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Chapter 1 : Mental Health Disorders in Adolescents - ACOG

Adv Adolesc Mental Health 4, A comparative study of adolescent reproductive behavior in the s examined difference in pregnancy, birth, and abortion levels among teenagers in developed countries especially in the US, Canada, the UK, France, the Netherlands, and Sweden.

This information is designed as an educational resource to aid clinicians in providing obstetric and gynecologic care, and use of this information is voluntary. This information should not be considered as inclusive of all proper treatments or methods of care or as a statement of the standard of care. It is not intended to substitute for the independent professional judgment of the treating clinician. Variations in practice may be warranted when, in the reasonable judgment of the treating clinician, such course of action is indicated by the condition of the patient, limitations of available resources, or advances in knowledge or technology. The American College of Obstetricians and Gynecologists reviews its publications regularly; however, its publications may not reflect the most recent evidence. Any updates to this document can be found on www. ACOG does not guarantee, warrant, or endorse the products or services of any firm, organization, or person. Neither ACOG nor its officers, directors, members, employees, or agents will be liable for any loss, damage, or claim with respect to any liabilities, including direct, special, indirect, or consequential damages, incurred in connection with this publication or reliance on the information presented. Mental health disorders in adolescence are a significant problem, relatively common, and amenable to treatment or intervention. Obstetricianâ€"gynecologists who see adolescent patients are highly likely to see adolescents and young women who have one or more mental health disorders. Some disorders or their treatments will affect the hypothalamicâ€"pituitaryâ€"gonadal axis, causing anovulatory cycles and various menstrual disturbances. Adolescents with psychiatric disorders may be taking psychopharmacologic agents that can cause menstrual dysfunction and galactorrhea. Adolescents with mental illness often engage in acting-out behavior or substance use, which increases their risk of unsafe sexual behavior that may result in pregnancy or sexually transmitted infections. Pregnant adolescents who take psychopharmacologic agents present a special challenge in balancing the potential risks of fetal harm with the risks of inadequate treatment. Although mental health disorders should be managed by mental health care professionals or appropriately trained primary care providers, the obstetricianâ€"gynecologist can assist by managing the gynecologic adverse effects of psychiatric medications and providing effective contraception and regular screening for sexually transmitted infections. This Committee Opinion will provide basic information about common adolescent mental health disorders, focusing on specific implications for gynecologic and obstetric practice. At least one in five youth aged 9â€"17 years currently has a diagnosable mental health disorder that causes some degree of impairment; one in 10 has a disorder that causes significant impairment. The most common mental illnesses in adolescents are anxiety, mood, attention, and behavior disorders. Suicide is the second leading cause of death in young people aged 15â€"24 years. Adolescents with mental illness often engage in acting-out behavior or substance use, which increase their risk of unsafe sexual behavior that may result in pregnancy or sexually transmitted infections STIs. During preventive care visits, all adolescents should be screened for any mental health disorder in a confidential setting if allowed by the laws of that locality. The obstetricianâ€"gynecologist has the opportunity to reduce morbidity and mortality associated with mental health disorders in adolescents by early identification, prompt referral, and care coordination. Introduction At least one in five youth aged 9â€"17 years currently has a diagnosable mental health disorder that causes some degree of impairment; one in 10 has a disorder that causes significant impairment 1 , 2. Only one third of these youth receive the necessary treatment 3. One half of all serious adult psychiatric disorders start by age 14 years, but treatment often does not begin for 6â€"23 years after onset 4. Anxiety and mood disorders are two to three times more prevalent in female adolescents than in male adolescents, although the reverse is true for attention deficit disorder. Obstetricianâ€"gynecologists who see adolescent patients are highly likely to see adolescents and young women who have one or more mental health disorders see Box 1. Some disorders or their treatments will affect the hypothalamicâ€"pituitaryâ€"gonadal axis, causing anovulatory cycles and various menstrual

disturbances such as secondary amenorrhea or abnormal uterine bleeding. Adolescents with mental illness often engage in acting-out behavior or substance use, which increase their risk of unsafe sexual behavior that may result in pregnancy or STIs. This Committee Opinion provides basic information about common adolescent mental health disorders, focusing on specific implications for gynecologic and obstetric practice. The emphasis is on recognition and referral, rather than specifics of treatment for each disorder. Although substance abuse disorders and eating disorders are included in the spectrum of mental illness and may coexist with other disorders, adequate discussion is beyond the scope of this document. The American College of Obstetricians and Gynecologists has addressed these issues in other documents 6â€”9. Additional information on eating disorders is available from the American Academy of Pediatrics Anxiety Disorders Anxiety disorders are the most common mental health disorders in adolescents. At any given time, one in eight adolescents meets clinical criteria for an anxiety disorder Anxiety disorders include generalized anxiety disorder, social anxiety disorder, and panic disorder see Box 1. Anxiety disorders are clinically significant when they interfere with important areas of functioning, such as school, work, or relationships with family and peers. See Box 2 for risk factors of anxiety disorders. Physical symptoms are common for many anxiety disorders. The gynecologist may be consulted for severe dysmenorrhea or chronic pelvic pain. Other symptoms include chest pains, palpitations, shortness of breath, dizziness, syncope, nausea, vomiting, recurrent abdominal pain, as well as disturbances in sleep patterns, appetite, and energy levels. Although closely related to anxiety disorders, OCD was felt to be complex enough to merit its own section and PTSD may manifest with symptoms that resemble mood disorders, or anxiety disorders, or both. Patients with OCD may present with vulvovaginitis from excessive attention to perineal hygiene or may have excessive concerns about the frequency, length, or amount of bleeding during their menstrual periods. Patients with PTSD may have an excessive fear of gynecologic examination, especially if they have a history of sexual assault or sexual abuse, and often will require additional time, reassurance, and anticipatory education. Mood Disorders and Depression At any given time, 1 in 20 adolescents meets clinical criteria for a mood disorder and up to one in four children will experience a mood disorder by their late adolescence Mood disorders include adjustment disorder with depressed mood, major depressive disorder, bipolar disorder, and premenstrual dysphoric disorder see Box 1. Depression is more common in female adolescents than in male adolescents. Adolescents with mood disorders show fewer vegetative symptoms eg, fatigue and low energy and more irritability than adults with mood disorders, frequently self-medicate with alcohol and other substances, and are at increased risk of suicidal behavior. Approximately two thirds of adolescents with a mood disorder have one or more mental disorders, including anxiety disorders, conduct disorders, and ADHD. See Box 2 for risk factors for mood disorders. Depressed mood may interfere with motivation for effective measures to prevent pregnancy and STIs. Unprotected sex with multiple partners is common during manic episodes. Depression may inhibit motivation to take medications as directed, including oral contraceptives, or keep scheduled appointments. Weight changes associated with depression or some psychopharmacologic agents may be attributed by patients or families to hormonal contraceptives, which may affect adherence to the hormonal contraceptive or the psychiatric medication. Adolescents who report symptoms of depression that adversely affect school, work, or interpersonal relationships, but experience these symptoms only during the 7â€”10 days preceding each menstrual period may have premenstrual dysphoric disorder 6. They should be evaluated for co-occurring mood or anxiety disorders. Adolescents with ADHD tend to be easily distracted, inattentive, and emotionally immature. They often have behavioral and educational problems. Adolescents with ADHD have an increased tendency for risk-taking behavior, including risky sexual behavior. They may require additional time spent on patient education with clearly presented instructions eg, use of contraceptives. Procrastination may lead to delays in filling or renewing prescriptions. Their impulsivity and lack of focus may be a barrier to consistent and correct use of contraceptive pills, patches, rings, or condoms. Disruptive Behavior Disorders Disruptive behavior disorders include oppositionalâ€”defiant disorder and conduct disorder. Females with conduct disorder often run away from home and are at increased risk of sexual exploitation or trafficking as well as engaging in high-risk sexual behavior. Disruptive behavior disorders frequently coexist with substance use disorder and mood and anxiety disorders. Patients with disruptive behavior disorders may be argumentative

and resistant to advice from any adults, including health care professionals. Although typically not diagnosed before age 18 years, onset typically takes place during adolescence. Borderline personality disorder is characterized by frequent bouts of anger, depression, and anxiety, lasting only hours, often alternating. Patients with borderline personality disorder are highly sensitive to rejection and fear abandonment, which causes them to demand frequent attention. Impulsive behavior includes binge-eating, high-risk sexual behavior, nonsuicidal self-injury, and suicide attempts. Somatization Disorders Somatic symptoms, common in children and adolescents, are reported by females more than males, especially after puberty The gynecologist may be consulted for chronic pelvic pain, severe dysmenorrhea, vulvovaginal pain or itching, ovarian cysts, or painful intercourse. A patient may request repeated STI testing despite low-risk behavior and previous negative test results. In the extreme, a patient may be convinced she is pregnant, have amenorrhea, abdominal enlargement, and other pregnancy symptoms without confirmatory evidence for pregnancy pseudocyesis It is often associated with OCD or social anxiety disorder. The management of somatization disorders can be difficult and frustrating. The obstetricianâ€”gynecologist should acknowledge the reality of the physical symptoms while emphasizing the normal findings on physical examination and avoiding excessive diagnostic testing. Unless the symptom is gynecologic, the patient should be referred to her primary care provider for comprehensive care and close follow-up. Gynecologic symptoms should be managed with appropriate treatments eg, nonsteroidal antiinflammatory drugs or hormonal contraceptives for dysmenorrhea. Suicidal Thoughts Suicide is the second leading cause of death in young people aged 15â€”24 years, with a rate of Obstetricianâ€”gynecologists should be particularly alert to the possibility of depression and possible suicidal ideation in pregnant and parenting adolescents and those with symptoms of anxiety disorder or mood disorder. Adolescents at risk include those who exhibit declining school grades, chronic sadness, family dysfunction, problems with sexual orientation, gender identity, physical or sexual abuse, alcohol or drug misuse, have a family his-tory of suicide, or have made a previous suicide attempt. Adolescents contemplating suicide rarely offer that information as a presenting symptom. However, they often feel relieved when the subject is broached. Questions should be asked in a direct, nonthreatening, nonjudgmental manner. Does this happen to you? The risk of suicide is highest when the patient can describe a plan for time, location, and means of suicide and has easy access to the means, especially medications or firearms When any risk of suicide attempt or serious self-harm is identified or admitted, the adolescent should be referred to a mental health crisis agency or emergency department for assessment by a mental health care professional. The obstetricianâ€”gynecologist should notify those who need to monitor, protect, and ensure the safety of the patient, even if this means breaching confidentiality. This may include providing information to parents or guardians about securing weapons or lethal drugs that may be available to the patient. This typically is done to obtain relief from negative feelings or cognitive states 5. Nonsuicidal self-injury often is associated with anxiety disorders, mood disorders, personality disorders, eating disorders, and especially with a history of sexual abuse or chronic neglect and maltreatment in childhood. Nonsuicidal self-injury should be suspected in patients with frequent accidents or questionable explanations, or unexplained wounds or scars noted during examination, or both. The obstetricianâ€”gynecologist may be more likely than other health care providers to see the patient undressed. If the obstetricianâ€”gynecologist notes scars or cuts on the breasts, abdomen, arms, or legs, he or she should ask about nonsuicidal self-injury and refer the patient to appropriate mental health assessment and management 6. Screening for depression and suicide also should include screening for nonsuicidal self-injury. Misuse was defined as use without a prescription; use in greater amounts, more often, or longer than the respondent was told to take them; or use in any other way a doctor did not direct the respondent to use them. Use of psychopharmacologic agents in adolescents depends on accurate diagnosis and typically is an adjunct to nonpharmacological treatment.

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Chapter 3 : PubMed Journals will be shut down | NCBI Insights

Advances in Mental Health. of need for autonomy and preference for seeking help from informal sources on emerging adults' intentions to access mental health.

Chapter 4 : Advances and Breakthroughs in Mental Health

The Mental Health Parity and Addiction Equity Act of , the Affordable Care Act of , and the recent Medicaid expansion in many states have helped improve access to mental health services for Americans of all ages. 1 Parity, in health insurance plans, means that mental health services are covered and reimbursed at the same levels as physical health care.

Chapter 5 : Adolescent brain development impacts mental health, substance use | EurekAlert! Science Ne

Advances in understanding adolescent brain development may aid future treatments of mental illness and alcohol and substance use disorders. The findings were presented at Neuroscience , the.