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Prognosis Prevention and Management of Bipolar Disorder in Human

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Perspective

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DESCRIPTION

A mental disease called bipolar disorder, formerly known as manic depression, is characterized by bouts of melancholy which last from days to weeks. The term "mania" or "hypomania" is used to describe an elevated mood that is extreme or linked to psychosis. During mania, a person acts or feels abnormally energized, cheerful, or irritated, and they frequently make hasty decisions without carefully considering the repercussions. During manic episodes, the need for sleep is typically decreased. The person may cry, have a pessimistic attitude on life, and make poor eye contact with others while depressed. Suicide is a serious concern; over a 20-year period, 6% of people with bipolar disorder committed suicide, while 30%–40% hurt themselves. Bipolar disorder is frequently accompanied by other mental health conditions, such as anxiety disorders and substance use disorders. Although the exact causes of this mood illness are unknown, it is believed that both hereditary and environmental factors are involved. Several genes, each with negligible effects, could play a role in the disorder's emergence. Between 70 and 90 percent of the chance of getting bipolar disorder is attributed to genetic factors. Childhood abuse history and chronic stress are two environmental risk factors. If there has been at least one manic episode, with or without depressed episodes, the disease is categorized as bipolar I disorder, and as bipolar II disorder, if there has been at least one hypomanic episode (but no complete manic episodes) and one major depressive episode.

1% of people worldwide suffer from bipolar disorder. In the US, it is predicted that 3% of people will experience symptoms at some point in their lives; percentages appear to be comparable in both males and females. Between the ages of 20 and 25, symptoms most frequently appear; earlier onset in life is linked to a worse prognosis. Bipolar disorder patients are becoming more and more interested in functioning, with a focus on certain areas including employment, education, social life, family, and cognition. Stress (such as childhood adversity or highly conflictual families) has been the focus of attempts to prevent bipolar disorder. While stress is not a diagnostically specific causal agent for bipolar, it does put genetically and biologically vulnerable people at risk for a more severe course of illness. Longitudinal studies risk state of the illness at an early intervention can stop its further development and/or improve its prognosis.

Using a combination of pharmacological and psychological strategies, management aims to safely treat acute episodes with medication and work with the patient in long-term maintenance to prevent additional episodes and optimize function. Hospitalization may be necessary, particularly if bipolar manic episodes are present. If permitted by local law, this may be voluntary or involuntary. Support services that are provided after (or in place of) a hospital admission can include drop-in facilities, visits from members of a community mental health team or an assertive community treatment team, supported employment, patient-led support groups, and intensive outpatient programmes. These can also be known as partial-inpatient programmmes. Because the symptoms are milder and more treatable in the early stages, early detection and treatments also enhance prognosis. Both genders have better outcomes when depression develops during puberty, and being a man lowers the risk of higher depression levels. Being a parent and having greater social functioning prior to the onset of bipolar disease are protective factors against women.