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Disrupted Relatedness and Shifting Perceptions of Others: Changing Moods Over Time for People Diagnosed with Bipolar Disorder

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Abstract

For people diagnosed with bipolar disorder, the relationship between mood episodes and interpersonal life is critical. Yet little is known about how their experience of other people changes during and between episodes of depression and mania. This longitudinal study aimed to investigate the experience of interpersonal change during depression, mania and euthymia (stability). Semi-structured interviews were conducted with three women at two time points and were analysed using longitudinal interpretative phenomenological analysis. One longitudinal theme, "Changing sense of others impacts relatedness," demonstrates profound changes in participants' experiences of other people within and between episodes. During depression, participants experienced other people as critical and threatening, making interactions impossible, whereas during mania they felt liberated from the expectations of others, who were seen as either subservient or irrelevant. For some participants, interpersonal disruption persisted during euthymia, making social interactions challenging. The findings highlight distinct forms of disrupted relatedness during depression and mania which were cumulative, impacting participants' ability to relate to others and reconnect during stable periods. This points to the clinical value of those affected by bipolar disorder gaining insight into their trajectory of interpersonal change, along with a focus on rebuilding relationships and relational connection during euthymic phases.

Keywords

bipolar disorder; interpersonal; bipolar episodes; longitudinal; qualitative

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Disrupted Relatedness and Shifting Perceptions of Others: Changing Moods Over Time for People Diagnosed with Bipolar Disorder

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For people diagnosed with bipolar disorder, the relationship between mood episodes and interpersonal life is critical. Yet little is known about how their experience of other people changes during and between episodes of depression and mania. This longitudinal study aimed to investigate the experience of interpersonal change during depression, mania and euthymia (stability). Semi-structured interviews were conducted with three women at two time points and were analysed using longitudinal interpretative phenomenological analysis. One longitudinal theme, "Changing sense of others impacts relatedness," demonstrates profound changes in participants' experiences of other people within and between episodes. During depression, participants experienced other people as critical and threatening, making interactions impossible, whereas during mania they felt liberated from the expectations of others, who were seen as either subservient or irrelevant. For some participants, interpersonal disruption persisted during euthymia, making social interactions challenging. The findings highlight distinct forms of disrupted relatedness during depression and mania which were cumulative, impacting participants' ability to relate to others and reconnect during stable periods. This points to the clinical value of those affected by bipolar disorder gaining insight into their trajectory of interpersonal change, along with a focus on rebuilding relationships and relational connection during euthymic phases.

Keywords: bipolar disorder; interpersonal; bipolar episodes; longitudinal; qualitative

Introduction

Bipolar Disorder (BD) is a chronic affective disorder characterised by recurring episodes of mania, hypomania or depression that create profound disruptions to mood, energy and behaviour (Vieta et al., 2018). With lifetime prevalence estimated at 2.4%, it is one of the leading causes of disability in young people (Merikangas et al., 2011; Vigo et al., 2016) and is associated with substantially shortened live expectancy (Chan et al., 2022). BD is associated with disruptions in interpersonal domains, including familial relationships, friendships and work relationships (Robb et al., 1997). Divorce is two to three times higher among individuals with BD than the general population in the US, with similar trends elsewhere (Kogan et al., 2004; Suppes et al., 2001). Families of people diagnosed with BD report high levels of caregiver burden which, in turn, adversely affects the clinical course and outcome of BD (Perlick et al., 2004; Shokrgozar et al., 2022).

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Social support has been identified as a protective factor for BD (Studart-Bottó et al., 2023). Its availability has been linked to improved BD clinical outcomes, with greater perceived social support associated with reduced risk of manic or depressive relapse during remission (Wang et al., 2018). Supportive others have been found to facilitate symptomatic remission following BD episodes (Cohen et al., 2004; Johnson et al., 2003) while specific family environments also impact the course of BD. Critical familial environments, characterised by high expressed emotion, are associated with higher relapse rates and poorer symptomatic outcomes (Miklowitz & Johnson, 2009). Instances of relationship breakdown, such as divorce, are related to a higher severity of episodes and the presence of residual episodes during stable periods (Grover et al., 2017).

Some studies suggest a bidirectional relationship between social support and BD clinical features (Greenberg et al., 2014). Episodes and the reduction of positive emotions can negatively impact personal relationships and are associated with a loss of social support (Koenders et al., 2015). Yet despite increasing recognition of an important relationship between interpersonal experiences and BD episodes, no work has examined how a person's experience of other people changes within and between episodes over time.

In the qualitative literature, a small number of cross-sectional studies indicate the impact of relationships and interpersonal events on episode management and vice versa. Positive relationships are seen to have an important role in supporting mood management and relapse prevention (Fernandez et al., 2014). Reliable and empathic friends and family allow for the discussion of experiences, facilitating self-awareness and acceptance, both of which support recovery (Warwick et al., 2019). Social interactions can also help distract from, or challenge, negative thoughts and enable greater control (Owen et al., 2015, 2017).

However, relationships are a delicate balance. Feeling misunderstood by family members or friends, along with a perceived lack of social support, or the loss of it, can exacerbate negative thoughts, increasing the risk of depressive episodes (Hormazábal-Salgado & Poblete-Troncoso, 2020). Even minor interpersonal events, such as a friend not returning a phone call, can trigger a downward negative spiral (Owen et al., 2015).

BD episodes themselves also impact relationship with other people. For example, mood volatility can lead to marital breakdown with disinhibited or risky behaviours during mania seen as particularly detrimental (Granek et al., 2016). For people with BD, relationship tensions over extreme behaviours and personality changes instil feelings of anxiety and shame (Inder et al., 2008). One study, however, suggests that if episodes are managed within spousal relationships, this can contribute to the strengthening of those relationships in the longer term (Granek et al., 2016).

These studies highlight the close association between BD episodes and interpersonal domains for people living with BD. And yet, the way this relationship changes across distinct episodes and stable periods is not clear. To date, no study has examined how relationships with others and BD episodes are experienced over time for people diagnosed with BD. And yet, an examination of this aspect is likely to provide important insight into what interpersonal changes occur within and between episodes of mania and depression and are constitutive of it. Taking a longitudinal approach, this study will therefore examine how people diagnosed with BD experience their interpersonal world and changes in other people within and between bipolar mood episodes and stable periods.

Method

Design

Longitudinal Interpretative Phenomenological Analysis (LIPA; Farr & Nizza, 2019) was selected to examine the participants' experiences during BD episodes and stability (euthymia). Interpretative Phenomenological Analysis (IPA) is well-positioned to examine the way people experience and make sense of other people. Used longitudinally, the unique strength of IPA versus other methods is its idiographic level of analysis that can identify each participant's trajectory and their evolving sense-making of change over time. The aim was to interview each participant on three separate occasions; once during each phase (depression, mania and stability). In practice, however, none of the participants experienced a manic episode during the study period and were, therefore, only interviewed during depression and stability. The interview schedule, however, explored all three states during each interview: participants were first asked about their interpersonal experiences in their current state before moving on to discuss this aspect during the remaining two states.

Ethical Considerations

The study received ethics approval from Camden and Kings Cross NHS research ethics committee (Ref: 15/LO/1875). Interview procedures were devised to minimise the risk of upsetting participants. Participants were reminded of their right not to answer questions or to stop the interview, while the researcher monitored their wellbeing and stopped should they appear distressed. If a participant disclosed a significant risk to themselves or intention to harm others, their clinician would be immediately notified. The terms of breaking confidentiality were outlined in the consent form and, in practice, no issues arose. Interviews were conducted at the service where clinical support was available to both participant and researcher. Recruitment procedures were devised to reduce risk and avoid breaking participant confidentiality. Prior to interviews, clinicians were approached to check the suitability of individuals, ensuring those who were known to be at risk were not included. In practice, no participants were excluded on this basis.

Participants

The participants were selected purposively to form a relatively homogenous sample. Inclusion criteria included a diagnosis of bipolar disorder and sufficient fluency in English to conduct an interview. Three participants were recruited and interviewed during depression and stability. Two participants were interviewed during stability in the first interview and during depression in the second interview, whereas one participant was interviewed first during depression and second during stability. Participants were female, white, aged 35-45 and had received a formal diagnosis of bipolar disorder within the last five years.

Recruitment and Setting

Suitable participants were identified by clinicians within a NHS community mental health service and invited to contact the researcher. The researcher sent the information sheet and consent form to potential participants, who were invited to discuss queries with the researcher or their clinician. Prior to participating in each interview, study details were reviewed with the participant and their consent was confirmed in writing. If they wished to participate, an interview time was arranged that was convenient for the participant. Interviews

were conducted in person. Before the depression interview, participants were screened for depression using the Beck Depression Inventory-II self-report questionnaire (Beck et al., 1996).

Data Collection

The same interview schedule was used for all interviews, regardless of phase, offering participants the opportunity to describe their current state in detail but also reflect on the other two states. This more inductive approach enabled participants to describe how they were feeling at the time rather than tailoring the interview schedule to a specific phase and assuming that change had taken place (Farr & Nizza, 2019). During the first part of the interview, questions were asked about the participant's current state. They were then asked to talk about their previous state and, finally, the third state they had not yet discussed.

Interviews were audio recorded and conducted in a private room at the service. After first interview, participants were asked whether they would be interested in participating in a second interview during a change in their state. All participants showed interest in continuing the study. Interviews lasted 65-100 minutes. The interviews were transcribed and all identifying information was anonymised.

Data Analysis

The following LIPA steps were followed (Farr & Nizza, 2019). For each participant, the data at each time point was analysed to produce two tables of themes, one for each interview conducted during depression and stability. This followed a cross-sectional IPA analysis, including the formation of a table of themes for each interview (Smith et al., 2021). Notes were made throughout a transcript, translated into experiential statements and clustered, producing a table of personal experiential themes (PETs) for that interview. This process was repeated for each interview, producing two tables of PETs for each participant (depression and stability). The formation of a table of themes at each time-point captured the participant's immediate experience of either depression or stability, along with their retrospective experience of mania.

The two theme tables for each participant were analysed longitudinally to form a table of themes that captured their experience across the three states. This involved looking across themes to identify changes between depression, stability and mania. Through this process, trajectories of change were established spanning both episodes and stability. This resulted in a longitudinal table of themes for each participant. Finally, a cross-case analysis of the three longitudinal table of themes was conducted to formulate a master longitudinal table of themes for all participants. To allow for sufficient depth, one master longitudinal theme will be presented in this paper.

The researcher (first author) who led the interviews and analysis is white, middle aged and female. She has no lived BD experience and had conducted this study for her doctoral thesis focusing on the experience of bipolar mood change and early intervention. The remaining two researchers are white, middle-aged and male, and supervised the Ph.D. research. The second author is an IPA expert and the third has extensive clinical experience of BD. IPA's analysis is formed through a double hermeneutic where the researcher is making sense of the participant's sense-making. Reflexivity supported an awareness of the researcher's position, how this differed from that of the participants and how this could influence the formation of analytic interpretations. This process was facilitated by an iterative analytic process during which possible interpretations were repeatedly reflected on by considering the data, the researcher's position and the participant's account. This was further facilitated by a member of

the research team (second author) cross-checking the researcher's interpretations against the data.

Results

The longitudinal theme – "Changing sense of others impacts relatedness" - tracks the changing trajectory of participants during each stage of depression, stability and mania (See Table 1. Below).

Table 1
Master Table of Longitudinal Themes for Participants

Depression	***Stability***	***Mania***
Changing Sense of Others Impacts Relatedness		
Self-isolating against social shame	Emerging trust builds relatedness	Mania: disinhibited self brings relational detachment

Changing Sense of Others Impacts Relatedness

The participants' experience of other people altered during the three states, creating a shifting interpersonal landscape where relational trust and social interactions changed and the meaning of even the closest relationships became redefined. Interpersonal disruptions during episodes could be cumulative, impacting the participants' relationship with others during stable (euthymic) periods.

Depression: Self-Isolating Against Social Shame

During depression, participants were overwhelmed by social condemnation and struggled to interact with other people.

Julia's feelings of worthlessness intensified in the presence of close others:

> Close people are judging you, you just want to disappear, you feel like you've lost the people who care about you (she cries). I think I'm afraid to lose them, that they won't be able to stay any longer. That feels quite possible, it makes you feel bad, like stressed, scared.

Julia struggles in the presence of close others, whose purpose, in her eyes, is to expose her worthlessness. She expresses an anxious awareness of their critical gaze and a sense of inadequacy in their company. This sense of condemnation is bodily felt, instilling a strong desire to "disappear" and escape their physical proximity. What is even harder for Julia is that the people who matter to her appear altered, imbuing her close relationships with a sense of estrangement and loss. This disruption instils fearful feelings that she could lose them completely.

Julia's feelings of worthlessness with others also structure her wider social world: "I feel worse than everybody else probably […] I'm like a way worse person than they are or anybody else."

Julia's social world only serves as proof of her inadequacy. By being "worse than everybody else" she lacks any normative attributes of social comparison and becomes both alienated and dehumanised. The shame of her inadequacy is unbearable, and Julia withdraws

into the relative comfort of isolation: "I don't want them to see me like this. Probably I feel ashamed of me, that why I don't want to see them."

When Karen is with others during depression, she is overwhelmed by a sense of failure:

> I just feel I can't face them, yeah, I can't face them, I don't know how to talk with them, I feel really bad in my relationships, I feel like a terrible wife, with the kids like a terrible mother cos I'm not taking care of their needs.

Karen fears having to face her family. Like Julia, she sees herself as the object of their critical judgements and lacking the ability to redeem herself. Her repetition of "can't face" suggests her inadequacy is exacerbated in their presence and it is this reflected sense of self that instils feelings of shame. Karen does not "know how to talk with" her family and this reinforces her belief that she is a "terrible" wife and mother. Whereas Julia could not tolerate perceived changes in others, Karen struggles with her inability to communicate and fulfil expected social roles. Similarly, Karen's impulse is to hide: "I'll kind of give my bubble wrap, kind of trying to remove myself from reality or having to face reality. Yeah, I can just hide myself away and hopefully they're gonna move on without me."

Karen's self-inflicted isolation acts as "bubble wrap," protecting her from having to become the wife and mother that she feels she cannot be. Far better that she "remove herself" from the expectations of others in the hope they "move on without me."

Like the others, Caroline cannot endure being with others: "You don't want to talk to anybody and you don't wanna communicate and you just wanna run away whenever you came, I just wanna go and be inside that cage."

For Caroline, her separation from others is a "cage" suggesting a punitive incarceration. This is no protective "bubble wrap" but an enforced solitary confinement where she is imprisoned by fear and self-critical thoughts:

> Everything feels scary, fearful, the fear is just lessening now, but the first couple of days, or even the whole week, I couldn't even communicate with my parents… the closest person to me, which is my mum, I felt the same, it felt lonely… I cannot say anything because it is all internal, internal dialogue, it is just monologue, just telling myself this how it is… you're not able.

Caroline experiences a critical "internal monologue" during depression that suppresses her speech and interactions. Like the others, her closest relationships have altered and people who previously offered companionship now appear distant, even threatening. Like Karen, her separation from close others manifests in a sense of threat – "everything feels scary" - that coincides with her inability to communicate. Despite self-isolating herself, her sense of loneliness is profound.

Stability: Emerging Trust Builds Relatedness

On becoming well, participants began to feel, in varying degrees, more comfortable in the company of others who were perceived as more welcoming.

Julia is no longer surrounded by the crushing judgment of others:

> You feel more positive about other people. You have a good opinion of other people, whereas before I probably have a bad one, I can forgive more… so it's about other people and you can see the beauty… I now have that positive-ness, I think now other people are good, they're nice.

Julia perceives, and is drawn towards, a more secure interpersonal world where she feels "positive about other people." The change to seeing the good in others rekindles a sense of safety and shared belonging but also enables self-transformation. Interpersonal trust has been restored and those others who previously appeared superior and estranged now feel affirming. Julia seems aware of the change in her perceptions of others and attributes this to the "positivity" of her transformed perceptions where her social world is revealed in a trusting and welcoming light. In her new relational world, she is reconnected and initiates interactions: "I do not ignore messages, I can answer it finally. Finally, you kind of show initiative."

Like Julia, Karen is relieved to be able to communicate easily with others:

> I feel good about others, I'm fairly relaxed and don't feel agitated. When I'm depressed, I just wouldn't be able to talk at all, so just having a decent conversation with somebody and feeling the different emotions. But I think every now and again I feel this person did this, this, this […] "Can I move on? Am I gonna hold that thing against them forever?" So, I'm trying to kind of figure out what I should be doing, the way that I should be acting.

Like Julia, Karen feels "good about others," suggesting a similar restoration of trust. Her newfound ability to interact also instils an emotional vitality and reconnection. Unlike Julia, however, Karen still worries about how she should act around others. As she is reminded of the past actions of others, her interactions falter and she questions; "Can I move on?" In contrast to Julia, Karen is unsure whether she can forgive others and searches for ways to feel sufficiently safe to "move on" and recover.

On becoming well, Caroline struggles with a persistent self-consciousness that limits her interactions with others:

> [I feel] Very sensitive, very sensitive, I just want like a miracle to happen and to make me not think all the time before I talk or before, or think after I talk of what conversation that has taken place, how it was and how I've come across or how people have judged me, it's keeping me quiet.

Caroline remains anxious during day-to-day interactions and preoccupied with how she is perceived. Her anxiety seems to arise not only from a lack of trust but also a loss of surety of how to behave in an acceptable way. She is engaged in constant self-analysis where she tries to predict "before I talk" and revisits afterwards "how I've come across." Caroline's self-scrutiny prevents her from engaging comfortably in interactions with others and is "keeping her quiet." Nonetheless, she is still fighting to reconceive and develop a socially acceptable way of being with them.

Mania: Disinhibited Self Brings Relational Detachment

Mania is described by participants as a release from social inhibitions and expectations along with a distancing from the concerns of others.

When Julia becomes manic, she revels in her sense of superiority: "When I'm high, I don't care what they [others] think, I think about myself well, and they're all wrong and it's only me who is right. I'm a Princess, Empress!"

Julia feels she possesses the superiority and control of an untouchable "Empress." Whereas during depression she was imprisoned by people's perceptions, during mania she is liberated from any need for social validation. Others are no longer perceived to possess the positivity they had during stability and seem irrelevant. Though Julia's liberating detachment

from others is very different to her social estrangement during depression, there are similarities in interpersonal structure. In both states, other people appear devoid of individuality, congregating as an anonymous "other" where "they're all wrong" and "it's only me who is right."

Karen's sense of uncertainty during stability is replaced by fury towards others:

> I've been very, very angry, at times, I used to blame people for things […] I used to get angry very, very quickly. It was almost like I perceived a completely different side to them and that was when all the anger and resentment came from, kind of stemmed from, I had a lot of anger inside me so I was venting out the anger.

Unlike Julia, Karen does not revel in the irrelevance of others but seems vividly alive to their significance. Her long-held anger is released when faced by a "different side" to others and it flares up with ferocity. Her perception of others switches, igniting her fury but also exposing the source of her feelings. Empowered by mania, Karen undergoes a change in her relationship with others from feeling anxiously accountable to assuming that others are answerable to her.

Like Karen, Caroline's mania releases her from her crippling self-consciousness and she freely befriends and speaks with anyone:

> Whatever comes, just comes, start talking to people, maybe become over friendly. So I start to talk and talk and talk - like I would feel very sexually active, so I became very friendly with men on the street or wherever.

Caroline feels released from interpersonal ties and other people no longer confer the pressure of expectation. She enjoys being able to talk feely with whoever she meets, driven by the urge to be with them physically. She feels "very sexually active" and becomes "very friendly with men on the street" viewing them as a source of pleasure. As with depression, people are imbued with a generality and detachment. However, during depression she perceived other people as a threat. Now, during mania, she views them as being subject to her own wants.

Freed from interpersonal constraints, all participants felt liberated to pursue their needs. As they stabilised, however, it is their recollection of interpersonal interactions that became particularly hard to manage.

Take Caroline, whose recovery from mania is accompanied by rising self-disgust:

> I feel I've exposed my body, that makes me punish myself. Feeling guilty about these things which all comes when I've just recovered from the episode, all comes into my head and I have to analyse it to realise it, which sometimes takes me into the deepest depression, so having to cope with these episodes, makes episodes.

Caroline is so horrified by her manic interactions that she is compelled to "punish" herself. The social humiliation of having freely "exposed" her "body" and her struggle to make sense of these actions pose an affront to her values and sense of self. Her efforts to understand her interactions, along with the social shame they create, risks tipping her into the "deepest depression."

Discussion

Participants experienced an unstable interpersonal world during BD episodes and euthymic periods which were characterised by changes in perceptions of others and a shifting relational connection. The significant influence of episode volatility on the relational experiences of people with BD is indicated in the qualitative literature (Granek et al., 2016; Inder et al., 2008), but studies have tended to focus on the impact of BD episodes on relationships, as well as how other people can help in the aftermath. This study shows that the way in which individuals with BD view others is critical: it shapes the way that other people appear to them, how they feel about them and how they can relate.

Furthermore, the longitudinal analysis shows that this dynamic can change dramatically over time, both during and between episodes. The participants' perceptions of others and associated interpersonal difficulties arose as part of changing relational connection during different states, characterised by disrupted relatedness. To better manage relational challenges during episodes and euthymic periods, findings therefore point to the potential benefit of individuals developing insight into their changing relational perceptions and feelings over time.

Qualitative work has looked at BD depression and suggests that interpersonal experiences are bound up with a person's shifting perceptions of others (Crowe et al., 2012; Owen et al., 2017). In one study, participants' perceptions of minor social events and innocuous responses reinforced a sense of worthlessness during BD depression (Owen et al., 2015). In other studies, perceptions of others' responses prompted a need to hide (Fernandez et al., 2014; Fletcher et al., 2013). BD cognitive models suggest that appraisals of others' responses during depression lead to withdrawal and exacerbate low mood (Fletcher et al., 2013; Mansell et al., 2007). Likewise, in our study, participants struggled with feelings of condemnation and shame in the presence of others, which drove them into isolation. Building on existing work, however, our findings suggest that these feelings primarily arose simply through being seen by others – and they arose bodily, rather than through any judgement of other people's responses. Writers suggest that people diagnosed with schizophrenia may take on self-positions that arise from how they feel they are seen by others (Lysaker et al., 2005). Due to difficulties in shifting positions, they are also at risk of becoming locked within a perceived negative position.

In this study, participants' feelings of being critically perceived were accompanied by a sense that even those closest to them had fundamentally changed, leading to estrangement. Writers argue that the life-affirming connectedness, and possibility for self-transformation, generated by interpersonal experience is lost during depression with the result that others become altered and threatening (Ratcliffe, 2015). This study supports this, but further highlights that for people affected by BD, relational disruption persists beyond depressive episodes, taking on different forms during specific states, including mania.

During mania, participants felt liberated from the constraints of others' perceptions, enabling them to freely interact and prioritise their own needs. Consistent with this, other BD work highlights that mania promotes disinhibition and social advantage (Lobban et al., 2012; Russell & Moss, 2013). Building on this aspect, our study suggests that, while the participants' move to self-actualise liberated their interactions with other people, it also involved a disconnection from them, with people often becoming either subordinate or insignificant. In this way, both depression and mania involved an interpersonal imbalance. During depression, they felt beholden to other people, who they saw as critical, making interactions impossible; during mania, this switched, with other people seen as subservient facilitators of their own needs. In the wider literature, manic behaviours are indicated to be detrimental to relationships (Granek et al., 2016). This study highlights the benefit of understanding this dynamic as part of an ongoing relational disconnection across different states.

The participants' awareness of interpersonal disruption during mania and depression led to feelings of relief at the return of relational positivity and trust during stability. This is consistent with other work in this area where recovery is associated with gaining control over social environment as well as the development of interpersonal trust (Owen et al., 2017). For two of the group in this study, however, relational disruption persisted during euthymia, and they struggled with anxiety over social interactions. In BD, functional recovery following a mood episode consistently lags behind symptomatic recovery, with depression and neurocognitive impairment identified as the strongest correlates of functional impairment (Gitlin & Miklowitz, 2017). This study further highlights that significant changes in interpersonal experience during different episodes are cumulative and that relational disruptions persist during euthymic periods, potentially increasing vulnerability to future episodes.

Strengths and Limitations

The primary strength is that this study is the first to examine the interpersonal experiences of people diagnosed with BD within and between different states. The phenomenological approach captures individualised experiences and identifies what matters, something that is not possible via standardised measures. All participants are female, making this essentially an account of the female experience of mood change and the transferability of the findings to males should be treated with caution. Some studies show differences in the clinical course as well as outcomes of BD in individuals with male versus female gender, including higher incidence of depression in women (Nivoli et al., 2011). Future studies need to explore the male experience of interpersonal change which is currently not known.

Conclusion

Findings highlight that individuals affected by BD undergo dramatic changes in perceptions of other people during depression and mania that lead to ongoing interpersonal disruption. These interpersonal difficulties during episodes are cumulative, can persist during euthymic periods and increase the risk of depressive relapse. The clinical value of individuals gaining insight into the trajectory of change during and between episodes is highlighted, along with a focus, during recovery, on managing shame and anxiety and rebuilding relationships with others. Involving close others in this aspect and understanding BD interpersonal volatility as part of a wider trajectory is likely to be of benefit.

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