Psychreg Journal of Psychology OPEN ACCESS

Volume 10, Issue 1, June 2026 ISSN 2515-138X | pjp.psychreg.org

CASE STUDY

"Bipolar disorder does not have to be forever": A case of full recovery

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Cite as: Veksler, D. (2026). "Bipolar disorder does not have to be forever": A case of full recovery. *Psychreg Journal of Psychology*, *10*(1), 39 to 46. https://doi.org/rmqt

ABSTRACT

Contemporary psychiatry classifies bipolar affective disorder (BD) as a chronic condition, effectively removing recovery from its diagnostic vocabulary. Prolonged stability without treatment is routinely coded as remission rather than recovery, regardless of how long it has lasted or how fundamentally the person has changed. This article identifies three conceptual gaps in the dominant model: the absence of objective diagnostic markers, the conflation of episodic symptoms with the disease as a long-term process, and the marginalisation of cognitive and personality-level change as mechanisms of improvement. It also examines how the diagnosis functions socially as a permanent stigma, discouraging help-seeking and constraining life opportunities. A clinical case is presented of a continuous-course MDI/BD with psychotic features confined to depressive phases, in which full, sustained stability was achieved without ongoing pharmacological treatment over approximately twenty years. The case is offered not as generalisation but as evidence that recovery is possible and that its absence from clinical and legal frameworks is a conceptual choice rather than a medical necessity. The article proposes criteria and a monitoring pathway by which prolonged stability could be formally recognised and the diagnosis lifted

Keywords: bipolar disorder; manic-depressive illness; psychiatry; psychology; recovery; stigma

In the past, manic-depressive psychosis (MDI) was viewed as a disorder with various courses, including cases of full recovery, in which personality and functioning were completely restored (Tortorella et al., 2025). Classical psychiatric descriptions documented both episodic and continuous forms of the illness, and the concept of "intermission" (the state between phases) encompassed not only remission but also stable, symptom-free recovery (Chuhunov et al., 2023). Kraepelin himself, whose work formed the foundation of modern mood disorder classification, acknowledged that some patients achieved lasting freedom from episodes without ongoing treatment (Bennett, 2024).

With the adoption of modern diagnostic systems in the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed.; American Psychiatric Association, 1980), a conceptual shift took place: MDI was transformed into "bipolar mood disorder", a chronic illness emphasising affective fluctuations and the necessity of lifelong treatment (Cyranka et al., 2023). The category of full recovery disappeared from classifications, and prolonged stability began to be interpreted solely as remission, regardless of its duration or the extent of life and health changes experienced by the patient (Yang et al., 2022).

Clinical practice changed in parallel: diagnostic criteria began to strictly record the presence of episodes but did not provide any criteria for lifting the diagnosis (Stein et al., 2022). As a result, the contemporary system lacks both theoretical and practical foundations for recognising recovery. This gap is not merely academic (Fu & Zhang, 2024); it shapes how clinicians communicate prognosis, how patients understand their futures, and how institutions allocate rights and resources (Stivers & Tate, 2023). In contrast, chronic illnesses such as certain cancers or autoimmune conditions allow for the classification of complete remission as recovery, suggesting that the exclusion of such a category in BD is not medically necessary but conceptual (Junt et al., 2025). The question worth asking is why psychiatry has not followed the same logic (Sartori & Orrù, 2023).

The aim of this article is to trace the historical transformation in the understanding of MDI/BD, to identify the key conceptual shifts in approaches to diagnosis and recovery, and to present a clinical case of full recovery that highlights the need to rethink current diagnostic categories. Modern

Received: 15 October 2025 | Accepted: 24 November 2025 | Published: 01 June 2026

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conceptions of bipolar affective disorder (BD) have developed gradually, evolving from the classical descriptions of manic-depressive psychosis in the early 20th century to the current DSM and ICD diagnostic criteria (El-Mallakh & Belmaker, 2023). At the core of this model lies the affective domain, namely mood changes and the alternation between manic (or hypomanic) and depressive phases.

BD is considered to have a strong genetic predisposition and is associated with specific neurochemical processes as well as endocrine and inflammatory changes. Family and twin studies indicate high heritability (Norman et al., 2024). At the molecular level, dozens of genomic loci have been found to be statistically associated with BD; however, none of them are specific or necessary. There is no biomarker that allows for a reliable diagnosis, which makes BD unusual among major psychiatric conditions in its reliance entirely on clinical judgement (Abi-Dargham et al., 2023).

Recent studies, including findings on alterations in grey matter volume and mitochondrial functioning, deepen our understanding of BD's neurobiology (Förster et al., 2023; Giménez-Palomo et al., 2024; Liberati et al., 2025), but none provide a clear threshold for diagnosis or predict long-term course on an individual level.

The diagnosis of BD is made exclusively through clinical observation and symptom description. The main diagnostic systems, DSM and ICD, classify the types of episodes, their duration, severity, and impact on functioning. Periods between episodes are seen as relative remission, but even during these phases, a vulnerability to future episodes is assumed.

The dominant approach remains pharmacological treatment, primarily mood stabilisers and antipsychotics, intended to stabilise mood and prevent new episodes. Psychotherapy is typically regarded as an auxiliary method aimed at improving compliance, teaching self-regulation skills, and helping patients adapt to the diagnosis. The overall message is that BD is a chronic illness requiring lifelong monitoring and treatment, a framing that leaves little conceptual room for the possibility of full recovery.

Conceptual gaps

Despite the stability of the dominant BD model, close examination reveals several serious gaps concerning both diagnosis and the understanding of disease progression and recovery.

There are no biological indicators that can reliably establish a BD diagnosis. All criteria rely on observed changes in behaviour, mood, and thinking, described by the patient or an observer. This makes diagnosis subjective and highly dependent on interpretation. Borderline cases, comorbidities, cultural differences, or atypical courses often lead to discrepancies and errors. In this respect, BD differs markedly from conditions where laboratory or imaging findings can confirm or exclude a diagnosis.

Current classifications essentially equate the disease with a set of symptoms. There is no clear distinction between temporary states such as a manic or depressive episode and the disease as a long-term process (Kent et al., 2023). As a result, prolonged symptom-free stability is automatically interpreted as remission rather than possible recovery.

Unlike many other medical conditions, BD lacks clear criteria for what constitutes recovery. Neither the time frames for sustained stability nor the cognitive and emotional functioning parameters that should be achieved are defined. Consequently, the concept of recovery is absent from diagnostic and scientific language, reinforcing the perception of incurability. This absence is itself a clinical problem, because it removes the target that patients and clinicians might otherwise work towards.

The official model focuses almost exclusively on mood changes, treating alterations in thinking and personality dynamics as secondary. In practice, however, thinking, including the ability to analyse one's own states, make decisions, and build conscious strategies, can play a key role in both the development of crises and their resolution. This domain remains undervalued in both research and clinical guidance.

The assertion of BD's chronic nature rests mainly on statistical data, not absolute laws. Relapse rates and averages are interpreted as universal, while individual trajectories are ignored or dismissed as atypical. This prevents recognition of full recovery cases and limits scientific thinking to probabilistic frameworks, foreclosing questions that the evidence does not actually rule out.

Clinical case

While not intended to generalise, this case demonstrates that full, stable recovery may be

possible in rare instances, justifying the need for conceptual and diagnostic flexibility.

The illness followed a continuous, non-intermittent course, with alternating depressive and manic phases of varying intensity and no stable intermissions. Transitions between phases occurred both gradually and abruptly.

The disorder began in adolescence, against a background of paternal hereditary burden and a highly critical maternal attitude, which fostered early negative self-perception. The first depressive episode emerged in this context. During depressive periods, suicidal thoughts arose and sometimes led to actions. There were two hospitalisations during depression and two during mania, the latter primarily to address insomnia. The outcomes were unsatisfactory. The total duration of illness was approximately 33 years.

Depressive phases recurred roughly every three years and were severe, featuring pronounced affective disturbances and psychotic phenomena. Central themes were delusions of guilt and sinfulness, experienced as obsessive and inescapable inner culpability, which often led to compulsive apologies to the mother and others. These experiences took the form of depressive psychosis, typical of classical descriptions of MDI with a continuous course.

Affective symptoms included profound anguish, inner immobilisation, a sense of isolation, and what the patient described as a "depressive helmet", a somatic sensation of pressure on the head and chest that created a felt separation from the world. Marked somatovegetative disturbances were also present: complete loss of appetite, significant weight loss, sleep disruption, psychomotor retardation, and loss of vitality.

Cognitive impairment manifested as slowed thinking, difficulty concentrating and making decisions, reduced memory, and a sense of time as thickened or viscous. A distinctive psychotic experience involved the perception of brief intervals before required actions, such as ten to twelve minutes before leaving home, as moments of suspended time, subjectively filled with calm and near-bliss. These functioned as rare points of relief within an otherwise oppressive state. Obsessive-compulsive phenomena were also present, including ritualistic behaviours such as arranging books by height, performed as a way of imposing order on internal chaos.

Psychotic symptoms appeared only during depressive phases. There were no grandiose delusions in mania; guilt and sin delusions dominated in depression, shaping emotional and behavioural states throughout. This pattern is atypical for modern descriptions of BD-I, where psychosis is usually associated with mania, but it aligns with older clinical accounts of MDI with a continuous course.

Manic phases were marked by heightened energy, inner uplift, and expanded activity. Mood was elevated or expansive, accompanied by a sense of clarity and mission. Progressive insomnia was among the most prominent features: sleep gradually shortened from early awakenings to severely reduced total sleep. The inability to sleep was exhausting, yet subjectively there was no fatigue. Other features included hyperergia, frequent switching between numerous projects, accelerated thinking and speech with dense associations, heightened irritability, and rapid social expansion involving spontaneous new connections and the active recruitment of others into personal initiatives.

A distinctive missionary theme emerged during manic phases: a heightened conviction of the need to share a higher truth with the world concerning the moral illness of the healthy. In subsequent depressive phases, this sense of mission transformed into obsessive shame and self-denigration, a transition consistent with classical manic-depressive accounts in early psychiatry.

Brief intermediate states, described in older literature as intermission with a hypomanic tint, appeared as periods of inner calm, clarity, and bliss with a sense of unity with nature, without accelerated thought or social drive. These were experienced as respites from pathological fluctuation but did not constitute stable normality.

Environmental influences

The relationship with the mother was uneasy from the outset, but involuntary hospitalisation through deception marked a major rupture. The patient perceived herself as a victim of the situation and considered herself a burden to her mother. The word "mother" was dropped early on, yet in depressive phases there was a magnetic pull towards her, a mixture of penitence and adoration. Her mother's voice had a calming effect, and doing things for her brought genuine joy.

The mother, however, lacked the patience to listen to depressive complaints, often cutting conversations short. When depression became especially intrusive, she would arrange hospitalisation. Suicidal attempts provoked not compassion but scolding, driven mainly by concern for her own reputation as a doctor and mother.

During manic phases, the mother distanced herself defensively: her daughter's intensity and independence defied control and unsettled her. In depression, by contrast, the patient became dependent and manageable, allowing the mother to occupy the role of caring parent while maintaining moral superiority.

A sister responded differently, regarding depression as illness and actively countering the patient's self-accusations, which helped to ease and shorten depressive episodes. There were no conflicts during manic periods, and her full acceptance provided consistent relief and emotional support.

In youth, the brother was a friend and partly a father figure. Later, influenced by the mother's account of events, he sided with her. During depressive phases he expressed care, but once stability returned, he withdrew, framing this as a form of protection.

Overall, the environment's reactions were phase-dependent: depression elicited sympathy and reinforcement of the suffering role, while mania provoked distance, judgement, or fear. This dynamic reinforced the cyclical course of the illness by consolidating distinct social roles across different phases.

Inpatient treatment followed standard Soviet psychiatric practices of the time, including insulin comas, amanozine, sulfazin, subcutaneous oxygen injections, haloperidol, and amitriptyline. These interventions produced only short-term effects and did not alter the overall illness course. Outside hospital settings, medication was taken sporadically, with no consistent maintenance therapy. Insomnia during manic phases was resistant even to strong hypnotics.

Psychological approach

Shortly before the onset of depressive episodes, characteristic pre-depressive dreams would typically appear situations of hopelessness in which everyone found a way out except the patient. After the last prolonged depression ended, these dreams unexpectedly returned. This coincided with a significant life change: her daughter got married and moved away, leaving her free to focus fully on her own condition.

She began online work with a Jungian psychologist who specialised in dream analysis and had personally experienced BD and found his own path to recovery. His approach centred on consciously working with the thoughts that arise during manic and depressive states to prevent them from developing into full episodes. The core idea was that if the patient could internally initiate the changes that had previously been produced by the illness, the phases would cease. This model proved effective.

The work was intensive, involving frequent shifts between phases and deep exploration of the unconscious through dreams. During depressive periods, the focus was on analysing the inner world; during manic periods, on examining contact with the external world and setting limits on activity. Exercises, dream interpretation, and awareness of phase-switching mechanisms were all employed. After approximately nine months, the phases became shorter and milder: manic periods provided energy for action, depressive periods became times of rest and sleep normalised.

Later, only residual phenomena remained, for which homeopathy was used temporarily. Over time, the process stopped entirely. For approximately twenty years, the patient has been living a stable, balanced life, with the same personality functioning consistently and no psychiatric disturbances.

The importance of the recovery category

The absence of a recovery category in contemporary psychiatry has serious clinical and social consequences. A BD diagnosis becomes a lifelong status that remains with a person regardless of their current condition, cementing stigma and limiting opportunities across multiple domains of life (Relojo-Howell & Beckstein, 2023). The stereotype of incurability creates a persistent stigma that continues to operate even in the complete absence of symptoms (Treufeldt & Burton, 2024). The patient is viewed through the lens of their diagnosis in medical, family, legal, and professional contexts, and a past diagnosis can be used against them in ways that have nothing to do with their present functioning (Jeske et al., 2024).

Knowing that the diagnosis is lifelong and rarely subject to revision often deters people from seeking

help in the first place. The prospect of a permanent label affecting all areas of life deprives individuals of the chance for early treatment and recovery, fostering a well-founded fear of the psychiatric system rather than confidence in it.

When recovery is not recognised as a possibility, the horizon of personal responsibility for change disappears. Patients are directed to manage a chronic illness rather than work towards restoration. This weakens intrinsic motivation and reinforces a dependent stance that may itself become an obstacle to improvement.

The recovery category should be reinstated in both clinical practice and legal frameworks. One possible pathway is the creation of an official mechanism for confirming recovery. A person who considers themselves recovered could formally register with a specialist and undergo regular follow-ups, whether monthly or quarterly. If stability is maintained for three years, the diagnosis could be legally removed. This approach integrates individual responsibility with professional oversight while restoring the person's right to social reintegration and release from stigma.

Similar frameworks already exist in other diagnostic domains, such as adjustment disorders or certain trauma-related conditions, where diagnoses are time-limited and contingent on functional status (Blakey et al., 2024). These precedents offer useful legal and ethical models, and there is no principled reason why BD should be exempt from comparable thinking.

The proposed monitoring system requires further development regarding implementation logistics, funding mechanisms, and risk mitigation strategies. As a starting point, the following criteria could form the basis of a formal assessment: (a) absence of manic, depressive, and psychotic episodes; (b) stable biological rhythms, including sleep, appetite, and energy; (c) restored cognitive and social functioning; and (d) ability to self-regulate without ongoing pharmacological dependence, meaning without the need for medication to maintain basic emotional and behavioural stability. Such a mechanism would allow remission to be distinguished from stable recovery, reduce stigmatisation, and give individuals a genuine pathway to a full life without the permanent status of a psychiatric diagnosis.

Acknowledgements: None declared
Conflict of interests: None declared
Ethical approval: Not applicable
Funding: None declared

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