

## Social Consequences of Recovering from Bipolar Disorder

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### **ABSTRACT**

This article is based on the author's personal experience of living for many years with bipolar disorder and then undergoing a deep psychological transformation that led to the cessation of mood phases and the formation of a stable personality. The author examines this process within the biopsychosocial model, showing how changes in the social environment, deep psychological work, awareness and working through of one's own functioning, emotional reactions, and ways of interacting with others gradually led to a transformation of the internal organization of the personality. As a result, a stable personality was formed, and the mental and physical symptoms of the disorder disappeared. After this, an ordinary stable life, not complicated by pathological states, could have begun.

However, after the cessation of the pathological process, the author encountered an unexpected problem. Family members were unwilling to change their attitude or to see the author beyond the previous diagnosis. Specialists insisted on the term "remission," whereas the author considered it inappropriate for describing the result that had been achieved. As a result, a contradiction arose between the author's internal state, which no longer corresponded to the former illness, and the external social framework that continued to keep the author in the status of a person with a mental disorder.

The article raises the question of what people should do when they have gone through a deep internal change and become free of the pathological process, but cannot live in a new status within their immediate social environment. How is existence after recovery possible if the previous diagnosis continues to determine the attitude of others? Bipolar disorder; recovery; diagnosis; social recognition; psychological transformation; remission; family; professional system

### **Introduction**

Bipolar disorder (BD) is usually considered a chronic illness requiring lifelong monitoring and treatment. The possibility of complete recovery is discussed very rarely.

This article is based on the author's personal experience. After many years of living with bipolar disorder, the author achieved a stable state through deep psychological work, which has been maintained for about twenty years despite the stress caused by the rejection of this recovery by the immediate environment.

The subject of the article is not only recovery itself, but also the reaction of others to it. The author encountered a paradoxical situation: after the disappearance of the pathological state, the previous diagnosis continued to influence relationships with relatives and specialists, as well as the interpretation of the author's words and life decisions. This experience raises the question of how ready modern society and the professional environment are to perceive both illness and the possibility of leaving it behind as realities of psychological experience.

The Paradox of Internal Transformation and External Diagnosis  
The central idea of the article is that the disappearance of the symptoms of bipolar disorder did not occur as a result of direct work with the symptoms themselves, but as a consequence of a deep psychological restructuring of the personality. In the course of this work, thinking, self-attitude, emotional reactions, and ways of experiencing guilt, shame, conflict, and life pressure changed. Gradually, not only depressive and manic episodes disappeared, but also the inner division in which the personality seemed to change depending on the phase of the illness.

Thus, recovery in this case cannot be reduced to the temporary disappearance of separate symptoms. It was a deeper process: the person changed, along with her way of perceiving herself, other people, and life events. In the author's view, this change became the basis of lasting stability.

At the same time, the author cannot consider herself completely free from the disorder in a social and biographical sense. The illness disappeared as an active clinical process, but the diagnosis

continued to exist in relationships with those who knew about it, primarily close relatives, as well as in the position of the professional community, where the view of bipolar disorder as a lifelong illness persists. Moreover, some family members, acting in bad faith, continued to actively use the diagnostic label for their own benefit. Rather than acknowledging the author's recovery, they weaponized the previous diagnosis, questioning the author's judgment, dismissing their statements as symptoms, and creating additional obstacles in everyday life. The label served as a tool to maintain control, discredit the author's autonomy, and avoid confronting the reality of change. Thus, the diagnosis was not merely a medical record; it became a means of manipulation and social coercion. This is the central paradox: internal liberation from the disorder took place, but external freedom remained limited by the previous diagnosis, which, in turn, inevitably affects the internal state.

### **Clinical Picture of the Disorder**

For many years, bipolar disorder manifested not only in the alternation of depressive and manic states, but also in a profound change in inner self-perception, thinking, emotional reactions, and the general mode of existence. In each phase, a different personality seemed to begin functioning, with a different perception of the self, other people, and reality.

### **Depressive Phase**

The mental manifestations of the depressive phase were expressed primarily through feelings of guilt, shame, personal badness, and wrongness. These experiences were not ordinary sadness or a temporary lowering of mood. They became the central content of consciousness and determined the perception of the self, the past, the future, and relationships with other people. Any life difficulties, conflicts, criticism, or rejection were perceived not as external circumstances, but as confirmation of an inner defect, triggering a system of self-blame.

The central experience was the feeling of being a source of problems for other people. Thinking became sharply narrowed. The main mental activity consisted of obsessive, repetitive, and limited thoughts connected with self-blame, hopelessness, the desire to escape this state, and reflection on possible ways out.

The physical manifestations of depression were pronounced and persistent. They included a decrease in vital energy, loss of appetite with significant weight loss, unstable and superficial sleep, and impairment of memory and concentration. Speech became slowed, quiet, and inexpressive. Movements slowed down. The face acquired a frozen, sorrowful expression. Smiling became impossible – not only emotionally, but almost physically.

Thus, depression manifested not only as psychological suffering, but also as a change in the entire bodily state. The body seemed to take the form of inner defeat: expressiveness disappeared, the capacity for normal contact with the outside world was reduced, and vital energy vanished.

### **Manic Phase**

Manic states had the opposite structure. This was not simply an improvement in mood; the author actually functioned as a different person, with different thinking, different energy

levels, different self-esteem, different reactions, and a different perception of reality. This reflected a deep phase-related restructuring of the entire psychic organization. The former suppression disappeared; elevation, accelerated thinking, numerous ideas, a sense of expanded possibilities, and a feeling of moving beyond ordinary limitations appeared.

There arose confidence in the ability to overcome everything. Creative drive intensified. Thoughts became rapid and associative, jumping from one subject to another. Minor details could be perceived as significant and requiring immediate action. The inner world became saturated, fast, vivid, and difficult to control.

Instead of a personality built around guilt and self-negation, another configuration emerged – free, active, confident, and creative. However, this state was unstable. It was accompanied by reduced critical judgment, irritability, conflict, and detachment from real limitations.

The physical manifestations of mania were also pronounced. The main symptom was severe insomnia, which responded poorly to medication. Despite the lack of sleep, high activity was preserved. Speech accelerated, becoming loud and rapid. Appetite increased. General motor and psychic energy intensified.

If in depression the body froze and lost strength, in mania it entered a state of excessive excitation. This state could give a sense of strength and expanded possibilities, but at the same time it made behavior unstable.

### **Formation of a Stable Personality**

The psychological work was based on the ideas of Carl Gustav Jung, in particular on the understanding of the symptom as a possible message from the unconscious. The symptom was viewed not only as a pathological manifestation that needed to be suppressed, but also as an indication of an internal conflict, a repressed experience, or a broken connection within the personality.

At the same time, the work was not carried out with an abstract “personality” as a whole, but with the different states of personality that manifested themselves in the phases of the illness. Initially, the work proceeded mainly through the manic phase: its energy, ideas, sense of expanded possibilities, creative drive, conflict, and detachment from real limitations were explored. Later, the work shifted to the severe depressive phase, where shame, self-blame, the feeling of inner defectiveness, and the inability to perceive oneself as a valuable person became central.

As these different phase-related states were understood and worked through, what occurred was not merely a weakening of separate symptoms, but a gradual change in the internal organization of the personality. The phases lost their strength and duration, sleep was restored, the intensity of physical manifestations decreased, and gradually the pathological process came to an end.

These changes became a natural result of the inner work that had been done and of the formation of a stable personality structure.

It is important to emphasize that this long-term stability, lasting more than twenty years, was achieved without the use of psychotropic medication and without strict monitoring of the condition (such as daily mood tracking, anticipation of relapse, or avoidance of triggers). This is what distinguishes the described case from classical remission, where stability usually requires maintenance pharmacotherapy and constant vigilance. Here, the very need for control disappeared — not because the author was careless, but because the internal dynamic that had previously made mood fluctuations autonomous and unpredictable had ceased to exist.

However, after this, another serious problem emerged. The changes that were obvious and deeply significant to the author were almost impossible to have recognized, discussed, or professionally confirmed. The disappearance of symptoms did not lead to a revision of the previous perception. The diagnosis continued to exist as a stable framework through which others interpreted the author's words, actions, and even the very fact of claiming recovery.

### **The Illness Ended but the Diagnosis Remained**

After the disappearance of symptoms, the author encountered not liberation, but a new form of unfreedom. The internal state no longer corresponded to the previous diagnosis, but the external environment was not ready to perceive the author outside the diagnostic framework. The illness had disappeared as an active process; however, the former diagnosis continued to determine the attitude of others, the interpretation of the author's words, and the evaluation of the author's life decisions.

A particularly important issue was the difference in understanding the result. Specialists insisted on the term "remission," because this was the term that existed within the familiar professional model of bipolar disorder as a chronic illness. However, the process through which the author had gone did not correspond to the subjective or factual understanding of remission as a temporary weakening of symptoms. This was not a period between phases, not a state maintained by medication, and not a temporary stabilization. As a result of long-term psychological work, the very structure of the personality changed: ways of reacting, thinking, self-attitude, and perception of life events. The internal organization that had previously made depressive and manic states possible disappeared.

For this reason, the author could not accept the term "remission" as sufficient to describe what had happened. This term devalued the nature of the changes, reducing a deep restructuring of the personality to a temporary absence of symptoms. However, the author's unwillingness to agree with this interpretation and her attempts to insist on another description of the result were perceived by specialists not as a subject for discussion, but as a possible sign of a pathological state. As a result, the very disagreement with the term "remission" could be interpreted as a manifestation of mania, an overestimation of one's own abilities, or impaired critical judgment.

A closed circle emerged. If the author agreed to the term "remission," the meaning of the inner work that had been done and the uniqueness of the process that had taken place disappeared.

If the author did not agree, this disagreement began to be viewed through the previous diagnosis. Thus, the professional system effectively left no space for describing a third possibility: not active illness, but not simple remission either — rather, a deep psychological transformation with disappearance of pathological manifestations.

The family reaction developed according to a similar logic, but in a harsher form. Relatives had already accepted the state of illness as a stable reality, adapted to it, and built their own explanations, roles, and advantages around it. The previous diagnosis allowed them to interpret the author's behavior in advance, without entering into a real discussion of the changes that had occurred. Therefore, recovery disrupted the established order and was met with distrust.

Some relatives, however, acted not merely out of inertia or disbelief, but in bad faith. They continued to actively wield the diagnostic label as a tool to control, discredit, and complicate the author's life. The label allowed them to dismiss the author's words as symptoms, question her autonomy, and avoid confronting the reality of change. For them, the diagnosis was not a medical record but a means of manipulation and social coercion.

Moreover, the author's statement about the cessation of the pathological process was not accepted as evidence of improvement. On the contrary, it became a reason for new suspicions. If a person who previously had a diagnosis of bipolar disorder states that the illness has ended, this statement can easily be presented as a lack of critical judgment. In the family interpretation, the disappearance of symptoms was not recognized as recovery. Instead, another version appeared: the illness had supposedly not disappeared, but had taken another form. Thus, the previous diagnosis was not removed from the perception of the author, but was expanded and turned into an even harsher form of distrust.

Paradoxically, it was precisely the resistance of the immediate environment - disbelief in recovery, suspicion, and expansion of the diagnosis - that pushed the author to turn to the professional system for confirmation and objective evaluation. However, there too the author encountered a dead end: the system did not have the tools to confirm this kind of transformation, and any disagreement with the term "remission" was interpreted as a symptom. Thus, the attempt to find external confirmation ran into the system's unreadiness, while returning to the family environment meant returning to the same distrust. The person found herself in double isolation.

This was the main paradox. Real changes had occurred within the author: a stable personality had formed, the phases had disappeared, sleep had been restored, and the pathological mental and physical manifestations had gone away. But externally, these changes were not confirmed. Specialists held them within the concept of remission or interpreted disagreement as a symptom. Relatives either did not believe in the changes or explained them by a new diagnosis. As a result, the author found herself in the position of a person who internally could no longer live in the old status of illness, but externally was not given the opportunity

to exist in the new status of someone who had undergone a deep change and had left the former pathological mode behind.

### The Limbo of Recovery

The new internal state no longer allowed the author to exist in the former mode or to maintain the old role. While the illness was active, others could perceive the author through a familiar scheme: symptoms, diagnosis, instability, the need for control, and distrust of the author's own assessments. But after the deep psychological restructuring, this scheme no longer corresponded to reality.

The author could no longer internally agree with the image of a person defined by the former disorder. Reactions, thinking, self-attitude, and attitude toward life events had changed. The internal structure that had previously supported depressive and manic states had disappeared. Therefore, functioning in the old status became impossible, while a new status failed to take shape.

Thus, recovery turned out not to be the end of the story, but the beginning of a new conflict. If earlier the main opponent had been the illness itself, then after its end the main obstacle became the impossibility of being recognized outside the diagnosis.

### Conclusion

The described case shows the need for more careful attention to long-term changes in bipolar disorder, especially when they are connected not only with the disappearance of separate symptoms, but also with a deep psychological restructuring of the personality. In this case, the disappearance of depressive and manic phases was not the result of a direct struggle with symptoms. It was the result of changes in the internal mechanisms that had previously supported pathological functioning.

However, this experience also shows that the disappearance of symptoms in itself does not guarantee liberation from the diagnosis in a social and professional sense. The previous diagnostic framework may continue to determine the perception of a person even when that person's internal state no longer corresponds to the former illness.

Therefore, an important question is not only the treatment of bipolar disorder, but also the possibility of professionally describing cases in which the achieved stability is connected with a deep personal transformation. If the only available term for such states is "remission," then a significant part of the real psychological process remains undescribed. And if disagreement with this term is automatically perceived as a symptom, the person is deprived of the possibility of testifying to their own change.

This article does not aim to propose a ready-made procedure for recognizing recovery from bipolar disorder or a developed system of criteria. The author's aim is to record the very fact that such a problem exists, to outline its key features — the unreadiness of the professional environment, the rigidity of family roles, and the absence of a language for describing

transformation — and to draw attention to it. A detailed system of criteria and procedures is the subject of separate work.

The possibility of recognizing recovery formally exists within the medical system itself. A change of diagnosis, confirmation of recovery, or revision of the previous clinical assessment should take place through the treating physician, long-term observation, professional evaluation, and the procedures provided for this purpose. However, this is where the main problem arises. If a person comes not with symptoms of illness, but with the result of deep psychological transformation and a long-term absence of pathological manifestations, the system is not always ready to regard this as recovery. More often, such a state is placed into the existing category of remission, even if the lived process and its result do not correspond to that concept.

As a result, the person finds themselves in a dependent position. Their own testimony about the cessation of the pathological process has no force by itself, while the specialists on whom official recognition depends may have neither a ready language, nor a procedure, nor a professional orientation for confirming such a result. Illness can be diagnosed and treated. Remission can be observed. But recovery achieved outside the familiar medical scheme becomes almost impossible to confirm if its signs do not fit existing professional concepts and have no criteria for confirmation [1-8].

This article is an invitation: to reconsider the assumption that bipolar disorder is necessarily lifelong, to develop ways of describing deep psychological transformation — and to ask ourselves: what would it take to recognize recovery when it happens.

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