Multiple Clinical Factors Tied to Poor Bipolar Med Adherence

Written by The Life Science Feed Editorial Team · Published 19 June 2026 · Edited by Mara Voss

> Medication non-adherence remains a significant challenge in the long-term management of bipolar disorder, contributing to higher rates of relapse, hospitalisation, and poorer functional outcomes. Understanding the specific clinical factors that predict poor adherence is essential for developing targeted interventions and improving patient care.

KEY TAKEAWAYS

- The Pivot: Identification of specific clinical factors, beyond patient demographics, that predict poor medication adherence in bipolar disorder.
- The Data: Psychiatric comorbidities and substance use disorders are consistently associated with reduced adherence.
- The Action: Clinicians should screen for and address co-occurring psychiatric conditions and substance use when managing bipolar disorder to improve medication adherence.

Bipolar disorder is a chronic condition requiring sustained pharmacological treatment to stabilise mood and prevent recurrence of episodes. However, adherence to prescribed medication regimens is often suboptimal, with reported rates varying widely but consistently indicating a substantial proportion of patients failing to take their medication as directed. This non-adherence is a primary driver of treatment failure and disease progression. While demographic and socioeconomic factors have been explored, a clearer understanding of clinical predictors is needed to inform practice. The global prevalence of bipolar disorder is estimated to be around 1-2%, with significant morbidity and mortality associated with the illness. Effective management relies heavily on long-term pharmacotherapy, typically involving mood stabilisers such as lithium or valproate, and atypical antipsychotics. These medications work through various mechanisms, including modulating neurotransmitter systems, stabilising neuronal membranes, and influencing intracellular signalling pathways, all aimed at restoring mood stability. However, the benefits of these treatments are severely compromised when adherence is poor, leading to increased rates of relapse, hospitalisation, and suicide attempts. Understanding the clinical factors that predict non-adherence is therefore crucial for developing targeted interventions and improving patient outcomes.

Clinical Factors Associated with Adherence

Analysis of patient cohorts with bipolar disorder consistently identifies several clinical characteristics that correlate with poor medication adherence. Psychiatric comorbidities, particularly anxiety disorders and personality disorders, are frequently observed in patients with suboptimal adherence. The presence of a co-occurring anxiety disorder, for instance,

has been linked to a 1.8-fold increased risk of non-adherence compared to those without anxiety. Similarly, patients diagnosed with a personality disorder demonstrate a 2.3-fold higher likelihood of discontinuing or inconsistently taking their prescribed mood stabilisers or antipsychotics. These comorbidities often introduce additional symptom burden, complex treatment regimens, and psychological barriers that complicate adherence to bipolar disorder medication.

Substance use disorders represent another critical predictor of poor adherence. Alcohol use disorder and illicit drug use are strongly associated with irregular medication intake. Patients with a co-occurring substance use disorder exhibit significantly lower rates of adherence, with some studies reporting adherence rates as low as 30% in this subgroup, compared to 60-70% in patients without substance use issues. The mechanisms are multifactorial, including impaired judgment, competing priorities, and direct interference with medication effects. Furthermore, the presence of substance use can exacerbate mood instability, leading to a vicious cycle where poor adherence contributes to worse mood symptoms, which in turn may drive further substance use.

The specific type of bipolar disorder also appears to influence adherence. Patients with rapid cycling bipolar disorder, characterised by four or more mood episodes within a year, often demonstrate lower adherence rates. The fluctuating and often severe nature of their symptoms, coupled with the complexity of managing multiple mood states, may contribute to difficulties in maintaining a consistent medication schedule. Furthermore, a history of previous hospitalisations for manic or depressive episodes is a predictor of future non-adherence, suggesting that severe illness presentation may indicate underlying challenges with treatment engagement. These patients often require more intensive monitoring and support to maintain adherence.

Cognitive impairment, which can be present in bipolar disorder even during euthymic periods, also plays a role. Deficits in executive function, memory, and attention can directly impede a patient's ability to remember to take medication, understand complex dosing schedules, or manage refills. While not always overtly assessed in routine clinical practice, subclinical cognitive difficulties can subtly undermine adherence efforts. These cognitive challenges are often more pronounced in patients with a longer illness duration or a history of multiple mood episodes, further complicating long-term treatment adherence.

The methodology employed in studies investigating these factors typically involves longitudinal observational designs, utilising self-report questionnaires, pill counts, electronic monitoring devices, and pharmacy refill data to assess adherence. Patient cohorts are often drawn from psychiatric clinics or hospital settings, encompassing a diverse range of ages, illness durations, and treatment histories. However, limitations in these studies include the potential for recall bias in self-report measures and the challenge of distinguishing between intentional and unintentional non-adherence. Future research could benefit from integrating objective measures of medication levels in biological samples to provide a more precise assessment of adherence.

Conversely, factors associated with better adherence include a strong therapeutic alliance with the prescribing clinician, psychoeducation tailored to the patient's understanding, and family support. The perceived efficacy of the medication and the patient's insight into their illness are also positive predictors. However, these factors often interact with the clinical complexities outlined above, making adherence a dynamic and multifaceted challenge.

CLINICAL IMPLICATIONS

The persistent issue of medication non-adherence in bipolar disorder is not merely a patient failing, but a complex interplay of clinical factors that demand a more nuanced approach from healthcare providers. It is insufficient to simply prescribe and expect compliance; the data clearly indicate that co-occurring psychiatric conditions and substance use are significant impediments. Clinicians must integrate routine screening for anxiety disorders, personality disorders, and substance use into their assessments of bipolar patients. A positive screen should trigger not just a referral, but a collaborative, integrated treatment plan that addresses these comorbidities concurrently with mood stabilisation.

The pharmaceutical industry also bears a responsibility. While novel formulations and extended-release options exist, there is still a need for treatments that simplify dosing regimens and minimise side effects, particularly for patients with cognitive challenges or those managing multiple medications. The development of digital adherence tools, while promising, must be rigorously tested in these complex patient populations to ensure they are genuinely helpful and not just an additional burden. Furthermore, the economic burden of polypharmacy and the cost of newer agents can inadvertently contribute to non-adherence, a factor that health policy makers and payers must consider.

Ultimately, improving adherence requires a shift from a purely pharmacological focus to a holistic, patient-centred model. This means investing in comprehensive psychoeducation that goes beyond basic drug information, fostering strong therapeutic alliances, and engaging family members or caregivers where appropriate. For patients with bipolar disorder, especially those with comorbidities, consistent medication intake is not a given; it is an outcome that must be actively supported through integrated care strategies. Ignoring these clinical predictors is akin to treating only half the patient, and the consequences, in terms of relapse and hospitalisation, are well-documented and preventable.

EDITORIAL & AI STANDARDS

AI tools are used to structure and summarise evidence from peer-reviewed primary sources. Articles that carry a signed Editor's take have been read in full by William Lopes. The others are not individually read by an editor, so check the cited source before relying on a figure.

REFERENCES

1. 1. Bartoli F, et al. Clinical and Sociodemographic Correlates of Poor Medication Adherence in People With Bipolar Disorder: A Systematic Review and Meta-Analysis. Bipolar Disord. 2026;28(5):e70127. doi:10.1111/bdi.70127
2. 2. Jawad I, et al. Medication nonadherence in bipolar disorder: a narrative review. Ther Adv Psychopharmacol. 2018;8(12):349-363. doi:10.1177/2045125318804364
3. 3. Tamene FB, et al. Medication non-adherence and its predictors among patients with bipolar disorder in Northwest Ethiopia. Sci Rep. 2025;15(1):1192. doi:10.1038/s41598-025-85379-3
4. 4. Jónsdóttir H, et al. Predictors of medication adherence in patients with schizophrenia and bipolar disorder. Acta Psychiatr Scand. 2013;127(1):23-33. doi:10.1111/j.1600-0447.2012.01911.x
5. 5. Oladunjoye AF, et al. Cannabis use and medication nonadherence in bipolar disorder: A nationwide inpatient sample database analysis. J Affect Disord. 2022;299:174-179. doi:10.1016/j.jad.2021.11.067
6. 6. Casaletto KB, et al. Predictors of psychotropic medication adherence among HIV+ individuals living with bipolar disorder. Int J Psychiatry Med. 2016;51(1):69-83. doi:10.1177/0091217415621267

LICENCE & RIGHTS

© 2026 The Life Science Feed. All rights reserved. This content is produced for medical education purposes. It may not be reproduced, distributed, or transmitted without prior written permission from The Life Science Feed.

MEDICAL DISCLAIMER

This content is intended for healthcare professionals only and does not constitute medical advice. Clinical decisions must be made by qualified practitioners based on individual patient circumstances.

FOLLOW THE LIFE SCIENCE FEED

Instagram @lifesciencefeed **LinkedIn** linkedin.com/company/thelifesciencefeed

thelifesciencefeed.com