Journal of Mental Health and Behavioural Science

ScitechJournals

Open Access

The Possibility of Recovery: Rethinking Bipolar Disorder Through a Biopsychosocial Lens

Abstract

Recovery from bipolar disorder is not typically considered a possible outcome within psychiatry. This article presents an autobiographical clinical case of bipolar disorder that began in adolescence and continued for approximately 33 years. In subsequent years, after serious psychological work, depressive and manic phases completely ceased. The author considers this condition as recovery and analyzes the possible mechanisms of these changes within the biopsychosocial model (Engel, 1977). Particular attention is given to distinguishing two levels of intervention: the biological and the psychological, with an emphasis on how the inner work led to a structural reorganization of personality. Based on personal experience, the author proposes criteria for differentiating between remission and recovery and raises the question of the need to reconsider the prevailing view of bipolar disorder as a lifelong chronic illness.

Keywords

Bipolar Disorder, Recovery, Remission, Biopsychosocial Model, Psychological Transformation, Personality Reorganization, Case Study, Healing

Case Report

Dina Veksler*

[1]*Social Services, Albania*

***Correspondence:** Dina Veksler, Social Services, Albania, E-mail: vekdi77@yahoo.com

Received: 09 Mar, 2026; **Accepted:** 27 March, 2026; **Published:** 10 April, 2026.

Introduction

Bipolar disorder is typically described in psychiatry as a chronic endogenous illness characterized by alternating depressive and manic phases. In clinical practice, the disappearance of symptoms is interpreted as remission – a temporary absence of manifestations of the illness while maintaining the assumption of its possible recurrence. The concept of recovery in bipolar disorder is virtually absent from the medical system, and criteria for its definition have not been developed.

This article presents an autobiographical clinical case of bipolar disorder that began in adolescence and continued for approximately 33 years. In subsequent years, after serious psychological work, depressive and manic phases completely ceased. The author considers this condition as recovery and analyzes the possible mechanisms of these changes within the biopsychosocial model (Engel, 1977).

The biopsychosocial model views mental disorders as the result of interactions between biological, psychological, and social factors. In the presented case, the manifestations of phases were closely linked not only to biological predisposition but also to the author's personality characteristics, internal conflicts, the nature of her existence in the social environment, and enduring patterns of psychological response.

Of particular significance in this case was the psychological level. Over a long period, the author engaged in complex inner work aimed not at suppressing symptoms but at investigating their structure, meaning, triggers, and internal mechanisms. The gradual understanding and modification of these mechanisms was accompanied first by a smoothing of the phases and then by their complete cessation. This is why the psychological level is considered the key factor in the recovery that occurred.

Case Description

Background

The illness was preceded by a difficult family situation. The author's mother constantly compared her negatively to her ex-husband, whom she considered the person who had ruined her life. Having children was perceived by her as a heavy life obligation, which she often complained about. As a result, the child gradually developed a persistent feeling of her own uselessness and an experience of her own worth as problematic, which was accompanied by low self-esteem.

Course of the Illness

The illness began in adolescence with a depressive episode and continued for approximately 33 years, manifesting in typical depressive and manic phases. Depressive states lasted for months and were accompanied by pronounced symptoms: feelings of guilt, delusions of shame, loss of concentration and memory, sleep disturbances, complete loss of appetite, and significant weight loss. During this period, there were suicide attempts.

Manic phases were characterized by accelerated thinking, an intense flow of ideas, a combination of euphoria and irritability, and severe insomnia. Sleep became increasingly shorter regardless of bedtime and was unresponsive to intervention. Behavior during this period became impulsive and unpredictable, although no dangerous actions towards others occurred.

Treatment was conducted within the conditions of Soviet psychiatry and included intensive therapeutic methods: insulin coma therapy, sulphazine, and aminazine. The first manic episode occurred during hospitalization. Despite the long course of the illness, the author continued to work and maintained professional activity throughout her life, except during periods of hospitalization.

The Social Level

The illness developed within a family environment whose reactions significantly influenced the course of the conditions. At different periods of life, the attitude of close people towards depressive and manic manifestations varied, and this noticeably affected the depth and duration of the phases.

The mother, a physician by profession, perceived the condition as a manifestation of illness; however, she considered periods of depression more “healthy” than manic states. Her attitude also contained another psychological factor. After manic episodes, the daughter experienced strong feelings of guilt and a tendency towards self-blame. This position – meek, obedient, acknowledging her guilt – to a certain extent corresponded to the mother’s expectations. Therefore, depressive periods turned out to be psychologically more acceptable for her. The daughter’s self-accusations were not actively questioned and usually met with a response like: “don’t do that anymore.” Such a reaction involuntarily reinforced, prolonged, and deepened the depressive phase, as the ideas of guilt received external confirmation.

This position was formulated quite directly by the mother: “When she is depressed, her thinking is better than when she is in that hyperactive state she is in now. During the depression, she considers me her mother, and we spend time together well.”

Later, the social situation changed: the patient began living with her own daughter. For the daughter, a completely different model of maternal behavior was preferable – active, energetic, engaged. The depressive state, in which the mother sat motionless, immersed in self-blame and barely reacting to the outside world, was perceived by her as an illness. Therefore, she constantly tried to persuade her mother, refuting her self-accusations and returning the conversation to facts.

Thus, the reactions of close people influenced the state differently. While living with her daughter, the course of the illness softened overall - the depth and intensity of both depressive and manic phases decreased. This observation showed that the social environment can significantly influence the course of phases, which aligns with the logic of the biopsychosocial model of mental disorders.

The Psychological Level

Depressive phases were usually preceded by specific dreams in which a situation of hopeless impasse developed for the author. These dreams recurred before the onset of depression and were gradually noticed as possible precursors to the state. At one point, such dreams began to appear after the depressive episode had already ended. This circumstance led the author to a dream analysis specialist and a Jungian analyst.

Within this work, it was suggested to consider the phases not as symptoms of illness, but as possible “messages” from the psyche about the need for certain changes - changes that needed to be undertaken instead of depressions and manias in order to achieve stable balance. The implication was that if this inner work was done, the problem itself would be resolved.

After this shift in approach, the author began not simply to live through the phases, but to investigate their structure and internal logic. These states came to be viewed as two different psychological configurations, each with its own experiences, ways of thinking, and emotional reactions - configurations that needed to be transformed in order to achieve balance.

The work included long-term self-inquiry - the analysis of thoughts and sensations and a purposeful engagement with them. This required an honest and deep examination of one's own needs and desires, a painful process of meeting oneself without any defenses. Central to this was attention to the symbolic manifestations of the psyche, including dreams. This approach gradually revealed the psychological mechanisms that could trigger and sustain various states. The work consisted of changing patterns of thinking and emotional reactions.

A key skill developed in the course of this work was the capacity to accept one's negative sides without falling into depression, and to see the positive aspects of what is "negative" in oneself; as well as the capacity to see positive sides without becoming manic, and to notice the shadow sides of what is "positive." This skill of balance and of holding wholeness became the foundation of a new stability.

Of particular importance was the work with manic states. The author learned to contain mental energy during manias through specific kinds of activities, and to control the energy of thinking - not suppressing it, but channeling it in ways that prevented it from escalating into a destructive phase.

As internal mechanisms became more understandable, the way of responding to emerging experiences changed. This led to a gradual weakening of the polar states and a change in the psychological structure that had previously supported the depressive and manic phases. Over time, the phases became less intense, their duration shortened, and accompanying physical symptoms- such as sleep disturbances- gradually disappeared. As a result, a stable state of mental equilibrium formed, which has now persisted for about twenty years. Depressions and manias truly had "nothing left to do"- the mechanism that generated them had ceased to exist.

The Biological Level

Along with social and psychological factors, the course of the illness also included a biological component. In this context, the biological level is understood as the ability to recognize bodily signals preceding the development of phases. During her self-analysis, the author maintained continuous attention to her internal processes and gradually learned to notice prodromal states-physically reproducible changes in the body that previously would have led to a full depressive or manic phase. These signals appeared as familiar bodily sensations before the development of pronounced symptoms.

Recognizing these signals, the author began to analyze possible psychological triggers, most often associated with stressful situations or internal conflicts. Changing her attitude toward the situation or her reaction to it often led to the disappearance of the bodily signal, preventing the further development of the phase.

Thus, the focus of the work was not the phase itself, but its early biopsychological signal. This made it possible to gradually interrupt the body's habitual transition into depressive or manic states.

Personality Changes in Phases

It's important to emphasize that depressive and manic states weren't simply "episodes" for the author-events occurring to an unchanging personality. On the contrary, the phases were characterized by a marked change in the very functioning of the personality, noticeable both to herself and to those around her.

In depressive states, behavior became inhibited. Social activity declined sharply, to the point of a complete inability to maintain contact. External, physical manifestations also changed: the tone of voice became quiet and timid, the facial expression dejected, and body language uncertain and guilty. This was even reflected in her choice of clothing: the author intuitively preferred dark and gray tones to appear invisible.

In manic states, the opposite, but equally pervasive, pattern was observed. Increased activity encompassed all behaviors: speech accelerated, thinking was overflowing with ideas, and impulsive actions arose. External manifestations changed accordingly: the tone of voice became louder, the facial expression open and expressive, the movements free and impulsive. Bright colors and expressive details appeared in clothing-as if the mania demanded its own visual embodiment.

These were distinct personality states, each with its own way of thinking, emotional world, physical embodiment, and even aesthetics. Attempts to merge these two distinct personalities into one by taking the desired traits from each were unsuccessful. Only by working with each personality separately did they succeed in creating a single, stable personality.

Results

For many years, the author has not experienced depressive or manic phases. Stable personality functioning has been maintained for approximately twenty years without a recurrence of previous symptoms.

Due to the psychological rupture that occurred, the previous emotional support from her daughter ceased. Moreover, the daughter came under the strong influence of her husband, who severed contact between the author and her daughter and grandchildren. Based on the official medical position regarding the chronic nature of bipolar disorder and denying the possibility of recovery, he interpreted the author's condition as a manifestation of another psychiatric diagnosis; paranoid schizophrenia.

In essence, the author found herself once again in a situation where she felt useless and rejected, that is, in the same state that preceded the onset of her illness several decades ago.

However, despite this severe stress, which would previously have been guaranteed to cause an exacerbation, her condition remained stable. This fact requires explanation: if it were simply a case of remission, such a strong trigger would most likely have caused a relapse. The absence of a relapse indicates deeper structural changes.

In light of this, the author consulted specialists to discuss and confirm her state of recovery. However, it became clear that the existing psychiatric system does not have the tools to determine recovery from bipolar disorder. Such an outcome of the disease is almost never considered; a prolonged absence of symptoms is interpreted exclusively as remission- a state of temporary disappearance of the manifestations of the disease while maintaining the possibility of its recurrence. This interpretation does not make sense in this case.

Discussion

The case presented raises a fundamental question: can the complete and sustained cessation of bipolar phases be understood as something other than remission?

In modern psychiatric practice, remission is defined as the temporary disappearance of symptoms while maintaining the assumption of the continued existence of the disease and the possibility of its recurrence. The concept of recovery - the permanent cessation of the pathological process - is virtually absent from the diagnostic system. The absence of symptoms is automatically interpreted as remission, regardless of duration or circumstances.

This case calls into question such an automatic interpretation. The author's stability not only lasted twenty years, but also survived the most severe stressors imaginable: the loss of a relationship with her daughter, social isolation, and stigmatization by her son-in-law. If it had been just remission, such a trigger would have reactivated the illness. But that did not happen.

The author suggests that what happened was not a suppression of symptoms, but a fundamental reorganization of the psychological structures that once gave rise to the phases. The personality itself changed. The mechanism was dismantled.

This raises a terminological question with real consequences: if there is no word in the psychiatric lexicon to describe this outcome other than "remission," then every patient who has achieved lasting stability is forever defined by a disease that may no longer exist. In essence, they are told that they are still sick-just not showing it temporarily. This is not a neutral description. It is a judgment that shapes identity, relationships, and life opportunities.

Conclusion

This case demonstrates that complete cessation of bipolar condition is possible and that it can occur through intensive psychological work that transforms the very structure of the personality. The author's twenty years of stability, maintained in the most painful circumstances, suggest that a profound reorganization has taken place, such that the old patterns no longer exist.

The absence of the concept of "recovery" in psychiatric vocabulary is not just a terminological gap. It is a conceptual obstacle that traps patients in the identity of chronic illness, even when the illness itself has disappeared.

Raising the question of the possibility of recovery has not only theoretical but also social significance. Given the existing stigma attached to psychiatric diagnoses, recognizing the possibility of sustainable recovery could help reduce the fear of seeking psychiatric help and change society's attitude toward mental disorders and their treatment.

References

1. Engel, George L. “The need for a new medical model: a challenge for biomedicine.” Science 196, no. 4286 (1977): 129-136.
2. Goodwin, Frederick K., and Kay Redfield Jamison. Manic-depressive illness: bipolar disorders and recurrent depression. Vol. 2. Oxford university press, 2007.
3. Grande, Iria, Michael Berk, Boris Birmaher, and Eduard Vieta. “Bipolar disorder.” The Lancet 387, no. 10027 (2016): 1561-1572.
4. Geddes, John R., and David J. Miklowitz. “Treatment of bipolar disorder.” The lancet 381, no. 9878 (2013): 1672-1682.
5. Engel, George L. “The clinical application of the biopsychosocial model.” The Journal of medicine and philosophy 6, no. 2 (1981): 101-124.
6. Anthony, W. A. “Recovery from mental illness: The guiding vision of the mental health services system in the 1990s.” Psychososial Rehabilitation Journal 5, no. 1 (1993): 61-65.
7. Alloy, Lauren B., Lyn Y. Abramson, Patricia D. Walshaw, Alex Cogswell, Louisa D. Grandin, Megan E. Hughes, Brian M. Iacoviello et al. “Behavioral approach system and behavioral inhibition system sensitivities and bipolar spectrum disorders: Prospective prediction of bipolar mood episodes.” Bipolar disorders 10, no. 2 (2008): 310-322.
8. CM, HARDING. “The Vermont longitudinal study of persons with severe mental illness.” Am J Psychiatry 144 (1987): 718-735.

Citation: Dina Veksler. “The Possibility of Recovery: Rethinking Bipolar Disorder Through a Biopsychosocial Lens.” J. Mental Health Behav. Sci (2026): 108. DOI: 10.59462/JMHBS.2.1.108