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Evaluation of Factors Affecting Treatment Outcome in Patients with Bipolar Disorders at a Tertiary Care Hospital

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Abstract

Background: Bipolar disorder is a chronic and recurrent psychiatric illness characterized by episodes of mania, hypomania, and depression, often leading to significant impairment in personal, social, and occupational functioning. Despite the availability of effective treatment, the outcome of bipolar disorder varies considerably among patients due to the influence of multiple socio-demographic, clinical, psychosocial, and treatment-related factors. Identification of these factors is important for improving prognosis, reducing relapse, and promoting long-term functional recovery.

Aim: To evaluate factors affecting treatment outcome in patients with bipolar disorders at a tertiary care hospital.

Materials and Methods: This hospital-based observational study included 85 patients diagnosed with bipolar disorder. Patients attending psychiatry outpatient services or admitted to inpatient services who fulfilled standard diagnostic criteria for bipolar disorder were enrolled using consecutive sampling after obtaining informed consent. Data were collected using a semi-structured proforma covering socio-demographic details, clinical variables, psychosocial factors, and treatment-related parameters. Variables studied included age, sex, marital status, education, type of bipolar disorder, age at onset, duration of illness, psychotic symptoms, substance use, family history, medication adherence, insight into illness, family support, stressful life events, and comorbid medical illness.

Results: Among the 85 patients, 51 (60.00%) had a favorable outcome and 34 (40.00%) had an unfavorable outcome. Bipolar disorder type I was present in 56 patients (65.88%), while psychotic symptoms were seen in 38 (44.71%) and substance use in 29 (34.12%). Good medication adherence was observed in 48 patients (56.47%), insight into illness in 44 (51.76%), and good family support in 50 (58.82%). Significant factors associated with favorable treatment outcome were good medication adherence ($p=0.001$), presence of insight ($p=0.003$), good family support ($p=0.009$), absence of psychotic symptoms ($p=0.012$), absence of substance use ($p=0.018$), and shorter duration of illness ($p=0.021$).

Conclusion: Treatment outcome in bipolar disorder is influenced by multiple interacting clinical and psychosocial factors. Strengthening medication adherence, improving insight, enhancing family support, addressing substance use, and ensuring early intervention may significantly improve long-term outcome in patients with bipolar disorder.

Key words: Bipolar Disorder; Treatment Outcome; Medication Adherence; Insight; Family Support.

INTRODUCTION

Bipolar disorder is a severe and recurrent mood disorder characterized by episodes of mania, hypomania, depression, or mixed affective states, with periods of incomplete or complete inter-episode recovery. It is now recognized not merely as an episodic illness, but as a complex psychiatric condition with marked heterogeneity in

presentation, course, and response to treatment. The disorder often begins in adolescence or early adulthood and may remain underrecognized for a considerable period because depressive episodes are more common at onset and manic symptoms may be overlooked, misinterpreted, or not spontaneously reported by patients. This delay in identification contributes to prolonged suffering, impaired psychosocial functioning, and difficulty in instituting timely and appropriate long-term management.[1] The diagnosis and clinical management of bipolar disorder remain challenging because the illness overlaps phenomenologically with recurrent depressive disorder, schizoaffective presentations, substance-related mood syndromes, and personality-related affective instability. The burden of the disorder extends far beyond mood episodes alone and includes impairment in occupational performance, interpersonal relationships, family life, and quality of life. In routine clinical practice, the course of illness is frequently modified by delayed diagnosis, inconsistent treatment exposure, poor continuity of care, and incomplete symptom remission. For this reason, contemporary psychiatric care increasingly emphasizes integrated and longitudinal management rather than episodic symptom control. Understanding the broad range of factors that shape treatment outcome is therefore essential for improving long-term prognosis in bipolar disorder.[2] Another important feature of bipolar disorder is its long-term medical and psychosocial burden. Even when acute mood symptoms improve, many patients continue to experience residual symptoms, cognitive difficulties, reduced stress tolerance, disturbed sleep, and limitations in social and occupational functioning. In addition, bipolar disorder is commonly associated with medical comorbidity, lifestyle-related health risks, and increased mortality. These observations suggest that treatment outcome in bipolar disorder should not be understood only in terms of acute symptom reduction, but also in relation to relapse prevention, functional recovery, treatment adherence, and overall psychosocial adjustment. The identification of clinical and psychosocial variables that influence these dimensions is particularly relevant in hospital-based populations, where patients often present with greater severity and complexity.[3] In recent years, bipolar disorder has increasingly been viewed as a chronic and potentially progressive condition requiring early recognition, sustained treatment, and preventive intervention. The illness is associated with repeated mood episodes, cumulative disability, and a substantial impact on families and health systems. Although pharmacotherapy remains the cornerstone of management, outcomes are not determined by medication alone. The course of illness may be affected by age at onset, subtype of bipolar disorder, episode polarity, psychotic symptoms, rapid cycling, duration of untreated illness, comorbid substance use, physical illness, and the presence of stressful life events. These factors may interact over time and influence both symptom burden and long-term recovery, making prognosis variable across patients.[4] Prediction of treatment outcome in bipolar disorder is therefore of major clinical importance. The concept of outcome includes not only favorable symptomatic response, but also sustained remission, fewer recurrences, less need for hospitalization, improved insight, better treatment adherence, and restoration of social and occupational functioning. Poor outcome, on the other hand, may be reflected by persistent residual symptoms, frequent relapse, treatment resistance, repeated admissions, and marked functional decline. The literature suggests that no single variable can fully explain outcome, and that prognosis is usually determined by a combination

of socio-demographic, clinical, treatment-related, and psychosocial factors. Identification of these factors may help clinicians stratify risk, individualize treatment plans, and provide more realistic prognostic guidance to patients and caregivers.[5] Among the modifiable determinants of outcome, treatment adherence has received particular attention. Bipolar disorder usually requires long-term or lifelong pharmacological management, yet many patients do not take medication regularly because of poor insight, adverse effects, stigma, complex prescriptions, lack of family supervision, or fluctuating illness beliefs. Nonadherence may lead to breakthrough episodes, relapse, rehospitalization, suicidality, and impaired functioning. Similarly, continuity of follow-up and collaboration between patient, family, and treating team play a crucial role in maintaining stability over time. Because adherence behavior is shaped by patient-level, treatment-level, and system-level influences, identifying its association with outcome is especially relevant in real-world tertiary care settings.[6]

MATERIALS & METHODS

This hospital-based observational study was conducted to evaluate factors affecting treatment outcome in patients with bipolar disorders at a tertiary care hospital. The study was designed to evaluate socio-demographic, clinical, psychosocial, and treatment-related variables that may influence therapeutic response and overall outcome among patients receiving psychiatric care in a tertiary care setting. The study included 85 patients diagnosed with bipolar disorder. Patients of either sex who fulfilled the diagnostic criteria for bipolar disorder as per the standard psychiatric diagnostic classification system were considered for inclusion in the study. The sample consisted of patients who were clinically stable enough to participate in interviews and assessments and who provided informed consent for participation.

Inclusion and exclusion criteria:

Patients aged 18 years and above with a confirmed diagnosis of bipolar disorder were included in the study. Both bipolar disorder type I and type II cases were considered, provided the diagnosis was established by a qualified psychiatrist. Patients with severe cognitive impairment, intellectual disability, major neurological illness, serious medical instability, or inability to provide reliable information were excluded. Patients with comorbid psychiatric conditions that could significantly interfere with assessment, such as schizophrenia or other primary psychotic disorders, were also excluded wherever diagnostic clarification was not possible.

Methodology

A consecutive sampling method was used to recruit eligible patients meeting the inclusion criteria until the required sample size of 85 was achieved. All eligible patients presenting during the study period were screened and enrolled after obtaining written informed consent. This method ensured practical feasibility and allowed inclusion of patients from both outpatient and inpatient services, thereby improving the clinical representativeness of the sample.

Data were collected using a semi-structured proforma specially designed for the study. Information regarding socio-demographic variables such as age, sex, marital status, education, occupation, residence, socioeconomic status, and family structure was recorded. Clinical details including age at onset of illness, duration of illness, type of bipolar disorder, polarity of first episode, number of previous episodes, number of hospitalizations, history of psychotic symptoms, suicidal attempts, family history of psychiatric illness, comorbid substance use, medical

comorbidities, and treatment adherence were also documented. Relevant treatment details such as current medications, use of mood stabilizers, antipsychotics, antidepressants, combination therapy, adverse effects, and history of treatment discontinuation were noted.

Special emphasis was given to variables likely to affect treatment outcome in bipolar disorder. These included age of onset, duration of untreated illness, episode frequency, predominant polarity, presence of rapid cycling, psychotic features, residual symptoms, insight into illness, medication adherence, family support, stressful life events, substance use, comorbid anxiety or medical disorders, and previous response to treatment. Treatment outcome was assessed in terms of symptomatic improvement, relapse pattern, recurrence, functional recovery, and need for hospitalization. Outcome was categorized on the basis of clinical evaluation and treatment response documented by the treating psychiatrist.

Diagnosis of bipolar disorder was established clinically according to standard diagnostic criteria. Severity and outcome were assessed using appropriate clinical rating measures and psychiatrist-based evaluation. A structured or semi-structured format was used to document current symptom profile, history of relapse, and level of functioning. Where applicable, assessment of adherence, insight, and psychosocial support was also incorporated to provide a multidimensional evaluation of treatment outcome. This helped in identifying not only biological and clinical determinants but also psychosocial contributors to outcome.

Each participant was interviewed in detail after recruitment into the study. Information was obtained from the patient and, whenever necessary, corroborated with family members or caregivers and review of medical records. Mental status examination and relevant clinical assessment were conducted by the psychiatrist. The collected data were entered into the study proforma systematically. The treatment outcome of each patient was evaluated in relation to the identified variables to determine factors associated with favorable or unfavorable outcomes.

Statistical Analysis

The collected data were entered into Microsoft Excel and analyzed using appropriate statistical software. Descriptive statistics such as mean, standard deviation, frequency, and percentage were used to summarize socio-demographic and clinical variables. Inferential statistical tests were applied to examine the association between different factors and treatment outcome. Categorical variables were compared using the chi-square test or Fisher's exact test as appropriate, while continuous variables were analyzed using independent t-test or other suitable parametric or non-parametric tests. A p-value of less than 0.05 was considered statistically significant.

RESULTS

Table 1 shows the socio-demographic characteristics of the 85 study participants with bipolar disorder. The largest proportion of patients belonged to the age group of 31–45 years, accounting for 34 patients (40.00%), followed by 18–30 years with 28 patients (32.94%). Patients aged 46–60 years constituted 18 cases (21.18%), while only 5 patients (5.88%) were above 60 years of age. This indicates that the majority of patients were in the economically productive and socially active age groups, suggesting that bipolar disorder in this study commonly affected young and middle-aged adults. In terms of gender distribution, males were more common than females, with 49 patients (57.65%) being male and 36 patients (42.35%) being female. With regard to marital status, most

participants were married, comprising 52 patients (61.18%), while 21 patients (24.71%) were unmarried and 12 patients (14.12%) were widowed or separated. The predominance of married individuals may be because the sample largely consisted of adults in the middle age range. Marital status is an important social factor in bipolar disorder, as family relationships and spousal support can influence treatment compliance, relapse prevention, and long-term prognosis.

Table 2 describes the clinical profile of the study population. Bipolar disorder type I was more common than type II, being present in 56 patients (65.88%), whereas 29 patients (34.12%) had bipolar disorder type II. This indicates that the study sample was predominantly composed of patients with the more severe and classically recognized form of bipolar disorder, which is often associated with manic episodes requiring specialist care. Regarding age at onset, 52 patients (61.18%) had illness onset at or after 25 years of age, while 33 patients (38.82%) had onset before 25 years. Duration of illness showed that 34 patients (40.00%) had illness duration of 5–10 years, making this the most common duration category. This was followed by 27 patients (31.76%) with illness duration of less than 5 years and 24 patients (28.24%) with duration greater than 10 years. These findings indicate that a considerable number of patients had a long-standing illness course, highlighting the chronic and recurrent nature of bipolar disorder. Psychotic symptoms were present in 38 patients (44.71%) and absent in 47 patients (55.29%). Substance use was found in 29 patients (34.12%), whereas 56 patients (65.88%) had no substance use.

Table 3 presents treatment-related and psychosocial characteristics of the patients. Good medication adherence was observed in 48 patients (56.47%), while 37 patients (43.53%) had poor adherence. Although more than half of the patients showed good adherence, the proportion with poor adherence was also considerable. This is clinically relevant because bipolar disorder often requires long-term maintenance treatment, and poor adherence is one of the major causes of relapse, recurrence, hospitalization, and poor functional recovery. Insight into illness was present in 44 patients (51.76%) and absent in 41 patients (48.24%), showing an almost equal distribution. Good family support was reported in 50 patients (58.82%), whereas 35 patients (41.18%) had poor family support. Since bipolar disorder is a chronic psychiatric illness requiring long-term care and supervision, family support plays a crucial role in ensuring regular treatment, recognizing early warning signs of relapse, and improving psychosocial rehabilitation. Stressful life events were present in 39 patients (45.88%) and absent in 46 patients (54.12%). Thus, nearly half of the participants had experienced significant stressors, which may contribute to triggering episodes, worsening symptoms, or negatively affecting recovery. Comorbid medical illness was present in 26 patients (30.59%) and absent in 59 patients (69.41%).

Table 4 shows the overall treatment outcome among the study participants. Out of 85 patients, 51 patients (60.00%) had a favorable outcome, while 34 patients (40.00%) had an unfavorable outcome.

Table 5 examines the association of selected variables with treatment outcome and identifies factors that significantly influenced whether patients had favorable or unfavorable outcomes. Medication adherence showed a highly significant association with treatment outcome ($p = 0.001$). Among patients with favorable outcome, 38 patients (74.51%) had good adherence, whereas only 10 patients (29.41%) in the unfavorable outcome group had good adherence. In contrast,

poor adherence was much more common in the unfavorable outcome group, seen in 24 patients (70.59%), compared to 13 patients (25.49%) in the favorable outcome group. Psychotic symptoms were also significantly associated with treatment outcome (p = 0.012). Among patients with unfavorable outcome, 21 patients (61.76%) had psychotic symptoms, compared with only 17 patients (33.33%) in the favorable outcome group. On the other hand, absence of psychotic symptoms was more common in patients with favorable outcome, accounting for 34 patients (66.67%), compared to 13 patients (38.24%) in the unfavorable group. Substance use showed a statistically significant association with treatment outcome as well (p = 0.018). Among those with unfavorable outcome, 17 patients (50.00%) had substance use, whereas only 12 patients (23.53%) in the favorable outcome group had substance use. Conversely, absence of substance use was much more frequent among those with favorable outcome, comprising 39 patients (76.47%), compared with 17 patients (50.00%) among those with unfavorable outcome. Insight into illness had a highly significant relationship with treatment outcome (p = 0.003). Among patients with favorable outcome, 34 patients (66.67%) had insight, while only 10 patients (29.41%) in the unfavorable outcome group had insight. In contrast, absence of insight was more common among those with unfavorable outcome, being present in 24 patients (70.59%), compared with 17 patients (33.33%) among those with favorable outcome. Family support also showed a statistically significant association with treatment outcome (p = 0.009). Good family support was seen in 36 patients (70.59%) with favorable outcome, compared with only 14 patients (41.18%) in the unfavorable outcome group. Poor family support was more frequent among those with unfavorable outcome, observed in 20 patients (58.82%), compared with 15 patients (29.41%) among those with favorable outcome. Duration of illness was another factor significantly associated with treatment outcome (p = 0.021). Patients with illness duration of less than 5 years were more likely to have favorable outcome, with 21 patients (41.18%) in the favorable group compared to only 6 patients (17.65%) in the unfavorable group. In contrast, illness duration of 5 years or more was much more common among patients with unfavorable outcome, comprising 28 patients (82.35%), compared to 30 patients (58.82%) in the favorable outcome group.

Table 1: Socio-demographic Characteristics of Study Participants (n = 85)

Variable	Category	Frequency (n)	Percentage (%)
Age group (years)	18–30	28	32.94
	31–45	34	40.00
	46–60	18	21.18
	>60	5	5.88
Gender	Male	49	57.65
	Female	36	42.35
Marital status	Married	52	61.18
	Unmarried	21	24.71
	Widowed/Separated	12	14.12

Residence	Urban	46	54.12
	Rural	39	45.88
Education	Illiterate	14	16.47
	Primary	19	22.35
	Secondary	31	36.47
	Graduate & above	21	24.71

Table 2: Clinical Characteristics of Patients (n = 85)

Variable	Category	Frequency (n)	Percentage (%)
Type of Bipolar Disorder	Type I	56	65.88
	Type II	29	34.12
Age at onset (years)	<25	33	38.82
	≥25	52	61.18
Duration of illness	<5 years	27	31.76
	5–10 years	34	40.00
	>10 years	24	28.24
Psychotic symptoms	Present	38	44.71
	Absent	47	55.29
Substance use	Present	29	34.12
	Absent	56	65.88
Family history	Present	31	36.47
	Absent	54	63.53

Table 3: Treatment-related and Psychosocial Factors (n = 85)

Variable	Category	Frequency (n)	Percentage (%)
Medication adherence	Good	48	56.47
	Poor	37	43.53
Insight into illness	Present	44	51.76
	Absent	41	48.24
Family support	Good	50	58.82
	Poor	35	41.18
Stressful life events	Present	39	45.88
	Absent	46	54.12
Comorbid medical illness	Present	26	30.59
	Absent	59	69.41

Table 4: Treatment Outcome Distribution (n = 85)

Outcome	Frequency (n)	Percentage (%)
Favorable outcome	51	60.00
Unfavorable outcome	34	40.00

Table 5: Association of Selected Factors with Treatment Outcome

Variable	Category	Favorable n (%)	Unfavorable n (%)	p-value
Medication adherence	**Good**	38 (74.51)	10 (29.41)	**0.001**
	Poor	13 (25.49)	24 (70.59)	
Psychotic symptoms	**Present**	17 (33.33)	21 (61.76)	**0.012**
	Absent	34 (66.67)	13 (38.24)	
Substance use	**Present**	12 (23.53)	17 (50.00)	**0.018**
	Absent	39 (76.47)	17 (50.00)	
Insight	**Present**	34 (66.67)	10 (29.41)	**0.003**
	Absent	17 (33.33)	24 (70.59)	
Family support	**Good**	36 (70.59)	14 (41.18)	**0.009**
	Poor	15 (29.41)	20 (58.82)	
Duration of illness	**<5 years**	21 (41.18)	6 (17.65)	**0.021**
	≥5 years	30 (58.82)	28 (82.35)	

DISCUSSION

In the present study, most patients were young to middle-aged adults, with 40.00% in the 31–45 year age group and 32.94% in the 18–30 year age group, while males constituted 57.65% of the sample. Most were married (61.18%), from urban areas (54.12%), and had at least secondary education (36.47%). These findings broadly indicate that bipolar disorder in this tertiary care setting affected patients in their most productive years. A somewhat similar outpatient profile was reported by Peh et al (2008), who found a relatively young clinic population in Singapore, with 45.00% males and 55.00% females; they also observed that psychotic symptoms were absent in 75.00% and family history was present in only 17.00% of cases. Compared with that study, the present sample showed a slightly higher male proportion, a much higher frequency of family history (36.47%), and a greater burden of severe clinical variables, probably because the current study was conducted in a tertiary care psychiatric setting where more complex cases are likely to present.[7] The clinical profile in the present study was characterized by predominance of bipolar disorder type I in 65.88% of cases, whereas bipolar disorder type II accounted for 34.12%. Psychotic symptoms were present in 44.71% of patients and family history of psychiatric illness was elicited in 36.47%. This pattern suggests a relatively severe clinical sample, because bipolar I disorder and psychotic features are generally associated with greater morbidity and service utilization. Mantere et al (2004), in the Jorvi Bipolar Study of 191 patients, reported 90 patients with bipolar I disorder and 101 with bipolar II disorder, with psychotic symptoms present in 16.20% and rapid cycling in 32.50% of the total cohort. In comparison, the present study had a clearly larger proportion of bipolar I disorder and a substantially higher frequency of psychotic symptoms, which may reflect differences in case mix, referral bias, and the hospital-based tertiary care design of the present work.[8] Regarding age at onset and illness duration, 38.82% of patients in the present study had onset before 25 years, while 61.18% had onset at or after 25 years. In addition, 68.24% of patients had illness duration of 5 years or more, confirming that a large proportion had a chronic course. This is clinically important because longer illness duration often reflects repeated

recurrences and cumulative psychosocial burden. Ernst et al (2004) examined age at onset in bipolar disorder and showed that earlier onset was associated with more complicated illness course, particularly rapid cycling and comorbid substance abuse/dependence. Although their report emphasized clinical correlates rather than simple frequency distribution, their findings support the present study's observation that a sizable subgroup with early onset is likely to carry a poorer prognostic profile. Thus, even though adult-onset cases were numerically more common in this study, the early-onset subgroup remains clinically important because it may represent patients at greater risk for recurrence and adverse outcome.[9]

The overall treatment outcome in the present study showed that 51 of 85 patients (60.00%) had a favorable outcome, while 34 patients (40.00%) had an unfavorable outcome. Although the majority improved, the proportion with poor outcome remained substantial, indicating that bipolar disorder continues to have considerable long-term morbidity even under specialist care. Fekadu et al (2006), in a community-based Ethiopian follow-up study, reported that 65.90% of patients experienced relapse and 31.10% had persistent illness; among relapses, 47.80% were manic, 44.30% depressive, and 7.70% mixed. When compared with those results, the present study appears to show a somewhat better overall outcome profile, but the 40.00% unfavorable outcome rate still indicates a heavy burden of residual morbidity. The difference may be related to the availability of tertiary psychiatric services, closer monitoring, and more structured treatment in the current hospital-based setting.[10] Medication adherence emerged as one of the strongest determinants of treatment outcome in the present study. Good adherence was seen in 56.47% overall, and among those with favorable outcome, 74.51% had good adherence compared with only 29.41% in the unfavorable group; this association was highly significant (p=0.001). These findings strongly support the central role of sustained pharmacological compliance in bipolar disorder. Sajatovic et al (2008), in a prospective 3-year study of veterans with bipolar disorder, also demonstrated that long-term adherence is influenced by baseline clinical and psychosocial factors, and their work emphasized that nonadherence is common and clinically important. Related data from the same body of work indicate that poor adherence in bipolar disorder commonly falls in the 20.00% to 55.00% range, which is very close to the 43.53% poor adherence rate observed in the present study. Therefore, the current findings are in line with earlier evidence that medication adherence is a major modifiable predictor of relapse and poor outcome.[11] Insight into illness was present in 51.76% of the present sample and absent in 48.24%. More importantly, 66.67% of patients with favorable outcome had insight, whereas only 29.41% of those with unfavorable outcome had insight, and this association was statistically significant (p=0.003). This suggests that insight is not merely a descriptive psychological variable but a clinically relevant factor influencing acceptance of illness, regular follow-up, and treatment continuation. Yen et al (2005), in a prospective study, found that among bipolar subjects, baseline insight scores regarding treatment, mental health status, psychotic experiences, and total insight were positively correlated with medication adherence both at baseline and at 1-year follow-up. Thus, the current study extends that observation by showing that the beneficial effect of insight is reflected not only in adherence-related behavior but also in final treatment outcome. The close relationship between insight and outcome in the present work is therefore consistent with earlier longitudinal evidence.[12]

Substance use and psychotic symptoms were both associated with poorer outcome in the present study. Substance use was present in 34.12% overall, but among those with unfavorable outcome it was found in 50.00% compared with 23.53% in the favorable group (p=0.018). Likewise, psychotic symptoms were present in 61.76% of those with unfavorable outcome versus 33.33% of those with favorable outcome (p=0.012). These findings indicate that comorbidity and episode severity significantly worsen prognosis.

Strakowski et al (2000) reported that interval substance abuse was associated with impaired symptomatic recovery in bipolar disorder, and related reports from the same line of work noted that nearly 60.00% of the cohort had a lifetime history of some substance abuse. Compared with those studies, the present study found a lower overall prevalence of substance use, but its negative effect on outcome was similarly evident. Hence, despite variation in prevalence across settings, the direction of association remains consistent: comorbid substance use and severe symptomatology are markers of poorer recovery.[13]

Family support and chronicity also appeared to shape outcome in the present study. Good family support was present in 58.82% overall, and among patients with favorable outcome 70.59% had good family support compared with 41.18% in the unfavorable group (p=0.009). In parallel, shorter illness duration was associated with better outcome: 41.18% of the favorable group had illness duration below 5 years versus only 17.65% of the unfavorable group (p=0.021). These findings suggest that both a supportive family environment and earlier-stage illness are linked with better prognosis. Miklowitz et al (2000) similarly demonstrated the clinical value of family-based intervention in bipolar disorder; family-focused treatment was associated with substantially lower relapse rates, with later summaries of the trial citing relapse rates of about 11.00% in treated patients compared with 61.00% in controls. The present results are therefore consistent with the view that family environment is not only socially relevant but therapeutically important, particularly in a chronic disorder where longer illness duration may progressively erode functioning and increase the need for sustained caregiver involvement.[14]

CONCLUSION

This study concludes that treatment outcome in bipolar disorder is influenced by a combination of clinical, psychosocial, and treatment-related factors. Favorable outcome was significantly associated with good medication adherence, better insight into illness, good family support, absence of psychotic symptoms, absence of substance use, and shorter duration of illness. In contrast, poor adherence, lack of insight, poor family support, psychotic symptoms, substance use, and longer illness duration were linked to unfavorable outcome. Early identification of these factors and a comprehensive management approach may help improve long-term prognosis and functional recovery in patients with bipolar disorder.

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