

Rapid Cycling Bipolar and Trauma-Related Personality Traits: Bridging the Gap Between Affective Dysregulation and Early-Life Adversity

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ABSTRACT: Rapid cycling bipolar disorder (RCBD) represents a severe and treatment-resistant subtype of bipolar disorder in which patients experience at least four mood episodes within a year, often accompanied by greater psychiatric comorbidity, functional impairment, and suicide risk compared to non-rapid cycling cases. Childhood trauma and early-life adversity have been identified as critical contributors to emotional dysregulation, impulsivity, and treatment resistance, yet their role is frequently underrecognized in clinical practice. This case report describes a 30-year-old woman diagnosed with RCBD and a history of emotional and physical abuse in childhood, aiming to illustrate the complex interaction between trauma and affective instability while integrating neurobiological, psychological, and clinical perspectives. The patient underwent four weeks of inpatient evaluation that included structured interviews, collateral history from caregivers, psychometric assessments using the Young Mania Rating Scale (YMRS), Hamilton Depression Rating Scale (HAM-D), and Difficulties in Emotion Regulation Scale (DERS), as well as daily multidisciplinary observation. Over the past year, she experienced six distinct mood episodes with severe deficits in emotional clarity and impulse control, elevated DERS scores, and only partial response to pharmacological treatment with valproate and quetiapine. Clinical patterns and supporting literature suggest that trauma-induced dysregulation, involving amygdala hyperactivation and hypothalamic–pituitary–adrenal (HPA) axis disruption, played a central role. Improvement was achieved only after trauma-focused psychotherapy and psychosocial support were incorporated into her care. This case highlights the necessity of early trauma screening and integrative, trauma-informed management to improve diagnostic accuracy, treatment engagement, and long-term outcomes in complex bipolar presentations.

Keywords: Bipolar Disorder, Childhood Trauma, Emotion Dysregulation, Trauma-Informed Care, Case Report.



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INTRODUCTION

Rapid cycling bipolar disorder (RCBD) is a particularly severe and complex subtype of bipolar disorder (BD), defined by the occurrence of at least four mood episodes—mania, hypomania, or

depression—within a 12-month period. This pattern of rapid mood fluctuation is associated with higher rates of psychiatric comorbidity, functional disability, and suicide risk than non-rapid cycling presentations. Additionally, RCBBD often exhibits poor response to standard pharmacological treatments, increasing the burden on both patients and clinicians.

Despite its clinical significance, RCBBD remains frequently underrecognized and misdiagnosed. Its fluctuating course and overlapping symptoms with borderline personality disorder (BPD), complex PTSD, or cyclothymic temperament often contribute to diagnostic uncertainty. Emotional lability, impulsivity, and interpersonal dysregulation—hallmarks of trauma-related disorders—can mimic or mask core affective symptoms, delaying appropriate intervention. These diagnostic challenges underscore the need for more nuanced clinical approaches that consider developmental and psychosocial factors (Grande, 2016).

In recent years, accumulating research has emphasized the pivotal role of early-life adversity and childhood trauma in the development and course of mood disorders, including BD. Traumatic experiences during formative developmental periods can dysregulate neurobiological systems—particularly the amygdala, hippocampus, and hypothalamic–pituitary–adrenal (HPA) axis—resulting in heightened emotional reactivity and impaired stress regulation. These changes are believed to contribute to vulnerability to affective instability, rapid cycling, and treatment resistance in bipolar patients.

However, trauma histories are often underassessed in psychiatric practice, especially in adult patients presenting with complex affective symptoms. Clinicians may focus primarily on symptomatic clusters without sufficiently exploring trauma-related personality features or coping adaptations that have evolved over time. This oversight may lead to misattribution of symptoms, overreliance on medication, and failure to address the root causes of dysregulation.

Furthermore, trauma-related personality traits—such as dissociation, chronic mistrust, identity disturbance, and emotional numbing—can further complicate the clinical picture. These traits often develop as adaptations to chronic childhood adversity and may not fit neatly into standard diagnostic frameworks. In the context of RCBBD, such traits may interact with mood symptoms, contributing to treatment noncompliance, erratic interpersonal behavior, and resistance to stabilization.

Although numerous studies have explored the general relationship between trauma and affective disorders, few have provided detailed clinical narratives that illustrate how trauma shapes the phenomenology, trajectory, and therapeutic challenges of RCBBD. Case-based analyses are particularly valuable in this regard, as they offer rich, context-sensitive insights that bridge theory and practice.

This case report aims to fill that gap by presenting the clinical course of a 30-year-old woman diagnosed with RCBBD and a documented history of emotional and physical abuse during childhood. Through an integrative analysis that combines clinical observation, standardized assessments, and theoretical frameworks, this report highlights how trauma-related emotional dysregulation may contribute to rapid mood shifts, impulsivity, and partial treatment response. In doing so, it supports the growing call for trauma-informed, multidisciplinary approaches to

complex bipolar presentations and invites further research into neurobiological and psychosocial mediators of treatment outcomes.

METHOD

This study utilized a single-case qualitative design to examine the clinical presentation, symptom progression, and treatment response of a 30-year-old female patient diagnosed with rapid cycling bipolar disorder (RCBD) and a documented history of childhood emotional and physical abuse. The case was selected for its illustrative value in demonstrating the intersection of trauma-related emotional dysregulation and complex affective symptomatology. The patient had experienced multiple hospitalizations and presented with longstanding emotional instability, impulsivity, and functional decline, prompting referral to an inpatient psychiatric unit for diagnostic clarification and treatment re-evaluation.

A comprehensive clinical evaluation was conducted over a four-week inpatient period, during which the patient was observed daily by a multidisciplinary psychiatric team. Semi-structured clinical interviews were administered by two board-certified psychiatrists, focusing on mood symptoms, trauma history, personality functioning, and prior treatment outcomes. Collateral interviews were conducted with the patient's parents and primary caregiver to verify developmental history, interpersonal functioning, and contextual triggers of mood episodes. In addition, past psychiatric records, including outpatient progress notes, emergency room reports, and prior inpatient discharge summaries, were reviewed to establish longitudinal symptom patterns and treatment history.

Standardized psychometric instruments were employed to quantify mood severity, emotional regulation capacity, and overall clinical status. The Young Mania Rating Scale (YMRS) (Young et al., 1978) was used to assess manic symptoms, the Hamilton Depression Rating Scale (HAM-D) to evaluate depressive features, and the Difficulties in Emotion Regulation Scale (DERS) (Gratz & Roemer, 2004) to explore key domains of emotional dysregulation, including impulse control, clarity, and emotional awareness. All assessments were administered within the first week of admission and repeated prior to discharge to evaluate clinical change.

Observational data were triangulated with interview findings and psychometric results to form an integrated clinical formulation. Throughout the inpatient stay, treatment progress, behavioral patterns, affective shifts, and interpersonal interactions were documented in daily clinical rounds and nursing reports. The formulation process was guided by both classical psychodynamic frameworks (e.g., defense mechanisms, ego structure) and contemporary neurobiological models that emphasize the role of trauma in disrupting limbic system regulation, specifically amygdala hyperreactivity and hypothalamic–pituitary–adrenal (HPA) axis dysfunction.

While the use of a single-case design inherently limits generalizability, it allows for an in-depth, context-sensitive understanding of the complex interplay between trauma and affective dysregulation. The absence of biological or neuroimaging data constitutes a methodological limitation; however, the incorporation of multi-source clinical evidence including structured

assessments, collateral information, and longitudinal observation provides a robust foundation for clinical interpretation and theoretical integration.

RESULT AND DISCUSSION

Affective Symptomatology

The patient, a 30-year-old woman, presented with a long-standing history of severe mood fluctuations, impulsive behavior, intermittent mild auditory hallucinations, and recurrent suicidal ideation. Over the preceding year, she experienced at least six distinct mood episodes, fulfilling the diagnostic criteria for rapid cycling bipolar disorder (RCBD) (Baldessarini et al., 2023; Miola et al., 2023). Depressive episodes were characterized by hypersomnia, psychomotor retardation, feelings of worthlessness, and passive suicidal thoughts, reflected in an initial Hamilton Depression Rating Scale (HAM-D) score of 24 (severe). Hypomanic phases involved elevated mood, racing thoughts, excessive spending, irritability, and distractibility, with a Young Mania Rating Scale (YMRS) score of 19 (mild to moderate). These episodes lasted from several days to weeks and significantly impaired her occupational performance and interpersonal relationships. Mood shifts were often reactive to interpersonal stressors, particularly perceived criticism or rejection.

Trauma-Related Personality Traits

Clinical interviews and retrospective self-report indicated a history of emotional neglect and physical abuse during early childhood, consistent with findings that early trauma increases risk for bipolar and other severe psychopathology (Anggadewi, 2020; Hasanah, 2018). Collateral information from family members supported these accounts. Early-onset affective instability and poor impulse control were evident, likely exacerbated by chronic adversity. The patient displayed interpersonal hypersensitivity, emotional lability, chronic feelings of emptiness, and episodes of dissociation (“blacking out” during conflict). These traits were consistent with post-traumatic adaptations rather than primary mood pathology, complicating the diagnostic process and therapeutic engagement.

Emotional Dysregulation

On the Difficulties in Emotion Regulation Scale (DERS), the patient showed marked deficits in emotional clarity (score: 18) and impulse control (score: 21). Observationally, she reacted with disproportionate emotional intensity to minor triggers, such as becoming verbally aggressive when reminded to follow ward structure, later expressing shame and confusion about her behavior. Such patterns supported the hypothesis of trauma-induced dysregulation involving amygdala hyperactivation and hypothalamic–pituitary–adrenal (HPA) axis dysfunction, which aligns with evidence linking childhood trauma to heightened impulsivity and suicidality in bipolar disorder (Dramilaraki et al., 2021; Guillen-Burgors et al., 2023).

Treatment Response

During her four-week inpatient stay, the patient was initiated on mood stabilizer therapy (valproate 1,000 mg/day) and a low dose of quetiapine, which improved sleep quality and reduced irritability within two weeks. Psychoeducation and trauma-focused supportive psychotherapy sessions were introduced, focusing on developing emotion regulation strategies and linking past trauma to current relational difficulties. By discharge, her HAM-D score had decreased to 13 (mild depression) and YMRS to 9 (subthreshold hypomania). Although acute mood symptoms improved, residual emotional dysregulation persisted. She was referred for continued outpatient psychotherapy with an emphasis on trauma processing and emotion regulation skills.

The patient's clinical presentation supports the growing consensus that early-life trauma plays a critical role in the pathogenesis and trajectory of rapid cycling bipolar disorder (RCBD). Neuroimaging and epigenetic studies have revealed that trauma exposure during sensitive developmental periods can lead to long-term structural and functional changes in the brain, particularly in the limbic system and prefrontal cortex. These alterations manifest as heightened reactivity to emotional stimuli, impaired impulse control, and reduced cognitive flexibility (Dannlowski et al., 2012; Nemeroff, 2016).

In addition, trauma is not only associated with neurobiological vulnerabilities but also with psychosocial disruptions such as low self-esteem, poor coping strategies, and maladaptive interpersonal styles. These factors interact bidirectionally with mood symptoms, creating a feedback loop that perpetuates instability and increases relapse risk. Cultural and systemic factors may further exacerbate outcomes, especially in low-resource settings where trauma disclosure is stigmatized and access to psychotherapy is limited. Therefore, clinicians are encouraged to move beyond a purely pharmacological paradigm and integrate trauma-informed frameworks at all levels of care, from assessment to long-term rehabilitation. This holistic approach aligns with current global mental health priorities and emphasizes recovery-oriented, patient-centered strategies.

Structural MRI studies have shown reduced volume of the hippocampus and prefrontal cortex in individuals with a history of childhood maltreatment, potentially accounting for deficits in emotion regulation and executive functioning (Teicher & Samson, 2016). Meanwhile, hyperactivation of the amygdala correlates with exaggerated emotional responses and vulnerability to mood instability. These neurobiological changes are mediated in part by epigenetic modifications, including methylation of genes such as BDNF and FKBP5, which are involved in synaptic plasticity and stress regulation (Goodman et al., 2022; Heim & Binder, 2012).

From a psychological standpoint, the patient demonstrated hallmark features of trauma-related personality traits, including emotional lability, interpersonal hypersensitivity, and identity disturbance. These features share common ground with borderline personality disorder (BPD), often leading to diagnostic confusion. However, the episodic and cyclic nature of the patient's mood symptoms, along with their temporal pattern, aligns more clearly with RCBD. This overlap underscores the importance of adopting a dimensional rather than categorical approach, as promoted by the Research Domain Criteria (RDoC) framework (Insel, 2010).

Pharmacological management of RCBBD in trauma-exposed individuals is particularly challenging. Although valproate and quetiapine have demonstrated efficacy in stabilizing mood episodes, patients with unresolved trauma often show partial or delayed treatment response (Noor et al., 2023). Chronic activation of the hypothalamic-pituitary-adrenal (HPA) axis, as seen in trauma survivors, may disrupt serotonergic and dopaminergic signaling, undermining the pharmacodynamics of mood stabilizers (Wisnujono & Machfoed, 2021). This neuroendocrine dysregulation may explain why mono-pharmacotherapy is often insufficient in complex cases (Hidayat, 2022; Matthew, 2020; Widarti et al., 2015).

Despite growing awareness of trauma's role in mood disorders, trauma screening remains underutilized in psychiatric settings, particularly in low- and middle-income countries. Several barriers hinder its routine implementation. Clinicians often lack training in trauma-informed interviewing, and patients may be reluctant to disclose past abuse due to fear of stigma, shame, or perceived irrelevance to current symptoms. In cases of RCBBD, trauma-related personality traits such as emotional lability or interpersonal distrust may further complicate the therapeutic alliance, reducing openness during assessments (Afifah, 2023). Additionally, some healthcare systems prioritize symptom stabilization over psychosocial exploration, inadvertently perpetuating a biologically reductionist approach that overlooks trauma histories. These systemic and interpersonal challenges highlight the need for integrating structured trauma screening tools—such as the Adverse Childhood Experiences (ACE) questionnaire—into standard psychiatric evaluations.

Stigma presents another significant obstacle. Individuals with bipolar disorder often face double stigma: one related to their psychiatric diagnosis and another rooted in their trauma experiences. This intersectional stigma can reduce treatment-seeking behavior, impair adherence, and increase internalized self-blame (Rahmawati, 2021). Efforts to promote mental health literacy, clinician empathy, and trauma-sensitive communication are essential to mitigate these effects. Implementing trauma-informed practices across services—emphasizing safety, trust, collaboration, and empowerment—not only improves diagnostic accuracy but also fosters long-term engagement and therapeutic alliance. Embedding these principles within clinical training, institutional policies, and community outreach aligns with global efforts to reduce the burden of mental illness and achieve SDG 3: Good Health and Well-being.

To address this, integrative treatment approaches combining pharmacotherapy with trauma-focused psychotherapies have shown superior outcomes. Wibisono et al. (2021) Interventions such as Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), and Eye Movement Desensitization and Reprocessing (EMDR) are effective (Sari & Winarni, 2020; Sudiyanto, 2017). In this case, supportive trauma-focused psychotherapy initiated during inpatient care laid the groundwork for outpatient therapy focused on processing childhood experiences and building emotion regulation skills.

Beyond individual treatment, the role of psychosocial factors must be emphasized. The patient's early exposure to familial conflict and lack of emotional support likely exacerbated her vulnerability. Research shows that individuals with low social support and high perceived stigma face greater difficulty adhering to treatment and maintaining long-term stability (Santoso &

Wijaya, 2022). Incorporating psychoeducation, family therapy, and resilience training into the treatment plan can buffer against environmental stressors and promote functional recovery.

Furthermore, the case illustrates how trauma-related traits such as impulsivity and identity disturbance can obscure the clinical picture (Astriliana & Kustanti, 2023). Studies indicate that co-occurring trauma symptoms delay the diagnosis of BD by an average of 5–10 years, resulting in prolonged suffering and inappropriate treatment (Janiri et al., 2023). Hence, clinicians should maintain a high index of suspicion for trauma histories in patients with unstable mood presentations.

Finally, this case supports the need for more personalized and trauma-informed psychiatry, especially in settings where stigma and resource limitations prevail. (Poletti et al., 2024) Future research should explore biomarkers of trauma-related affective dysregulation, such as cortisol levels, neuroinflammatory markers, or functional brain connectivity, to guide tailored interventions. Multidisciplinary collaboration between psychiatry, psychology, social work, and community health is essential for improving long-term outcomes in patients with complex mood and trauma comorbidities.

Culturally adapted psychoeducational materials and community-based mental health outreach may further reduce stigma and improve access to trauma-sensitive services, especially in regions where mental illness remains highly misunderstood or pathologized

Limitations and Recommendations

This case study offers important insights into the interplay between childhood trauma and rapid cycling bipolar disorder (RCBD); however, several limitations must be acknowledged. First, the single-case design limits generalizability. While the patient's clinical course illustrates many trauma-related patterns observed in the literature, individual variability in trauma responses, neurobiology, and treatment outcomes remains substantial. Second, recall bias may have influenced the accuracy of the patient's trauma history, particularly given its retrospective and self-reported nature. Objective documentation of childhood adversity—such as medical, legal, or third-party reports—was not available in this case.

Additionally, the absence of neuroimaging or biological testing prevents direct correlation between clinical symptoms and structural brain changes or stress biomarkers. Although existing literature supports Association, (2013) between trauma, HPA axis dysregulation, and limbic alterations, these mechanisms were inferred rather than directly measured in this study. Future case reports or cohort studies should consider incorporating neurobiological data, including cortisol levels, functional imaging (fMRI), and epigenetic markers such as BDNF methylation, to strengthen causal inferences.

Another limitation concerns treatment monitoring. While initial improvements were observed during inpatient care, longitudinal follow-up data were not included, making it difficult to assess long-term efficacy of trauma-informed interventions in RCBD. This underscores the need for extended observation and outcome tracking post-discharge.

Despite these limitations, the findings have practical implications. Clinicians should be encouraged to incorporate trauma screening tools routinely in BD assessment, particularly in patients with affective instability, treatment resistance, or overlapping personality traits. Training programs should integrate trauma-informed care principles, emphasizing the recognition of trauma's behavioral, neurobiological, and emotional consequences.

Research-wise, there is a clear need for prospective, multicenter studies examining trauma's impact on bipolar disorder subtypes, especially in underserved populations. Investigating the efficacy of integrative treatments—combining pharmacotherapy with CBT, DBT, and EMDR—can help build robust, personalized care models. These directions are vital for bridging the current gap between biological psychiatry and trauma-informed clinical practice. Such efforts are not only clinically necessary but also ethically imperative to ensure equitable mental health care access for trauma-exposed individuals.

This case further underscores the necessity of adopting a multidimensional treatment framework in managing complex bipolar disorder. Beyond pharmacological stabilization, attention to trauma-informed care allows clinicians to address the deep-rooted emotional vulnerabilities that often perpetuate rapid cycling and treatment resistance. Integrating family psychoeducation, supportive psychotherapy, and structured community-based interventions may strengthen adherence and foster resilience, particularly in resource-limited settings. Moreover, the case illustrates how single-case studies, though limited in generalizability, can illuminate pathways for hypothesis generation and clinical innovation. Future research should expand on this model by incorporating neurobiological markers, longitudinal follow-up, and culturally sensitive interventions tailored to patients in diverse clinical contexts.

CONCLUSION

This case underscores the critical impact of childhood trauma on the onset, severity, and treatment resistance of rapid cycling bipolar disorder (RCBD). The interplay between trauma-induced neurobiological alterations and emotion dysregulation contributes significantly to the complexity of symptomatology and therapeutic challenges. A trauma-informed approach—integrating pharmacological, psychotherapeutic, and psychosocial interventions—is essential in improving clinical outcomes.

While mood stabilizers and antipsychotics remain foundational in treatment, their effectiveness may be compromised without addressing the underlying trauma-related personality traits and emotional vulnerabilities (Dewi & Santoso, 2024). Therefore, screening for trauma history should be a standard component in the assessment of bipolar patients, particularly those presenting with affective instability, impulsivity, or treatment resistance.

Future research should focus on identifying neurobiological biomarkers of trauma-related affective dysregulation and evaluating the efficacy of integrative, personalized interventions. Multidisciplinary collaboration is vital in developing holistic care strategies that address the biological, psychological, and environmental determinants of RCBD.

Overall, this case reinforces the importance of a multidimensional approach. Integrating biological, psychological, and sociocultural perspectives not only improves diagnostic accuracy but also enhances the effectiveness of treatment and recovery. In clinical practice, early identification of trauma in bipolar patients should be prioritized, particularly among those with atypical presentations. Embedding trauma-informed approaches into routine psychiatric care holds promise for enhancing treatment outcomes and reducing the global burden of mood disorders.

REFERENCE

- Afifah, A. (2023). Pengaruh Disregulasi Emosi dan Self-Esteem terhadap Perilaku Self-Injury pada Remaja. UIN Jakarta.
- Anggadewi, P. (2020). Pengaruh Trauma Anak Usia Dini terhadap Risiko Gangguan Psikologis Bipolar. *Buletin Psikologi*, 28(2), 73–85.
- Association, A. P. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.).
- Astriliana, D., & Kustanti, E. R. (2023). Pengalaman sebagai Pasien dengan Gangguan Bipolar Tipe I (Sebuah Studi Fenomenologis Interpretatif. *Jurnal Empati*, 12(1), 1–12.
- Baldessarini, R. J., Faedda, G. L., & Vázquez, G. H. (2023). Characteristics of rapid cycling in 1261 bipolar disorder patients. *International Journal of Bipolar Disorders*, 11(1), 21.
- Dannlowski, U., Kugel, H., Huber, F., Stuhrmann, A., Redlich, R., Grotegerd, D., & Suslow, T. (2012). Childhood maltreatment is associated with an automatic negative emotion processing bias in the amygdala. *Human Brain Mapping*, 33(2), 289–299. <https://doi.org/10.1002/hbm.21200>
- Dewi, N. R., & Santoso, H. (2024). Antipsychotic switching in bipolar disorder with metabolic comorbidities: A case report. *Sinergi International Journal of Psychology*, 3(2), 37–44. <https://doi.org/10.55681/sijp-782>
- Dramilaraki, S., Antoniou, A., Porichi, E., Efstathiou, V., Michopoulos, I., Gournellis, R., Douzenis, A., & Ferentinos, P. (2021). Childhood trauma and suicidality in bipolar disorder: The mediatory role of impulsivity. *Psychiatriki*. <https://doi.org/10.22365/jpsych.2021.016>
- Goodman, A. M., Hankin, B. L., & Hamilton, J. L. (2022). Neurobiological mechanisms linking childhood adversity and emotion dysregulation: A transdiagnostic perspective. *Neuroscience & Biobehavioral Reviews*, 134, 104524. <https://doi.org/10.1016/j.neubiorev.2021.104524>
- Grande, I. (2016). Bipolar disorder: Current clinical and research perspectives. *The Lancet*, 387(10027), 1561–1572.

- Gratz, K. L., & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the Difficulties in Emotion Regulation Scale. *Journal of Psychopathology and Behavioral Assessment*, 26, 41–54. <https://doi.org/10.1023/B:JOBA.0000007455.08539.94>
- Guillen-Burgors, H., Morino Lopez, S., & Acevedo, K. (2023). Risk of childhood trauma exposure and severity of bipolar disorder in Colombia. <https://doi.org/10.1186/s40345-023-00289-5>
- Hasanah, C. D. U. (2018). Hubungan Faktor Trauma Masa Lalu dengan Status Mental Beresiko Gangguan Psikosis Pada Remaja Akhir di DKI Jakarta. *Jurnal Psikologi dan Kesehatan Mental*, 3(2).
- Heim, C., & Binder, E. B. (2012). Current research trends in early life stress and depression: Review of human studies on sensitive periods, gene–environment interactions, and epigenetics. *Experimental Neurology*, 233(1), 102–111. <https://doi.org/10.1016/j.expneurol.2011.10.032>
- Hidayat, T. (2022). *Dinamika Psikologis Individu dengan Gangguan Kepribadian Ambang*. ResearchGate.
- Insel, T. R. (2010). Research Domain Criteria (RDoC): New classification. *Am J Psychiatry*, 167(7), 748–751. <https://doi.org/10.1176/appi.ajp.2010.09091379>
- Janiri, D., Moccia, L., & Montari, S. (2023). Primary emotional systems, childhood trauma, and suicidal ideation in youths with bipolar disorders. <https://doi.org/10.1016/j.chiabu.2023.106521>.
- Matthew, W. S. (2020). A day in the life of borderline personality disorder: A preliminary analysis of within-day emotion generation and regulation. <https://doi.org/10.1007/s10862-020-09836-1>
- Miola, A., Tondo, L., Pinna, M., Contu, M., & Baldessarini, R. J. (2023). Characteristics of rapid cycling in 1261 bipolar disorder patients. *International Journal of Bipolar Disorders*. <https://doi.org/10.1186/s40345-023-00300-z>
- Nemeroff, C. B. (2016). Paradise lost: The neurobiological and clinical consequences of child abuse and neglect. *Neuron*, 89(5), 892–909. <https://doi.org/10.1016/j.neuron.2016.01.019>
- Noor, N. U., Perwitasari, D. A., & Sawitri, S. (2023). Hubungan Terapi Kombinasi Mood Stabilizer dan Antipsikotik dengan Kemampuan Fungsional Pasien Gangguan Afektif Bipolar di Rumah Sakit Jiwa Grhasia Yogyakarta. *Jurnal Sains Kesehatan*, 7(1), 45–56.
- Poletti, S., Mazza, M. G., & Benedetti, F. (2024). Inflammatory mediators in major depression and bipolar disorder. *Translational Psychiatry*, 14, 247. <https://doi.org/10.1038/s41398-024-02852-2>

- Rahmawati, S. (2021). Hubungan Trauma Psikologis dengan Tingkat Depresi pada Mahasiswa Kedokteran. *Jurnal Malahayati*.
- Santoso, B., & Wijaya, D. (2022). Dampak-Dampak yang Terjadi Akibat Disregulasi Emosi pada Remaja Akhir: Kajian Literatur Sistematis. *Journal of Psychology Research*.
- Sari, D. P., & Winarni, S. (2020). Intervensi dalam Pengelolaan Perasaan pada Remaja dengan Gangguan Bipolar: Tinjauan Literatur. *Jurnal Keperawatan Jiwa*, 8(2), 123–135.
- Sudiyanto, A. (2017). Keefektifan Psikoterapi Untuk Menurunkan Skor Kecemasan Pasien Gangguan Anxietas. *Indigenous: Jurnal Ilmiah Psikologi*, 2(1), 1–10.
- Wibisono, S., Widyastuti, T., & Widyadharma, P. E. (2021). Cognitive Behaviour Therapy untuk Mengatasi Gejala Post Traumatic Stress Disorder pada Korban Kekerasan dalam Rumah Tangga. *Gajah Mada Journal of Professional Psychology (GamaJPP)*, 7(2), 123–134.
- Widarti, L., Mahfoed, M. H., Kuntoro, & Sudiana, K. (2015). Respons Psikologis (Kecemasan dan Depresi) dan Respons Biologis (Cortisol, IFN- γ dan TNF- α) pada Pasien Stroke Iskemik dengan Pendekatan Model Home Care Holistic. *Jurnal Ners*, 10(1), 1–10.
- Wisnujono, D. A., & Machfoed, M. H. (2021). Hubungan Intensitas Nyeri Kepala, Stres Psikologis, dan Kadar Kortisol Serum pada Penderita Tension Type Headache. *Aksona: Jurnal Anestesiologi dan Kedokteran Perioperatif*, 1(1), 24–30.
- Young, R. C., Biggs, J. T., Ziegler, V. E., & Meyer, D. A. (1978). A rating scale for mania: reliability, validity and sensitivity. *British Journal of Psychiatry*, 133(5), 429–435. <https://doi.org/10.1192/bjp.133.5.429>