels of sadness), may improve creative output. It may be important for the clinician working with the CPBD to provide psychoeducation to the client regarding how elevated mood is a symptom seen in manic and hypomanic states, but this symptom does not occur in isolation in mania or hypomania. For example, elevated mood may be accompanied by distractibility and increased goal-directed activity that carries a high risk of negative consequences and these symptoms may detract from or disrupt the client's creative work. Thus, the bipolar client who wishes to retain the perceived benefits of euphoria may place him/herself at risk for a full-blown mood episode that carries a high likelihood of impairment.

Interestingly, Schoenewolf (2002) posits that emotional disturbances do not enhance art; rather, they create blockages for creativity and prevent artists from being able to create or result in the artist creating distorted works. Schoenewolf (2002) suggests that by resolving such emotional disturbances and underlying conflicts in therapy, creative blocks are diminished, and the artist's flexibility and objectivity are increased, so that their output has a more universal appeal. If overcoming creative blocks is a goal of the creative client, then educating the CPBD that they can overcome creative blocks, in part by managing illness symptoms, may help to enhance their treatment adherence.

Creative blocks are often related to traumatic events early in one's life (Schoenewolf, 2002). One way to help creative clients overcome creative blocks is to help

the client work through resistance to remembering and then talking about how, for example, writer's block is related to traumatic aspects of the client's childhood (Schoenewolf, 2002). When such resistances are worked through, Schoenewolf (2002) states, many other areas of a client's life may also improve, including improved relationships, abstaining from substance use, and better overall functioning. A history of childhood trauma (including emotional, physical, and sexual abuse, and neglect [both emotional and physical]) is found in 25% to 70% of individuals diagnosed with bipolar disorder, and a history of childhood trauma is associated with greater severity of symptoms (Cakir, Durak, Ozyildirim, Ince, & Sar, 2016; Etain et al., 2013; Larrison et al., 2013). Given the high prevalence of and severity of symptoms associated with childhood trauma, working through issues related to traumatic events may be an important piece of therapeutic work with CPBDs.

Many clients believe that their creative work is promoted by episodes of elevated mood and energy, although, as noted earlier, such output may be of poorer quality (Murray & Johnson, 2010). Evaluating and challenging the belief that manic periods are always beneficial to creative output may be an important part of the work in therapy. Schuldberg (2000) notes, creative accomplishment requires attention to detail and analytical thinking that may be impaired during manic or hypomanic episodes. Murray and Johnson (2010) posit that clinicians should provide evidence to clients that creativity is not necessarily linked to episodes of mania, that people with histories of hypomanic episodes tend to have more creative accomplishments as compared to people with histories of mania, and that normal family members of bipolar clients tend to have more creative accomplishments than individuals with histories of hypomanic episodes. It may be helpful for the therapist

to ask the client to recall times when (s)he displayed creative output that was associated with euthymic mood, as a way of illustrating that mood disturbance is not “an essential ingredient” in the creative process nor in one’s identity as a creative person. Similarly, when reviewing periods of increased creative output that the client links to a period of mania or hypomania, it may be helpful to discuss additional consequences of those particular mood episodes that were not as positive (e.g., increased conflict in interpersonal relationships, engagement in high-risk behaviors that resulted in negative consequences, etc.).

Similarly, many artistic clients may believe that suffering is necessary to promote or influence their artistic vision (Schoenewolf, 2002). Schoenewolf (2002) suggests that, in fact, suffering that has been understood and processed may actually help clients in their creative work, but many patients believe that any tampering with their “neurotic sensitivity” may harm their artistic talent. Helping the client to reframe how they see things and change their self-defeating attitudes may help clients remain in therapy and reevaluate the role of their illness in their creative life and understand how their illness can be destructive (Schoenewolf, 2002).

Additionally, psychoeducation with the CPBD should address self-management strategies that the client can use to stay well. A study by Russell and Browne (2005) indicates that these strategies may include acceptance of the diagnosis, psychoeducation regarding the illness, identification of triggers and warning signs of mood episodes, sufficient sleep, stress management, medication adherence and social support. A similar study found six content themes that clients found to be useful in their self-management strategies: (a) sleep, rest, exercise and diet, (b) paying close attention to moods and

behavior, (c) enacting a plan when the client recognizes an impending manic or depressive episode (e.g., a Wellness Recovery Action Plan [WRAP]), (d) mindfulness and/or reflective practices (e.g., meditation, Tai Chi, journaling, praying), (e) understanding bipolar disorder, and (f) maintaining social and professional support and connections (Suto, Murray, Hale, Amari, & Michalak, 2010). Presumably, for the creative client, participation in creative activities would be added to this list.

The nature of creative work may result in the CPBD associating with friends and colleagues who may encourage spontaneity and who also may have irregular schedules. This would pose another challenge to the creative client (e.g., disrupted sleep schedule) and it may be beneficial for the clinician to initiate a discussion regarding how the client could address these issues with friends and colleagues. Specific techniques that may help the client address these issues with friends and colleagues may be to develop a “script” with the client which they can use in difficult interpersonal situations and to roleplay those potential situations with the client. Further, therapist and client may want to discuss techniques for limit-setting with individuals who are not respectful of these specific needs of the client. Such a discussion might also raise issues of to whom and in what ways does the client feel comfortable disclosing the illness to others.

In regards to cultural considerations, Jacob (2010) suggests that clients and relatives of clients from different cultures may offer non-medical explanations for the client’s disorder, such as black magic, evil spirits, sin, punishment by God, karma, etc. Additionally, some clients and relatives of clients may simultaneously have medical, non-medical, religious, and supernatural explanations that are often contradictory (Jacob, 2010). When multiple types of explanations are held, clients may concurrently seek bio-

medical and non-biomedical interventions (Jacob, 2010). Psychoeducation with the client may include a discussion surrounding which explanations they hold and which types of interventions they have sought out. Jacob (2010) suggests contrasting the beliefs held by clients with those of their culture in order to determine similarities in the explanations for their illness.

Family interventions. Family stress and other familial factors can affect the bipolar individual regardless of whether or not the individual lives at home with their family (Miklowitz, 2007). High expressed-emotion (EE) attitudes in families contribute to the stress the bipolar individual faces. High EE attitudes are characterized by elevated degrees of criticism, hostility, and/or emotional over-involvement from a family member (usually a spouse or parent) during or immediately after a bipolar client's acute manic or depressive episode, and clients who return to a so-called high EE household following illness episodes are two to three times likelier to experience a relapse in the following 9 months (Miklowitz, 2004, 2007). A need for family interventions in such family systems is clearly present, and such findings more generally suggest that decreasing stress within the family environment of those with bipolar disorder is beneficial as well.

Family interventions such as Family Focused Therapy (FFT) for bipolar disorder are largely psychoeducational in nature and clients are instructed to identify and distinguish symptoms and signs of the illness, create strategies for early intervention with new episodes, and increase medication adherence and consistency (Miklowitz, 2004). FFT begins shortly after a client's acute mood episode, involves the client and at least one family member, is conducted in 21 sessions over 9 months, and consists of three modules: (a) psychoeducation, (b) communication enhancement training, and (c) problem-solving skills

training (Miklowitz, 2004). Research has found FFT to be effective in the treatment of clients diagnosed with bipolar disorder and study participants who underwent a course of FFT treatment were found to have better symptomatic and global functioning as compared to patients who received standard hospital care (Miklowitz & Otto, 2006).

Family interventions such as FFT may be appropriate for creative individuals considering that creativity likely runs in families, so the characteristics and challenges faced by creative individuals may also be seen in their family of origin, possibly aggravating susceptibilities and stressors (Murray & Johnson, 2010; Reuter, Roth, Holve, & Hennig, 2006; Simeonova, Chang, Strong, & Ketter, 2005). Additionally, research has shown evidence for elevated insecure attachment in musicians, which creates challenges and opportunities for family-based work (Costello, 2007; Murray & Johnson, 2010). Murray & Johnson (2010) point out that career-development problems specific to creative professions may be an obstacle to economic independence and occupational growth, which may cause further family tensions.

Interpersonal social rhythm therapy. Research has emphasized the link between psychosocial stressors and changes in biological rhythms in bipolar illnesses (Ehlers, Frank, & Kupfer, 1998; Ehlers, Kupfer, Frank, & Monk, 1993). Life events associated with alterations in daily routine that can be considered generally benign to normal individuals (e.g., jet lag, or change between standard and daylight savings time) can put significant stress on an bipolar individual's physiological system and its efforts to preserve coordinated energy, appetite, sleep-wake, and alertness cycles that characterize euthymic conditions (Frank, 2007). For most persons, the effects of such disruptions abate quickly as we adjust to new routines. However, clients with vulnerabilities to affective disorders may

have a harder time adjusting to such disruptions and may potentially remain in the cognitive and somatic states associated with disrupted circadian rhythms (Frank, 2007). Subsequently, these individuals may experience such states as fully syndromal periods of mania or depression (Frank, 2007). Frank (2007) suggests that principles of social rhythm stabilization, then, should be an integral component of the treatment of bipolar disorder.

Interpersonal Social Rhythm Therapy (IPSRT) assumes a preventative approach to the recurrence of affective episodes by applying social rhythm theories to the treatment of bipolar disorder (Frank, 2007). The goals of IPSRT include the stabilization of clients' routines while improving the quality of clients' interpersonal relationships and fulfillment of social roles (Frank, 2007). IPSRT aims to improve clients' current mood and functioning and impart clients with skills that will prevent future affective episodes (Frank, 2007).

Two large-scale studies have supported the effectiveness of IPSRT as an adjunct treatment to psychopharmacotherapy in regards to treating bipolar disorders. A study by Frank et al. (2005) indicated that clients who were assigned to treatment with IPSRT (as opposed to intensive clinical management [ICM], focusing on psychoeducation regarding BD and medication management) persisted longer without a new mood episode and had higher consistency of social rhythms than those assigned to treatment with ICM. In the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD), which examined three psychosocial treatments for bipolar disorder (i.e., family-focused therapy, IPSRT, and cognitive behavioral therapy for bipolar disorder) as compared to collaborative care (CC, which was comprised of three psychoeducational sessions over six weeks), clients who received intensive therapy had significantly higher year-end recovery rates and

shorter times to recovery than those clients placed in the CC control condition (Frank, 2007).

Goodwin and Jamison (2007) propose that psychosocial causes may interact with biological causes to create three likely pathways to the relapse of mood episodes: (a) disturbances in social rhythms, (b) non-adherence with medication, (c) and stressful life occurrences. IPSRT targets each of these probable pathways through education regarding medication-adherence, the provision of space to explore feelings about their disorder and grieve “the lost healthy self,” and the addressing of clients’ interpersonal and social role difficulties (Frank, 2007). Additionally, IPSRT encourages clients to be more vigilant regarding the maintenance of stability in terms of the consistency of daily schedules and the impact of both positive and negative stressors (Frank, 2007). Given the irregular work schedules that many creative clients face, IPSRT is likely to be quite useful in maintaining stability and regularity in the client’s life.

IPSRT has two basic elements: the improvement of interpersonal relationships and the managing of mood symptoms (Frank, 2007). IPSRT aims to achieve these goals through three components: psychoeducation, social rhythm therapy (SRT), and interpersonal therapy (Swartz, Levenson, & Frank, 2012). The psychoeducation component targets the disorder and its consequences, pharmacotherapeutic routes and their potential side effects, and the recognition of prodromal symptoms and early warning signs of affective episodes (Swartz, Levenson, & Frank, 2012). Elements of social rhythm therapy are implemented by the use of the Social Rhythm Metric (SRM), an instrument developed to assess rhythm regularity by detecting behavior that could potentially impact rhythm stability.

Additionally, the measure assists in contributing to rhythm stability through recognizing

where rhythms could be regularized through lifestyle changes (Monk, Flaherty, Frank, Hoskinson, & Kupfer, 1990; Swartz, Levenson, & Frank, 2012). Finally, parts of Interpersonal Therapy (IPT) are used to identify the connection between interpersonal difficulties and mood dysregulation by focusing on five problem areas (Swartz, Levenson, & Frank, 2012). These areas include interpersonal deficits, role disputes, role transitions, grief, and grieving “the lost healthy self” (i.e., the client is encouraged to grieve the life they may have had if not for bipolar disorder) (Swartz, Levenson, & Frank, 2012). For the CPBD, grieving the lost healthy self may include examining the difficulties bipolar disorder has caused in their creative work and/or relationships.

IPSRT contains four phases of treatment. In the *initial* phase, which normally consists of three to five sessions, the therapist obtains a detailed history, which focuses on the impact that the client’s interpersonal problems and disruptions in social rhythms have contributed to affective episodes, and provides psychoeducation regarding the client’s illness (Frank, 2007). This extended intake phase recommended by IPSRT may be welcomed by the creative individual, who may appreciate the opportunity to tell his or her story and discuss the importance of creativity in their lives. In this phase, the therapist also evaluates the quality of the client’s interpersonal associations through an instrument called the *Interpersonal Inventory* and evaluates the consistency of the client’s social routines through the SRM (Frank, 2007). Finally, the clinician and client decide on an initial interpersonal focus from among the aforementioned 5 problem areas (Frank, 2007). In working with the creative client, this phase may include the clinician gathering history regarding the client’s creative work and any effects the symptoms of bipolar disorder may have had on their work or work relationships.

In the *intermediate* phase of therapy, the therapist's aim is to regularize the client's social routines and provide interventions in the client's selected problem area (Frank, 2007). This may require the creative client to adopt a new work schedule, which may prove to be challenging if irregular work schedules have been the norm for the client in the past and/or are seen as an integral aspect of an artistic lifestyle. As such, the rationale for such a change may need to be repeatedly reviewed. The sacrifice of spontaneity in one's daily routine, which may be highly valued by creative individuals, can be presented as being in the service of promoting long-term wellness which, in turn, may increase the likelihood of a productive artistic career. In the initial and intermediate phases of IPSRT treatment, the client is seen on a weekly basis. As the therapy progresses to the next phase of treatment, known as the *continuance*, or *maintenance*, phase, clients may be seen on a bi-monthly, and eventually monthly, basis (Frank, 2007). The continuance phase of therapy focuses on improving the client's self-assurance that they can implement the skills learned in earlier phases, including maintaining consistent social routines (even when faced with disruptions such as employment changes, vacations, and unexpected life disturbances) and improving interpersonal relationships (Frank, 2007). Techniques for achieving these goals are found in the manual for IPT (Klerman, Weissman, Rounsaville, & Chevron, 1984). The *final* phase of treatment, which occurs over three to five monthly visits, focuses on the conclusion of therapy and the further lessening in the occurrence of sessions (i.e., reducing the frequency to occasional check-ups or booster sessions) (Frank, 2007).

As noted earlier, a need for treatment of the CPBD may be to focus on navigating irregular and unpredictable schedules without exacerbating symptoms of bipolar disorder. As such, IPSRT may be particularly relevant for CPBDs. As previously noted, because

creative clients may value their ability to be spontaneous and may have work schedules that are inherently irregular, helping the client accept the rationale for greater stability in one's daily life may be a more prolonged process.

Murray and Johnson (2010) provide a useful correlation between internal circadian rhythm and the role of a drummer in a musical group:

Just as coordinated self-expression by the band depends on the drummer's rhythm, staying well with BD depends on a stable 24 hour rhythm. This metaphor is appealing to clients because it underscores that, i) BD is grounded in a biological adaptation to the earth's rotation, ii) a stable 24 hour sleep/wake cycle is vital to psychological health, and iii) the patient has a role in staying well through maintaining circadian rhythmicity. (p.728)

Cognitive-behavioral therapy. Cognitive-behavioral therapy (CBT) for bipolar disorder typically consists of five treatment targets: (a) medication adherence, (b) early detection and intervention, (c) stress and lifestyle management, (d) treatment of comorbid conditions, and (e) treatment of bipolar depression (Otto, Reilly-Harrington, & Sachs, 2003).

Identifying specific thoughts, feelings, and behaviors that accompany prodromal symptoms of affective episodes and having a contracted plan in place to enact when such thoughts, feelings, and behaviors occur can be an effective technique in preventing relapse (Otto et al., 2003). Although inaccurate thoughts can occur at any time throughout the course of the illness, helping the client to identify them early can be an effective tool in preventing the occurrence of mood episodes. Targeted thoughts relevant to creative individuals may include the aforementioned idea that the client's creativity is linked to

symptoms of their illness, that creativity may suffer from the use of psychotropic medications, or specific thoughts about the client's self-worth in light of a diagnosis of bipolar disorder. The contracted plan may include specific individuals (i.e., family members, friends, mental health professionals) who the client can contact and early intervention strategies that these individuals may enact when early warning signs are exhibited by the client (Otto et al., 2003).

Cultural considerations should be taken into account when examining potentially inaccurate thoughts related to the illness. For example, Jacob (2010) notes that knowledge regarding a client's cultural or religious sub-group is necessary when determining whether certain held beliefs are delusional in nature or are shared among the client's local culture. For example, black magic is a frequently held belief amongst people in India, although there are certain beliefs (e.g., delusions of persecution and control through black magic that are directed at individual persons or a group of individuals) that are not generally shared by the ethnic subculture (Jacob, 2010). Thus, understanding the local culture would be necessary to assess for delusions of persecution or control related to black magic (Jacob, 2010). Similarly, when assessing insight, western practitioners should take into account ideas regarding healthiness and sickness in non-western cultures, and local criteria regarding insight may be required to be used when evaluating insight in individuals with psychotic disorders (Jacob, 2010). See Jacob (2010) for proposed schemes to assess insight across different cultures.

In terms of stress and lifestyle management, self-monitoring and schedule setting can be important techniques for the bipolar individual to maintain mental health (Otto et al., 2003). Monitoring whether the individual is experiencing over- or under-activity may

signify if the client is suffering from prodromal symptoms or symptoms of a manic or depressive episode (Otto et al., 2003). This may be challenging for the creative client as they may be asked in CBT to formally monitor their creative output (e.g., with activity logs) and its relation to mood, which may be an activity that is resisted, especially if the client sees it as something that is too time-consuming or that might potentially distract them from their creative work. Discussing with the client of the importance of symptom monitoring can be helpful at this point (e.g., such prospective monitoring gives a clearer picture of the illness because it is likely to be more accurate than retrospective recall of symptoms and functioning). Flexibility in terms of how activity logs are completed may also strengthen adherence to this type of task. For example, a client could do this in a journal format rather than on activity log worksheets. CBT techniques can be used in the management of sleep/wake schedules by identifying the desired number of sleep hours and setting regular sleep times (Otto et al., 2003), as well as instituting behavioral interventions such as sleep hygiene techniques. CBT techniques may also be used in the treatment of co-morbid conditions, such as substance-use and anxiety disorders (Otto et al., 2003).

CBT techniques in therapy for bipolar depression may include activity management strategies and cognitive restructuring (Otto et al., 2003). Additional strategies may include emotional and social problem-solving techniques.

For the creative client, CBT techniques may include challenging cognitive distortions the client may hold. For example, “I’m more creative when I’m feeling euphoric or depressed” may be a common thought encountered among CPBDs. The clinician should work with the client to identify times that they were creative and not symptomatic to

challenge such thoughts. Socratic questioning could be used to gather such information. For example, asking “Have you ever engaged in creative work when your mood was neither elevated nor depressed?” And if so, “How would you explain your ability to create at these times when your mood was more stable?” Behavioral experiments may be beneficial at this point as well. Challenging the client to create while their mood is euthymic and gathering feedback about the quality of their work could help in challenging cognitive distortions. For many creative individuals, substance misuse may also be linked to their creativity (i.e., they may feel that they are only able to create while under the influence of alcohol or drugs). Such clients can similarly be challenged to create while not under the influence of substances and asked to evaluate the quality of their work.

Schoenewolf (2002) states that a common problem among creative clients is an inability to fully feel emotions and that these clients often complain of feeling “numb.” Additionally, they may tend to intellectualize their feelings rather than experience them in their bodies. A sense of numbness or inability to feel emotions may be experienced during depressive episodes and thus, this observation has relevance to CPBDs. Schoenewolf (2002) suggests this inability to fully experience emotions manifests problems in clients’ creative work, such as visual artists who are unable to paint in color (which, he states, is a visual representation of emotion). In order to put clients in contact with their emotions, Schoenewolf (2002) suggests using a behavioral experiment known as the Paradoxical Exaggeration Technique, in which the therapist encourages the client to make themselves feel “even more numb” than they already feel. This technique, he states, may paradoxically allow the client’s emotions to push through to the surface, so that the client is able to fully experience them. Schoenewolf (2002) provides a case example of a patient who was able to

begin painting in color once she began fully experiencing emotions after using the Paradoxical Exaggeration Technique. Additionally, the client began to feel more optimistic and less depressed and self-disparaging.

Increasing Medication Adherence in the CPBD.

Medication adherence in the treatment of bipolar disorder may be jeopardized by the fact that medications are intended to be taken when no symptoms are present (and henceforth, the client may not associate medication directly with symptom relief), and medication adherence may be impacted by the recall of past symptoms and the consequences of affective episodes; furthermore, side effects of medications may decrease motivation and act as a deterrent for taking medication (Otto et al., 2003). Further complicating medication adherence for the creative bipolar client is the fact that the client may view symptoms of the illness as beneficial or necessary to their creativity. Detailed history taking regarding the contexts and consequences of prior affective episodes and the construction of timelines to remind clients of such memories may benefit the client in increasing their intrinsic motivation to adhere to medications (Otto et al., 2003). The creative client should be gently challenged to consider whether the symptoms of their disorder have ever adversely affected their creative work. In doing so, it is important to attend to full range of symptoms that are associated with mood episodes and not to primarily or solely focus on changes in mood.

The relationship between medication for bipolar disorder and creativity is under-researched and not well understood (Andreasen, 2008). Some indications exist that lithium improves creative production over time, as seen in Hamilton's (1982) study of the poet Robert Lowell and the seminal Iowa workshop study (Andreasen & Canter, 1974). In

both of these studies, lithium increased creative output by diminishing symptoms and disturbances caused by relapses into episodes of mania or depression (Michalak & Murray, 2010). Conversely, clients often assume that mood-stabilizers flatten their capacity for emotional expression, alertness and insight, and those medications may inhibit the creative process (Rothenberg, 2006).

Motivational interviewing is another technique that may enhance medication adherence and can be done throughout treatment to acknowledge ambivalent feelings clients may have regarding medication use and to remind clients of the reasons for their motivation to continue taking medications (Otto et al., 2003).

Additionally, medication adherence for clients with bipolar disorder can be challenging as it involves changes in behavioral routines (Laakso, 2012). Through motivational interviewing, the clinician can help to increase the client's intrinsic motivation for taking medications by using a directive and client-centered approach through targeting their ambivalence for medication treatment and helping to promote behavioral change (Laakso, 2012). For the creative client, motivational interviewing will likely involve a discussion regarding the perceived effect medication has on the client's creativity and a weighing of what the client perceives as the positives and negatives related to that discussion.

There are four broad principles that are involved in motivational interviewing: (a) expressing empathy, (b) developing discrepancies, (c) rolling with resistance, and (d) supporting self-efficacy (Laasko, 2012; Miller & Rollnick, 2002). When bipolar clients are received with empathy, they are more likely to explore their ambivalence to taking medication and sharing their story with the clinician (Laasko, 2012). Specifically for the CPBD, an atmosphere of empathy may be conducive to them sharing their fears of

medication side effects impacting their creativity. By developing discrepancies, the clinician and client explore the conflict between the consequences of the bipolar client's present behaviors and their larger values and goals (Laasko, 2012). Exploring the effects of the creative client's current behavior and examining whether or not those behaviors are detracting from their creativity or creative work may be an important task for the clinician in therapy. Rolling with resistance involves not challenging client resistance, but rather accepting ambivalence as information to better understand the client's inner conflict (Laasko, 2012). Creative clients may appreciate this, as they are encouraged to generate their own solutions for the difficulties they face when considering medications. When encountering obstacles in treatment (such as with medication adherence), the therapist may wish to explicitly call upon the client's creativity in trying to come up with a solution to the problem. Supporting self-efficacy can be critical in motivational interviewing with the creative client as it helps to increase the client's confidence in their own abilities for change (Laasko, 2012).

There are four general techniques used in motivational interviewing that can be remembered by the acronym OARS: Open-ended questions, Affirmations, Reflective listening, and Summaries. Examples of open-ended questions that can be used with the creative client include "What are some of your concerns about how medication will affect your creativity?" or "If you were to start taking your medication again, what would that be like for your creative work?" Affirmations may involve statements such as "I understand that making the decision to go back on medications is a difficult one, and it is something you have struggled with in the past." Reflective listening might include statements such as "It seems as though you are concerned about the effect of medication on your creativity.

But you also seem aware that being off your medications in the past has negatively affected your work and relationships.” Summaries might include statements such as “To sum everything up, you’ve told me that you don’t want to continue taking your medication because you fear that it hurts your creativity. But on the other hand, you mentioned that the quality of your creative work suffers when you’re in a manic episode, and causes stress in your marriage. Is this accurate?”

Additionally, psychoeducation has been shown to increase medication adherence in bipolar disorder, and it may be particularly applicable to the creative population, who may face unique challenges in considering medications (Miklowitz & Scott, 2009; Murray & Johnson, 2010). Additionally, CBT approaches may be utilized to help increase medication adherence. For example, a study that examined the efficacy of a short-term (i.e., 6-weeks in duration) cognitive-behavioral preventative approach to lithium non-adherence in outpatient treatment found that intervention patients were significantly more adherent with lithium treatment than control patients, both immediately after receiving the intervention and after 6 months (Cochran, 1984). The cognitive-behavioral treatment was adapted from an approach by Beck, Rush, Shaw, and Emery (1979) for the treatment of depression and aimed at altering cognitions and behaviors that interfere with compliance (Cochran, 1984).

Ragesh, Hamza, and Chaturvedi (2016) conducted a comprehensive review of the literature regarding treatment and medication non-adherence in individuals diagnosed with bipolar disorder, and found several general factors related to non-adherence; these factors include family factors (e.g., non-adherence is positively related with inadequate support from family, negative expressed emotions, caregiver burden, disorganized home

environments, and poor knowledge about the illness), socio-demographic aspects (e.g., treatment non-adherence is positively related with low level of education, minority ethnicity, younger age, single marital status, male gender, unemployment, and homelessness), and religious beliefs (e.g., non-adherence is associated with stronger religious beliefs). Additional factors include stigma (e.g., non-adherence is positively related with perceived stigma of the illness), social support (e.g., non-adherence is positively related with unsupportive social networks and lack of perceived social support), financial aspects (e.g., non-adherence is positively related with financial burden), and health care system-related factors (e.g., non-adherence is positively related with lack of health education, unavailability of medications, and accessibility issues). Such sociocultural factors should be considered and addressed when working with clients of various cultures to increase medication adherence.

Systematic/chronic care models. Systematic or Chronic Care Models are team-based interventions for the long-term treatment of bipolar disorders and are founded on models for treatment of clients with chronic illness (Bauer et al., 2006; Von Korff, Gruman, Schaefer, Curry, & Wagner, 1997; Wagner, Austin, & Von Korff, 1996). These multicomponent interventions include 5 elements: (a) assessment and care planning, (b) structured monthly telephone calls, (c) feedback to the mental health treatment team, (d) structured group psychoeducational programs, and (e) as-needed support, education, and care coordination (Simon, Ludman, Bauer, Unutzer, & Operskalski, 2006).

Assessment and care planning. The initial module includes obtaining and reviewing the client's psychosocial history and the development of a collaborative treatment plan. This assessment and treatment planning phase incorporates obtaining

information regarding the client's present medication regimen, projected frequency of continuing appointments, early warning signs of manic or depressive episodes, plans to cope for countering warning signs, and identifying social supports (Simon et al., 2006). When working with the creative client, the clinician may have to take into account any traveling the client may have and identify coping plans and social supports for the client while he/she is away from home. For example, working with the client to develop a detailed itinerary ahead of time based around their travel schedule may help in maintaining regular wake-sleep cycles while they are away from home. Further, creating a list of social supports that they can check in with and discuss any recurrence of symptoms while traveling may help the client identify signs of potential relapses. Additionally, if a client is travelling to a location that involves a change in time zones, recommending that the client arrive to their destination one or two days early may be effective in helping them adjust to the time change.

Structured monthly telephone calls. Structured monthly telephone calls are used to obtain clients' ratings of current symptoms, current medication use, and medication side effects (Simon et al., 2006). For the CPBD, this may include monitoring any perceived effects that the medication is having on their creative work. This may be beneficial for the creative client, whose work and travel schedule may be unpredictable, in that structured telephone calls add an element of stability to the routine of the client and may help the client to track symptoms during periods of irregularity in their schedules.

Feedback to the mental health treatment team. In the Systematic/Chronic Care model of treatment, following the monthly telephone call, feedback is provided to the treatment team regarding current mood symptoms, medication use, medication side

effects, and recommendations regarding adjusting medications, laboratory testing, and follow-up appointments (Simon et al., 2006).

Structured group psychoeducational program. The Systematic/Chronic Care model of treatment also incorporates psychoeducation. The Life Goals Program by Bauer and McBride (2003), provides a representative example of one form that such psychoeducation may take. Specifically, the Life Goals Program includes 5 weekly group meetings (phase 1) followed by bi-monthly meetings (phase 2) up to a total of 48 sessions. In phase 1, education is provided regarding the nature of bipolar disorder, early warning signs, triggers, and coping techniques. Phase 2 involves a structured problem-solving design with the goal of accomplishing specific life objectives. For the creative client, this will likely involve a discussion regarding how they will continue to function creatively in the context of their illness and treatment. For example, one concern of the client may be how they will maintain an intensive treatment schedule with regularity given irregular work and travel schedules. Flexibility may have to be maintained by the treatment provider in terms of fitting treatment sessions in around the client's schedule. The therapist may choose to conduct sessions via telephone or a face-to-face technology application (e.g., Skype) to maintain a sense of treatment regularity in the face of irregular work and travel schedules. Additionally, group members create self-management plans that describe early warning signs, triggers, and techniques to cope with the illness (Simon et al., 2006). Such plans may be brief and compact, so that they can be taken with the client when they are traveling or working away from home, which may be particularly beneficial to CPBDs.

As-needed support, education and care coordination. As indicated, clinicians make additional contacts with the client via telephone in the Systematic/Chronic Care

treatment model to provide general support and reinforcement to attend group therapy sessions and follow-up appointments. Additionally, treatment providers educate clients regarding medication side effects and crisis intervention, and assist with overcoming barriers to treatment (Simon et al., 2006). This part of the treatment may be beneficial to creative individuals in that regular check-ins and continued psychoeducation via telephone can help motivate the client and remind them to attend appointments in the context of irregular work or travel schedules.

Chapter 4: Discussion

Several studies have been conducted regarding the relationship between bipolar disorder and creativity, and treatment issues related to bipolar disorder (e.g., medication and therapy non-adherence; Andreasen & Glick, 1998; Andreasen, 2008; Berk et al., 2010; Clatworthy, Bowskill, Rank, Parham, & Horne, 2007; El-Mallakh, 2007; Jamison, 1996). However, there is a lack of research examining the CPBD's individual experience in therapy and medication treatment, as well as on issues of therapy adherence within this subgroup of clients diagnosed with bipolar disorder. The CPBDs potentially face several unique challenges and circumstances when engaging in treatment and therefore could benefit from a set of suggestions specifically made for them. The purpose of the current study was to develop a set of treatment suggestions that could be used in therapy with CPBDs. In order to achieve this end, this researcher collected information from bodies of literature that focused on three general research areas: (a) the relationship between bipolar illness and creativity, (b) the treatment of bipolar individuals, and (c) psychotherapy treatment of creative individuals. The information gleaned from these three areas was synthesized and used to inform the general treatment suggestions.

Many of the traditional and empirically-based treatments for bipolar disorder can be adapted for use with CPBDs. This study examined several of the existing approaches to the treatment of bipolar disorder and provided suggestions for ways in which those treatments could be tailored for use with CPBDs. This project discussed how modifications can be made to various treatment modalities, including psychoeducation, family interventions, interpersonal social rhythm therapy, cognitive-behavioral therapy, and intensive therapies. Consideration was given to various phases of treatment, including

intake, diagnosis, and treatment planning, and other aspects related to treatment, such as increasing medication adherence.

Several themes emerged across treatment phases and modalities, such as beliefs CPBDs may hold and unique challenges the CPBD may face. Attempts were made to take into account unique aspects of the CPBD's experience when making treatment suggestions. General areas that were addressed in this study that might be of concern to the CPBD include challenges associated with creative blocks, getting in touch with their emotions, disturbances associated with irregular schedules and travel (e.g., sleep disturbances), thoughts that their creativity is specifically linked with symptoms of their illness (i.e., which may lead to treatment or medication non-adherence), and issues related to self-identity in light of a bipolar diagnosis.

Strengths, Limitations, and Future Directions

The aim of this dissertation project was to provide suggestions in the treatment of CPBDs. In examining and integrating literature that addresses the treatment of both creative clients and those with bipolar disorder, this writer believes clinicians who read this dissertation or utilize the attached resource will be made aware of unique treatment issues faced by CPBDs.

One limitation of the current study was the lack of literature available which focused specifically on the treatment of creative individuals. A possibility for future research may be to study the unique treatment issues and concerns that arise when working with creative clients in general. Much of the literature found during the current study consisted of case studies that described the general course of treatment with specific individual clients. Such case descriptions may not be generalizable to other creative clients.

Other areas for future research may include developing treatment suggestions for use with creative clients diagnosed with other disorders, such as psychotic or anxiety disorders. As noted earlier, much of the literature revolving around the treatment of creative individuals is in the form of individual case studies; future research may take the form of larger scale studies including multiple individuals. Relevant to this dissertation, future specific areas of study may include surveying clients to assess the needs of CPBDs in treatment; surveying treatment providers who work with bipolar clients, creative clients, or both, to determine unique needs or common presenting problems of such individuals; and researching treatment outcomes of CPBDs who undergo various forms of treatment.

The current study sought to provide suggestions for the treatment of CPBDs, although it was beyond the scope of this paper to implement the suggestions in an empirical study to assess issues such as client satisfaction with treatment and the utility or effectiveness of the recommendations. Additionally, these suggestions were not submitted to subject matter experts (e.g., seasoned clinicians or clinical researchers with expertise in bipolar disorder or creativity or both) to determine factors such as the appropriateness or content validity of the suggestions. Future research may focus on testing whether the recommendations generated from this project are beneficial in the treatment of CPBDs. Such studies may take the form of randomized clinical trials where CPBDs undergo treatment based on the recommendations contained within this study.

Creativity and bipolar disorder have been observed to co-occur, and bipolar disorder is a condition that carries significant risks of adverse outcomes and often results in decreased psychosocial functioning. Effective psychiatric and psychological (i.e., psychotherapeutic) interventions have been developed for the treatment of individuals

diagnosed with bipolar disorder, though additional research can be conducted to better understand how these interventions can be adapted to improve outcomes with certain clinical subgroups. CPBDs reflect one such subgroup, and it is hoped that the suggestions for therapeutic adaptations contained within this dissertation begin to draw more attention to an under-researched group.

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APPENDIX A

Resource of Treatment Suggestions for Working with Creative Persons with Bipolar

Disorder

TREATMENT SUGGESTIONS FOR WORKING WITH CREATIVE PERSONS WITH BIPOLAR DISORDER



PURPOSE

The purpose of this resource is to provide psychotherapy treatment suggestions for mental health professionals (e.g., psychologists, psychiatrists, LMFTs) working with creative persons diagnosed with bipolar disorder (i.e., CPBDs). Although extensive literature exists describing psychotherapeutic treatment of bipolar disorder, and some literature exists concerning the treatment of creative individuals, there is very limited information regarding the intersection of these two client populations. Given that, compared to the general population prevalence of approximately 1%, multiple studies have suggested that 10% of artists endorse symptoms of bipolar disorder¹ and approximately 8% of individuals diagnosed with bipolar disorder may be considered creative², CPBDs represent a segment of the population that may benefit from tailored treatment recommendations. For the purpose of this booklet, creative persons are defined as individuals who are either involved in a creative industry or persons who are involved in the study of creative arts.

¹ Goodwin, F. K., & Jamison, K. R. (2007). *Manic-depressive illness – Bipolar disorders and recurrent depression*, 2nd ed. Oxford University

² Akiskal, H. S., & Akiskal, K. K. (2007). In search of Aristotle: Temperament, human nature, melancholia, creativity and eminence. *Journal of Affective Disorders*, 100, 1-6. doi: 10.1016/j.jad.2007.04.013

BACKGROUND

Historically, there has been a common fascination regarding the intersection between mental illness and creativity. Psychological researchers have contended there is a disproportionate rate of psychopathology, especially bipolar disorder, in highly creative individuals and certain symptoms of mania or hypomania (e.g., flight of ideas, lowered inhibitions, and heightened sensitivity and productivity) may enhance creativity.^{3 4}

Dating back to Greek psychological medicine and philosophy, great thinkers have related the distress associated with melancholia or “madness” with artistic creativity.⁵ Likewise, throughout the Italian Renaissance, those with superior creative ability were described in terms of melancholia or madness and artists were thought to embody the qualities of eccentricity, sensitivity, moodiness, and solitariness.⁶ In the late 18th and 19th centuries, the Romantic movement again introduced the concept that madness endowed artists with a mystical or inexplicable inspiration that differentiated them from the typical person of the time.⁷ Similarly, modern artists such as Emily Dickinson, T. S. Eliot, Sylvia Plath, and Ernest Hemingway were believed or known to have suffered from bipolar or unipolar depression.⁸ Additionally, studies of creative individuals indicate that there is also a higher rate of both creativity and affective disorder in their first-degree relatives, suggesting these traits are genetic and run together in families.^{9 10}

³ Jamison, K. R. (2011). Great wits and madness: More near allied? *The British Journal of Psychiatry*, 199, 351-353. doi: 10.1192/bjp.bp.111.100586

⁴ Sadre, M., & Brock, L. J. (2008). Systems in conflict: Labeling youth creativity as mental illness. *Journal of Family Psychotherapy*, 19(4), 358-378. doi: 10.1080/08975350802475098

⁵ Akiskal, H. S., & Akiskal, K. K. (2007). In search of Aristotle: Temperament, human nature, melancholia, creativity and eminence. *Journal of Affective Disorders*, 100, 1-6. doi: 10.1016/j.jad.2007.04.013

⁶ Becker, G. (2001). The association of creativity and psychopathology: Its cultural- historical origins. *Creativity Research Journal*, 13(1), 45-53. doi: 10.1207/S15326934CRJ1301_6

⁷ Becker, G. (2001). The association of creativity and psychopathology: Its cultural- historical origins. *Creativity Research Journal*, 13(1), 45-53. doi: 10.1207/S15326934CRJ1301_6

⁸ Jamison, K. R. (1996). *Touched with fire: Manic-depressive illness and the artistic temperament*. Toronto, Canada: Maxwell Macmillan Canada.

⁹ Andreasen, N. C. (1987). Creativity and mental illness: Prevalence rates in writers and their first degree relatives. *American Journal of Psychiatry*, 144, 1288-1292.

¹⁰ Andreasen, N. C. (2011). A journey into chaos: Creativity and the unconscious. *Mens Sana Monographs*, 9(1), 42-53. doi: 10.4103/0973-1229.77424

The idea that mental illness, and specifically bipolar disorder, confers advantages to the creative individual remains common today. However, it is important to remember that bipolar disorder is frequently associated with significant impairment. Bipolar disorder is the sixth leading cause of disability among young adults and is associated with increased suicide risk.¹¹ Considering the apparent association with creativity, and impairment caused by and risks associated with bipolar disorder, it is important to address issues related to treatment of this vulnerable population (i.e., creative persons diagnosed with bipolar disorder).

¹¹ Berk, L., Hallam, K. T., Colom, F., Vieta, E., Hasty, M., Macneil, C., & Berk, M. (2010). Enhancing medication adherence in patients with bipolar disorder. *Human Psychopharmacology*, 25, 1-16. doi: 10.1002/hup.1081

GENERAL RECOMMENDATIONS

- Over the past 25 years, it has become evident that psychosocial interventions are frequently a useful adjunct to medication for the treatment of bipolar disorder.¹²
- Therapies may need to be modified for the treatment of the creative bipolar client.

Examples of Modifications:

- Psychoeducation may need to focus on the unique concerns and needs faced by the CPBD.¹³
- Traits often seen in CPBDs (e.g., Openness, Expressiveness) should be considered,ⁱⁱ and such traits may lead to greater comfort with group-based interventions.¹⁴ Additionally, many creative professionals are accustomed to receiving feedback (e.g., from critics, peers, etc.) regarding their creative work and may welcome the additional perspectives that fellow group members can provide.
- Internet- or phone-based treatments may be necessary for working with CPBDs whose work and travel schedules preclude them from attending traditional in-person therapy sessions.¹⁵
- The client's creativity should be used as a treatment tool whenever possible (e.g., through therapeutic writing, using the client's artwork or music to express nonverbal feelings). Research indicates that clients with mental health needs who participate in creative activities experience increased levels of empowerment, improvements in mental health difficulties, social inclusion,¹⁶

¹² Frank, E., Swartz, H. A., & Kupfer, D. J. (2000). Interpersonal and social rhythm therapy: Managing the chaos of bipolar disorder. *Biological Psychiatry*, 48(6), 593-604.

¹³ Murray, G., & Johnson, S. L. (2010). The clinical significance of creativity in bipolar disorder. *Clinical Psychology Review*, 30, 721-732. doi: 10.1016/j.cpr.2010.05.006

¹⁴ Miller, T. R. (1991). The psychotherapeutic utility of the five-factor model of personality: A clinician's experience. *Journal of Personality Assessment*, 57(3), 415-433.

¹⁵ Marks, I., & Cavanagh, K. (2009). Computer-aided psychological treatments: Evolving issues. *Annual Review of Clinical Psychology*, 5, 121-141.

¹⁶ Hacking, S., Secker, J., Spandler, H., Kent, L., & Shenton, J. (2008). Evaluating the impact of participatory art projects for people with mental health needs. *Health and Social Care in the Community*, 16(6), 638-648.

improved mood,¹⁷ better relationships between client and therapist,^{18 19} a means of nonverbal communication of unconscious feelings,²⁰ improved self-esteem and self-confidence,²¹ and a protective effect on mental well-being (through promotion of relaxation, through a means of self-expression, and through reduction of blood pressure).²²

- Schoenewolf (2002) suggests that working with creative clients requires a special therapeutic approach. First, he states, the therapist must communicate an understanding of the importance of the arts, either by demonstrating that the therapist is an artist him/herself, or by showing an appreciation of the arts. Second, the therapist must demonstrate an understanding of a special kind of sensitivity that most artists embody (which Schoenewolf terms “neurotic sensitivity”), which makes them susceptible to emotional disorders. Finally, the therapist must understand that creative clients must create, and they cannot be fulfilled unless they actualize their creativity in some way.²³
- Emotional disturbances do not enhance art; rather, they create blockages for creativity and prevent artists from being able to create or result in the artist creating distorted works. Resolving such emotional disturbances and underlying conflicts in therapy may help address creative blocks, and increase the artist’s flexibility and objectivity, so that their output has a more universal appeal. If overcoming creative blocks is a goal of the creative client, then educating the CPBD that they can overcome creative blocks may help to enhance their treatment adherence.²³

¹⁷ Petrillo, L. D., & Winner, E. (2005). Does art improve mood? A test of a key assumption underlying art therapy. *Art Therapy: Journal of the American Art Therapy Association*, 22(4), 205-212.

¹⁸ Dalley, T. (Ed.). (1984). *Art as therapy: An introduction to the use of art as a therapeutic technique*. London: Tavistock.

¹⁹ Schaverien, J. (1995). *Desire and the female therapist: Engendered gazes in psychotherapy and art therapy*. New York: Routledge.

²⁰ Carter, F. J. (1996). *The journey*. Queensland, Australia: Post Pressed.

²¹ Heenan, D. (2006). Art as therapy: An effective way of promoting positive mental health? *Disability and Society*, 21(2), 179-191.

²² Leckey, J. (2011). The therapeutic effectiveness of creative activities on mental well-being: A systematic review of the literature. *Journal of Psychiatric and Mental Health Nursing*, 18, 501-509.

²³ Schoenewolf, G. (2002). *Psychotherapy with people in the arts: Nurturing creativity*. Binghamton, NY: The Haworth Press, Inc.

- Creative blocks are often related to traumatic events early in one's life and a history of childhood trauma is found in 25% to 70% of individuals diagnosed with bipolar disorder.^{24 25} One way to help creative clients overcome creative blocks is to help the client work through resistance to remembering and then talking about how writer's block is related to traumatic aspects of the client's childhood. When such resistances are worked through, many other areas of a client's life may also improve, including improved relationships, abstaining from substance use, and better overall functioning.²³



GENERAL CONSIDERATIONS FOR INTAKE, DIAGNOSIS, AND TREATMENT PLANNING

INTAKE

- CPBDs may feel constrained by a medical-model assumption of treatment because many creative individuals may value impulsive expression of needs and emotions, and they may feel constricted by defining and quantifying symptoms.²⁶

²⁴ Etain, B., Aas, M., Andreassen, O. A., Lorentzen, S., Dieset, I., Gard, S., Kahn, J., Bellivier, F., Leboyer, M., Melle, I., & Henry, C. (2013). Childhood trauma is associated with severe clinical characteristics of bipolar disorders. *The Journal of Clinical Psychiatry*, 74(10), 991-998.

²⁵ Larsson, S., Aas, M., Klungsoyr, O., Agartz, I., Mork, E., Steen, N. E., Barrett, E. A., Lagerberg, T. V., Rossberg, J. I., Melle, I., Andreassen, O. A., & Lorentzen, S. (2013). Patterns of childhood adverse events are associated with clinical characteristics of bipolar disorder. *BMC Psychiatry*, 13(97), 1-9.

²⁶ Rothenberg, A. (2006). Creativity, self creation, and the treatment of mental illness. *Medical Humanities*, 32, 14-19.

- During the intake process, it is recommended that the therapist openly discuss treatment goals, including an analysis of which parts of spontaneity (which may be viewed by the client as essential to creativity) the client may wish to retain.¹³
- A discussion should be held with the CPBD regarding any unique concerns the client may have about the structure of intake and treatment (e.g., When conducting an intake with a visual artist, for example, would they prefer to present a piece of visual art which represents the difficulties they are having? Likewise, would a writer prefer to present a written narrative describing their symptoms?).
- CPBDs may prefer a high degree of flexibility throughout the intake process, and may appreciate greater control over the direction of the interview. This may allow the patient to have “their story heard.” This should be balanced with attention to carefully gathering information on mood episodes (e.g., their scope, timing, duration) to help ensure accurate diagnosis of the bipolar disorder.



DIAGNOSIS

- Misdiagnosis of bipolar disorder as unipolar depression is relatively common. A comprehensive psychosocial history should be gathered to assess for symptoms of mania or hypomania.²⁷
- Symptoms of mania or hypomania may be assessed by inquiring into a history of symptomatology as related to creative work output – e.g., asking clients if there was ever a time where their creative work output was higher than usual, or periods where they were feeling so low that they felt they could not create.
- Inquiries should also be made regarding symptoms or factors the client feels most benefit their creative work – for example, does the client experience flight of ideas, which may contribute to novel and unique artistic ideas?

- Importantly, the therapist should not assume that mania or hypomania are the only mood states that clients may link to their creativity. Along with the increased productivity they may experience during mania or hypomania, for example, some clients may perceive benefits from depressive periods (e.g., which may influence the content of their work).

²⁷ Angst, J., & Cassano, G. (2005). The mood spectrum: Improving the diagnosis of bipolar disorder. *Bipolar Disorders*, 7(Suppl. 4), 4-12.



TREATMENT PLANNING

- Creative individuals often work as a part of a team (e.g., musicians, dancers, actors) and most performers function in a social context. Considering this, CPBDs may appreciate a collaborative approach to treatment planning where their ideas are welcomed and valued.²⁸
- Psychoeducation (discussed in more detail later) may be appropriate at this stage of treatment.
- Common individual challenges CPBDs face include potential reinforcement of emotionality (e.g., from teachers, critics, or fans of their creative work, who encourage the client's expression of extreme emotionality), occupational stress, substance misuse, irregular sleep and activity schedules, challenges to goal regulation, impulsivity, legal difficulties related to their illness, hospitalizations, and relationship problems.¹³ All of these areas should be assessed and addressed.
- Instillation of hope is an important activity at this stage, and a discussion should be initiated with the client regarding prognosis of treatment and the idea that a diagnosis of bipolar disorder does not necessarily mean the client will not lead an unproductive or unsatisfying life. For example, pointing out specific examples of famous artists, musicians, and writers who have been diagnosed with and managed bipolar disorder and have successfully led productive and creative lives may help to improve the client's outlook on treatment.

²⁸ Kogan, N. (2002). Careers in the performing arts: A psychological perspective. *Creativity Research Journal*, 14(1), 1-16.

SPECIFIC TREATMENTS FOR BIPOLAR DISORDER

PSYCHOEDUCATION

- Can be offered to clients in group or individual format.
- Assuming that higher creative output is a goal for CPBDs, clients can be educated that people with less severe symptoms of bipolar disorder may accomplish more than those who are experiencing more severe symptoms.
- Clients can also be educated that the elevated mood seen in manic and hypomanic states may be perceived by clients as improving creative output, but it is often accompanied by distractibility and increased goal-directed activity that carries a high risk for negative consequences. Such symptoms may then detract from a client's creative work. Hypomania and mania are characterized by impairments (e.g., problems with attention, critical thinking difficulties) that make creative achievement difficult.²⁹
- Information can be imparted that several studies indicate that moderate positive affect supports creativity (as opposed to low or intense levels of emotion, which may actually impede creativity).^{30 31}
- As noted above, clients may view some of their symptoms as beneficial to their creative work and may be hesitant to accept a diagnosis of bipolar disorder. A discussion should be initiated by the therapist regarding how the client views their identity in light of a bipolar disorder diagnosis, and help the client differentiate which aspects of their experiences are part of their personality/identity and separate from the disorder. Such discussion should include a focus on aspects of creativity and artistic identity that are constant in the client's life and not linked to mood episodes.

²⁹ Schuldberg, D. (2000-2001). Six subclinical spectrum traits in normal creativity. *Creativity Research Journal*, 13(1), 5-16.

³⁰ Davis, M. A. (2009). Understanding the relationship between mood and creativity: A meta-analysis. *Organizational Behavior and Human Decision Processes*, 108(1), 25-38.

³¹ De Dreu, C. K. W., Baas, M., & Nijstad, B. A. (2008). Hedonic tone and activation level in the mood-creativity link: Toward a dual pathway to creativity model. *Journal of Personality and Social Psychology*, 94(5), 739-756.

- Related to the above point, therapists should help clients generate evidence that creativity is not specifically linked to manic or depressive phases. Therapists can also note that people with milder illness episodes tend to have more creative accomplishments as compared to people with more severe episodes, and that non-affected family members tend to have more creative accomplishments than those with histories of hypomania.
- Psychoeducation should also focus on self-management strategies that the client can use to stay well, including education about bipolar disorder, acceptance of the diagnosis, adequate sleep, stress management, identifying triggers and warning signs, medication adherence and social support.³² Participation in creative pursuits can be included as a wellness strategy.
- The nature of the work that CPBDs engage in may result in the client associating with friends and colleagues who encourage spontaneity and also have irregular schedules. It would be beneficial for the therapist to initiate a discussion regarding how the client could address these issues with friends and colleagues. This may also involve helping the client to come up with a “script” to use in such situations and roleplaying.

³² Russell, S. J., & Browne, J. L. (2005). Staying well with bipolar disorder. *Australian and New Zealand Journal of Psychiatry*, 39(3), 187-193.

FAMILY INTERVENTIONS

- Family interventions (e.g., Family Focused Therapy [FFT]) are largely psychoeducational in nature and clients are taught to identify and recognize signs and symptoms of bipolar disorder, develop new strategies for intervening early with new episodes, and increase medication adherence and consistency.³³
- FFT is conducted in 21 sessions over 9 months and consists of three modules: 1) psychoeducation, 2) communication enhancement training, and 3) problem-solving skills training.⁹
- Family interventions such as FFT may be appropriate for CPBDs, as creativity likely runs in families, and the characteristics and challenges faced by creative individuals may also be seen in the family of origin, potentially exacerbating vulnerabilities and stressors.^{13 34 35}

INTERPERSONAL SOCIAL RHYTHM THERAPY [IPSRT]

- Individuals who are vulnerable to mood disorders may have a more difficult time adjusting to disruptions in their daily routine. Life events that are generally considered benign (e.g., jet lag, transition from standard to daylight savings time) can put significant stress on a bipolar individual's physiological system and its attempts to maintain normal sleep-wake, appetite, energy, and alertness cycles. Individuals with bipolar disorder may potentially remain in the cognitive and somatic states associated with disrupted circadian rhythms and may experience such states as fully syndromal periods of mania or depression.³⁶
- IPSRT takes a preventative approach to the recurrence of affective episodes by applying social rhythm theories to the treatment of bipolar disorder.³⁴
- The goals of IPSRT include the stabilization of clients' routines while improving the quality of clients' interpersonal relationships and fulfillment of

³³ Miklowitz, D. J. (2004). The role of family systems in severe and recurrent psychiatric disorders: A developmental psychopathology view. *Development and Psychopathology*, 16(3), 667-688.

³⁴ Reuter, M., Roth, S., Holve, K., & Hennig, J. (2006). Identification of first candidate genes for creativity: A pilot study. *Brain Research*, 1069(1), 190-197.

³⁵ Simeonova, D. I., Chang, K. D., Strong, C., & Ketter, T. A. (2005). Creativity in familial bipolar disorder. *Journal of Psychiatric Research*, 39(6), 623-631.

³⁶ Frank, E. (2007). Interpersonal and social rhythm therapy: A means to improving depression and preventing relapse in bipolar disorder. *Journal of Clinical Psychology: In Session*, 63(5), 463-473.

social roles. IPSRT aims to improve clients' current mood and functioning, and impart clients with skills that will prevent future affective episodes.³⁴

- IPSRT targets three psychosocial pathways that are thought to contribute to the recurrence of affective episodes: 1) stressful life events, 2) disruptions in social rhythms, and 3) medication non-adherence. IPSRT targets each of these pathways through education regarding medication adherence, the provision of space to explore feelings about their disorder and grieve "the lost healthy self," and addressing clients' interpersonal and social role difficulties.³⁴
- Given the irregular work schedules that many creative clients face, IPSRT can be useful in maintaining stability and regularity in the clients' lives. This work may be challenging if the client strongly feels that schedule irregularity is a necessary or desirable part of their creativity or artistic lifestyle.

COGNITIVE-BEHAVIORAL THERAPY [CBT]

- CBT for bipolar disorder typically consists of five treatment targets: 1) early detection and intervention, 2) stress and lifestyle management, 3) medication adherence, 4) treatment of comorbid conditions, and 5) treatment of bipolar depression.³⁷
- Complicating medication adherence for the CPBD is the fact that the client may view symptoms of bipolar disorder as beneficial or necessary to their creativity. The creative client should also be gently challenged to consider whether the symptoms of their disorder have ever adversely affected their creative work. Detailed history-taking of the contexts and consequences of prior affective episodes and construction of timelines to illuminate periods where symptoms adversely affected functioning (including creativity) may be helpful in increasing clients' intrinsic motivation to adhere to medications.¹³
- Identifying specific thoughts, feelings, and behaviors that accompany prodromal symptoms of affective episodes and having a contracted plan in place to enact when such thoughts, feelings, and behaviors occur can be an effective technique in preventing relapse. Although inaccurate thoughts can occur at any time throughout the course of the illness, helping the client to identify them early can be an effective tool in preventing the occurrence of mood episodes. Targeted thoughts may include the idea that the client's creativity is linked to symptoms of their illness, that creativity may suffer from the use of psychotropic medications, or specific thoughts about the client's self-worth and artistic identity in light of a diagnosis of bipolar disorder. The contracted plan may include specific

³⁷ Otto, M. W., Reilly-Harrington, N. A., & Sachs, G. S. (2003). Psychoeducational and cognitive-behavioral strategies in the management of bipolar disorder. *Journal of Affective Disorders*, 73, 171-181.

individuals that the client can contact and early intervention strategies that these individuals may enact when early warning signs are exhibited by the client.¹³

- Other techniques that may be effective for the CPBD include self-monitoring and schedule setting. Monitoring whether the individual is experiencing over- or under-activity may signify if the client is suffering from prodromal symptoms or symptoms of a manic or depressive episode.¹³ Self-monitoring may be challenging for the creative client, as there may be resistance to interventions such as formally monitoring creative output (e.g., with activity logs), especially if such interventions are seen as too time-consuming, detracting from their creative work, or medically-oriented. It is therefore important to adopt a certain degree of flexibility in working with the client to determine the easiest and most acceptable way to complete CBT-related assignments.
- Schedule setting can be a beneficial technique in managing sleep/wake schedules by identifying desired number of sleep hours and setting regular sleep times.¹³ Due to the irregularity of many creative person's schedules, this intervention may be especially important.
- CBT techniques may also include challenging cognitive distortions the CPBD may hold, particularly regarding the necessity of illness symptoms to fuel creativity. For example, "I'm more creative when I'm feeling euphoric or depressed" may be a thought the client maintains. The clinician should work with the client to identify times they were creative and not symptomatic to challenge such thoughts.
- Behavioral experiments may be an effective technique as well for challenging the belief that illness episodes aid creativity. Challenging the client to create while their mood is euthymic and gathering feedback about the quality of their work could help in challenging cognitive distortions.

SYSTEMATIC/CHRONIC CARE MODELS

- Systematic or chronic care models are team-based interventions for the long-term treatment of bipolar disorder and are founded on models for treatment of clients with chronic illness.^{38 39 40}

³⁸ Bauer, M. S., McBride, L., Williford, W. O., Glick, H., Kinosian, B., Altshuler, L., Beresford, T., Kilbourne, A. M., & Sajatovic, M. (2006). Collaborative care for bipolar disorder: Part I. Intervention and implementation in a randomized effectiveness trial. *Psychiatric Services*, 57(7), 927-936.

³⁹ Wagner, E. H., Austin, B.T., & Von Korff, M. (1996). Organizing care for patients with chronic illness. *Milbank Quarterly*, 74, 511-544.

⁴⁰ Von Korff, M., Gruman, J., Schaefer, J., Curry, S. J., & Wagner, E. H. (1997). Collaborative management of chronic illness. *Annals of Internal Medicine*, 127, 1097-1102.

- These multicomponent interventions include five elements: 1) assessment and care planning, 2) structured monthly telephone calls, 3) feedback to the mental health treatment team, 4) structured group psychoeducational programs, and 5) as-needed support, education, and care coordination.⁴¹
- The assessment and care planning stage incorporates obtaining information regarding the client's current medications, expected frequency of continuing appointments, early warning signs of manic or depressive episodes, coping plans for countering warning signs, and identifying social supports.³⁹ When working with the CPBD, the clinician may have to take into account any traveling the client may be doing and identify coping plans and social supports for the client while he or she is away from home.
- Structured monthly telephone calls are used to obtain clients' ratings of current symptoms, current medication use, and medication side effects.³⁹ This may be beneficial for the CPBD, whose work and travel schedule may be unpredictable; for example, structured telephone calls add an element of stability to the routine of the client and may help the client to track symptoms during periods of irregularity in their schedules.
- Following the monthly telephone call, feedback is provided to the treatment team regarding current mood symptoms, medication use, medication side effects, and suggestions regarding adjusting medications, laboratory testing, and follow-up appointments.³⁹
- A prototypical structured group psychoeducational program is the Life Goals Program, which consists of 5 weekly group meetings (phase 1) followed by bi-monthly meetings (phase 2) up to a total of 48 sessions. In phase 1, education is provided regarding the nature of bipolar disorder, triggers, early warning signs, and self-management techniques. Phase 2 involves a structured problem-solving design with the goal of accomplishing specific life objectives.⁴² Adaptation of such a group for the CPBD will likely involve a discussion regarding how they will continue to function creatively in the context of their illness and treatment. Additionally, group members create self-management plans which describe triggers, early warning signs, and coping techniques.³⁹ A group that is comprised of creative individuals with bipolar disorder may include discussion of how engagement in creative activities can be utilized as a coping mechanism.
- As necessary, additional contacts are made to the client via telephone to provide general support and encouragement to attend group sessions and follow-up appointments. Additionally, treatment providers educate clients regarding

⁴¹ Simon, G. E., Ludman, E. J., Bauer, M. S., Unutzer, J., Operskalski, B. (2006). Long-term effectiveness and cost of a systematic care program for bipolar disorder. *Archives of General Psychiatry*, 63, 500-508.

⁴² Bauer, M., & McBride, L. (2003). *Structured group psychotherapy for bipolar disorder: The Life Goals Program* (2nd ed.). NY: Springer Publishing Co., Inc.

medication side effects and crisis intervention, and assist with overcoming barriers to treatment.³⁹ This may be a useful tool in treatment, as creative individuals may lead lifestyles where they travel often and may not be able to attend in-person appointments regularly.



INCREASING MEDICATION ADHERENCE

- Clients often assume that mood-stabilizers flatten expression, insight and alertness, and that those medications may inhibit the creative process.⁵
- Clinicians should consider motivational interviewing as a technique to help the client in a discussion weighing the advantages and disadvantages of psychiatric treatments.⁴³
- Through motivational interviewing, the clinician can help to increase the client's intrinsic motivation for taking medications by using a directive and client-centered approach through targeting their ambivalence for medication treatment and helping to promote behavioral change.⁴⁴
- For the CPBD, motivational interviewing will likely involve a discussion regarding the perceived effect medication has on the client's creativity and a weighing of what the client perceives as the positives and negatives related to that discussion.
- There are four broad principles that underlie motivational interviewing: 1) expressing empathy, 2) developing discrepancies, 3) rolling with resistance, and 4) supporting self-efficacy.¹⁵
- Specifically for the CPBD, an atmosphere of empathy may be conducive to helping the client share their fears of medication side effects impacting their creativity.

⁴³ Miller, W. R., & Rolnick, S. (2002). *Motivational interviewing: Preparing people to change*. NY: Guilford Press.

⁴⁴ Laakso, L. J. (2012). Motivational interviewing: Addressing ambivalence to improve medication adherence in patients with bipolar disorder. *Issues in Mental Health Nursing*, 33, 8-14.

- Exploring the effects of the creative client's current behavior, which may include not adhering to medication and treatment recommendations, and examining whether or not those behaviors are detracting from their creativity or creative work may be an important task for the clinician in therapy.
- 'Rolling with Resistance,' involves not challenging client resistance, but accepting client ambivalence as information to better understand their inner conflict.¹⁵ Creative clients may appreciate this, as they are encouraged to come up with their own solutions for the problems they face when considering medications. Therapists can frame generating new solutions in treatment as tapping into the client's creative abilities.
- Supporting self-efficacy can be critical in motivational interviewing with the creative client as it helps to increase the client's confidence in their own abilities for change.¹⁵



CULTURAL CONSIDERATIONS

- Cultural factors influence the epidemiology, phenomenology, outcome, and treatment of major mental disorders, including bipolar disorder and studies have indicated that cultural background affects the presentation and diagnosis of bipolar disorder.^{45 46}
- For example, some research suggests that African American individuals with bipolar disorder may be more likely to present with more severe hallucinations and inappropriate sexual or social behavior while Caucasian bipolar patients may be more likely to exhibit persecutory delusions. African bipolar individuals may be more likely than whites to show mainly manic presentations, Afro-Caribbean bipolar individuals may be more likely to have mood-incongruent delusions, and Caucasian individuals with bipolar disorder may be more likely to have suicidal ideas or actions.⁴⁷
- The cultural background of the clinician treating the bipolar individual may also have a direct influence on the diagnosis of bipolar disorder (e.g., clinicians from western societies may not be accustomed to the manner in which symptoms of mania manifest in other cultures; for example, in India, hostile and irritable affect is noted to be a common symptom of mania [see below]).

⁴⁵ Viswanath, B., & Chaturvedi, S. K. (2012). Cultural aspects of major mental disorders: A critical review from an Indian perspective. *Indian Journal of Psychological Medicine, 34*(4), 306-312.

⁴⁶ Strakowski, S. M., McElroy, S. L., & Keck, P. E. (1996). Racial influence on diagnosis in psychotic mania. *Journal of Affective Disorders, 8*, 157-162.

⁴⁷ Strakowski, S. M., McElroy, S. L., & Keck, P. E. (1996). Racial influence on diagnosis in psychotic mania. *Journal of Affective Disorders, 8*, 157-162.

- Jacob (2010) suggests that clients and relatives of clients from different cultures may provide non-medical explanations for the client's illness, such as black magic, evil spirits, sin, punishment by god, karma, etc. Additionally, some clients and relative of clients may simultaneously have medical, non-medical, religious, and supernatural explanations that are often contradictory. When multiple types of explanations are held, clients may simultaneously seek bio-medical and non-biomedical interventions.⁴⁸ Creative clients may also be interested in the integration of treatments.
- Culture may also greatly influence the way in which depressive symptoms are manifested. A study by the World Health Organization (as cited in Viswanath and Chaturvedi, 2012) indicates that patients assessed for core depressive symptoms from Basel, Montreal, Tehran, Nagasaki, and Tokyo all had several symptoms in common, including impaired concentration, lack of interest and energy, anhedonia, sadness, and ideas of worthlessness. However, feelings of guilt and suicidal ideation were least common in patients assessed from Tehran. Other studies have indicated that guilt is less common in Indian patients than patients from western countries and that physical symptoms are a more common presenting problem for Indian patients who suffer from depression. Additionally, somatic complaints and disorders of conduct were more common in non-western societies in patients assessed for depression.⁴⁶
- In regards to manic symptoms, studies have found a higher prevalence of delusions of grandiosity, persecution, reference, and those related to sexual or religious themes in Indian patients than those in the west. Additionally, hostile irritability is common among Indian manic patients and recurrent unipolar mania is more common in India and tropical countries than it is in western societies. Such cultural differences should be considered when diagnosing clients of varied cultural backgrounds.⁴⁶
- Clinicians should consider cross-cultural differences in standards of treatment. Additionally, clients of different cultures may choose to participate in traditional healing practices that can be used in conjunction with psychotherapy, and it is important for clinicians to understand the concepts, classification, and management of other health systems in order for the treating therapist to have effective liaisons with other treating health professionals. The therapist may want to consider other variables when planning treatment with clients of different cultures, including: 1) use of religion or spirituality, 2) family involvement (i.e., clients of non-western cultures may prefer more active family involvement), 3) lower emphasis on individual responsibility and autonomy (e.g., non-western cultures value collectivism and interdependence over individualism and autonomy), 4) the power differential between therapist and client (e.g., in Indian societies, the

⁴⁸ Jacob, K. S. (2010). The assessment of insight across cultures. *Indian Journal of Psychiatry*, 52(4), 373-377.

doctor is considered superior and the patient assumes a submissive role), 5) greater active participation by the therapist (e.g., therapists working with clients from developing countries may need to be more active and direct), and 6) single session therapy use for the poor and underprivileged.⁴⁹

⁴⁹ Viswanath, B., & Chaturvedi, S. K. (2012). Cultural aspects of major mental disorders: A critical review from an Indian perspective. *Indian Journal of Psychological Medicine, 34*(4), 306-312.

APPENDIX B
IRB Exemption

PEPPERDINE UNIVERSITY

Graduate & Professional Schools Institutional Review Board

December 9, 2016

Sean Agopian

Project Title: The Development of Therapy Suggestions for Addressing Issues of Creativity in Individuals Diagnosed with Bipolar Disorder

Re: Research Study Not Subject to IRB Review

Dear Mr. Agopian:

Thank you for submitting your application, *The Development of Therapy Suggestions for Addressing Issues of Creativity in Individuals Diagnosed with Bipolar Disorder*, to Pepperdine University's Graduate and Professional Schools Institutional Review Board (GPS IRB). After thorough review of your documents you have submitted, the GPS IRB has determined that your research is **not** subject to review because as you stated in your application your dissertation **research** study is a "critical review of the literature" and does not involve interaction with human subjects. If your dissertation research study is modified and thus involves interactions with human subjects it is at that time you will be required to submit an IRB application.

Should you have additional questions, please contact the Kevin Collins Manager of Institutional Review Board (IRB) at 310-568-2305 or via email at kevin.collins@pepperdine.edu or Dr. Judy Ho, Faculty Chair of GPS IRB at gpsirb@pepperdine.edu. On behalf of the GPS IRB, I wish you continued success in this scholarly pursuit.

Sincerely,



Judy Ho, Ph. D., ABPP, CFMHE
Chair, Graduate and Professional Schools IRB

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives
Mr. Brett Leach, Compliance Attorney
Dr. Stephanie Woo, Faculty Advisor