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Mental Health Disorders in Adolescents

ABSTRACT: Mental health disorders in adolescence are a significant problem, relatively common, and amenable to treatment or intervention. Obstetrician–gynecologists who see adolescent patients are highly likely to see adolescents and young women who have one or more mental health disorders. Some of these disorders may interfere with a patient's ability to understand or articulate her health concerns and appropriately adhere to recommended treatment. Some disorders or their treatments will affect the hypothalamic–pituitary–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. Whether providing preventive women's health care or specific obstetric or gynecologic treatment, the obstetrician–gynecologist has the opportunity to reduce morbidity and mortality from mental health disorders in adolescents by early identification, appropriate and timely referral, and care coordination. Although mental health disorders should be managed by mental health care professionals or appropriately trained primary care providers, the obstetrician–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.

Recommendations and Conclusions

The American College of Obstetricians and Gynecologists makes the following recommendations and conclusions:

- At least one in five youth aged 9–17 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 15–24 years.
- Obstetrician–gynecologists who see adolescent patients are highly likely to see adolescents and young women who have one or more mental health disorders.

- 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).
- Adolescents with psychiatric disorders may be taking psychopharmacologic agents that can cause menstrual dysfunction and galactorrhea.
- Pregnant adolescents who take psychopharmacologic agents present a special challenge in balancing the potential risks of fetal harm with the risks of inadequate treatment.
- 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 obstetrician–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 9–17 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 6–23 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. Obstetrician–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 of these disorders may interfere with a patient’s ability to understand or articulate her health concerns and to appropriately adhere to recommended treatment. Some disorders or their treatments will affect the hypothalamic–pituitary–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. Adolescents with psychiatric disorders may be taking psychopharmacologic agents that can cause menstrual dysfunction and galactorrhea. Pregnant adolescents who take psychopharmacologic agents present a special challenge in balancing the potential risks of fetal harm with the risks of inadequate treatment.

The most common mental illnesses in adolescents are anxiety, mood, attention, and behavior disorders. The criteria to make each specific diagnosis are outlined and discussed in the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-V) (5) and summarized in Box 1. This Committee Opinion provides basic

Box 1. Common Mental Health Disorders* ←

Anxiety Disorders

Generalized Anxiety Disorder (GAD): Excessive anxiety and worry (apprehensive expectation) about a number of events or activities. The intensity, duration, or frequency of the anxiety and worry is out of proportion to the actual likelihood or effect of the anticipated event. The individual finds it difficult to control the worry and to keep worrisome thoughts from interfering with attention to tasks at hand. Somatic symptoms frequently are associated.

Social Anxiety Disorder: Marked and persistent fear of one or more social or performance situations, provoking symptoms of anxiety and causing extreme distress or avoidance of the situation.

Panic Disorder: Recurrent unexpected panic attacks.

Panic Attack: An abrupt surge of intense fear or intense discomfort that reaches a peak within minutes and during which time four or more of 13 physical and cognitive symptoms occur (palpitations, pounding heart, or accelerated heart rate; sweating; trembling or shaking; sensations of shortness of breath or smothering; feelings of choking; chest pain or discomfort; nausea or abdominal distress; feeling dizzy, unsteady, light-headed, or faint; chills or heat sensations; paresthesias [numbness or tingling sensations]; derealization [feelings of unreality] or depersonalization [being detached from oneself]; fear of losing control or “going crazy”; fear of dying).

Obsessive–Compulsive Disorder (OCD): Although the specific content of obsessions and compulsions varies among individuals, certain symptom dimensions are common in OCD, including those of cleaning (contamination obsessions and cleaning compulsions); symmetry (symmetry obsessions and repeating, ordering, and counting compulsions); forbidden or taboo thoughts (eg, aggressive, sexual, and religious obsessions and related compulsions); and harm (eg, fears of harm to oneself or others and related checking compulsions).

Posttraumatic Stress Disorder (PTSD): The development of characteristic symptoms (including fear-based re-experiencing, emotional and behavioral symptoms, anhedonic or dysphoric mood states, negative cognitions, arousal and reactive-externalizing symptoms, dissociative symptoms, or combinations of these symptom patterns) after exposure to actual or threatened death, serious injury, or sexual violence.

Mood Disorders

Adjustment Disorder With Depressed Mood: The development of emotional or behavioral symptoms in response to an identifiable stressor(s) that occur within 3 months of the onset of the stressor(s) in which low mood, tearfulness, or feelings of hopelessness are predominant.

Major Depressive Disorder (MDD): A period of at least 2 weeks during which there is either depressed mood or the loss of interest or pleasure in nearly all activities. In children and adolescents, the mood may be irritable rather than sad.

(continued)

Box 1. Common Mental Health Disorders* (continued)

Mood Disorders (continued)

Bipolar Disorder: A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least 4 consecutive days and present most of the day, nearly every day, or that requires hospitalization.

Premenstrual Dysphoric Disorder: The cyclic recurrence of severe, sometimes disabling, changes in affect—such as mood lability, irritability, dysphoria, and anxiety—that occur in the luteal phase of a woman’s menstrual cycle and subside around, or shortly after, the onset of menses. These symptoms may be accompanied by the common physical and behavioral symptoms of premenstrual syndrome.

Attention Deficit Hyperactivity Disorder

Symptoms of inattention and hyperactivity or impulsivity present for at least 6 months to a degree that is maladaptive and inconsistent with developmental level.

Disruptive Behavior Disorders

Conduct Disorder: Repetitive and persistent pattern of behavior that violates the basic rights of others or the age-appropriate societal norms, including aggression to people and animals, destruction of property, deceitfulness or theft, or serious violation of rules (such as running away, truancy, curfew violations.)

Oppositional–Defiant Disorder: Pattern of negativistic, hostile, and defiant behavior that includes four or more of the following—often losing temper, often arguing with adults, often refusing to follow rules, often annoying others, often blaming others, often angry or resentful, often spiteful or vindictive.

*For complete diagnostic information, consult the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition.

Data from American Psychiatric Association. *Diagnostic and statistical manual of mental disorders*. 5th ed. Arlington (VA): APA; 2013.

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 (6–9). Additional information on eating disorders is available from the American Academy of Pediatrics (10).

Anxiety Disorders

Anxiety disorders are the most common mental health disorders in adolescents. At any given time, one in eight

Box 2. Risk Factors for Anxiety or Mood Disorders ⇐

- History of depression or other mental health disorder
- Parental history of anxiety or mood disorder or other mental health disorder
- Increased academic or social demands
- Stressful family environments (eg, poverty, harsh discipline, minimal support)
- Early or significant losses (parental death, divorce, termination of a relationship)
- Chronic illness
- History of being bullied, including cyberbullying
- History of neglect or physical, mental, or sexual abuse
- History of alcohol or other substance use
- History of conduct disorder, delinquency, or other antisocial behaviors

adolescents meets clinical criteria for an anxiety disorder (11). 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. They often occur in conjunction with depressive disorders or attention-deficit/hyperactivity disorder (ADHD) and are associated with an increased risk of suicide. 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.

Obsessive-compulsive disorder (OCD) and post-traumatic stress disorder (PTSD) now are classified separately from anxiety disorders in DSM-V. 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 (12). 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 7–10 days preceding each menstrual period may have premenstrual dysphoric disorder (6). They should be evaluated for co-occurring mood or anxiety disorders.

Attention-Deficit/Hyperactivity Disorder

Approximately 1 in 20 adolescents meets clinical criteria for ADHD (13). 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 oppositional-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.

Borderline Personality Disorder

Borderline personality disorder affects 1–3% of adolescents and young adults, mostly females (14). 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. Attitudes toward others shift rapidly from idealization (seen as “all good”) to devaluation (seen as “all bad”). 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. These patients often report a history of abuse, neglect, or separation in childhood and 40–70% report a history of sexual abuse (15).

Somatization Disorders

Somatic symptoms, common in children and adolescents, are reported by females more than males, especially after puberty (16). 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) (17).

Body dysmorphic disorder, an obsessive preoccupation that some aspect of one’s body is flawed and must be hidden or corrected, usually begins during adolescence. It is often associated with OCD or social anxiety disorder.

The management of somatization disorders can be difficult and frustrating. The obstetrician–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 15–24 years, with a rate of 13.9 deaths by suicide in this population per day; the rate of suicide attempts is 100–200 times higher than that of completions (18). Obstetrician–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 history 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. The obstetrician–gynecologist may begin with, “*Sometimes adolescents dealing with similar issues or problems get very down and start to question life itself. Does this happen to you?*” A positive answer should be followed with questions such as:

- “*Have you ever thought about suicide or harming yourself?*”
- “*Are you thinking about suicide now?*”
- “*Do you have a plan for suicide?*” (If the patient answers affirmatively, ask for details of the plan and whether she has ever attempted suicide in the past.)

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 (19). 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 obstetrician–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.

Nonsuicidal Self-Injury

Nonsuicidal self-injury (eg, “cutting”) is intentional self-inflicted damage to the surface of one’s body with the expectation that the injury will lead to only minor or moderate physical harm. This typically is done to obtain relief from negative feelings or cognitive states (5). The estimated lifetime prevalence of nonsuicidal self-injury among high school students is 12–23%, with rates higher in females than males. 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 obstetrician–gynecologist may be more likely than other health care providers to see the patient undressed. If the obstetrician–

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.

Obstetric and Gynecologic Implications of Psychopharmacologic Agents

In 2015, 28% of youths aged 12–17 years reported using prescription psychotherapeutic drugs (use or misuse) and 6% reported misuse of psychotherapeutics (20). *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. Among young adults aged 18–25 years, 44% used and 15% misused prescription psychotherapeutic drugs (20). Use of psychopharmacologic agents in adolescents depends on accurate diagnosis and typically is an adjunct to nonpharmacological treatment. The best role for the obstetrician–gynecologist is to address the obstetric and gynecologic implications of these agents. Table 1 includes details about psychopharmacologic medications often prescribed for adolescents. Obstetrician–gynecologists should recognize the complexity of prescribing for an adolescent and young adult population, and that they differ from the adult population. The complexity of prescribing for adolescents is well-reviewed elsewhere (21, 22). An adolescent should be managed by a health care provider with experience and training treating adolescents with mental health disorders. Additionally, narcotics should not be prescribed for underlying pain or dysmenorrhea. Obstetrician–gynecologists should be familiar with local and state rules regarding the medical use of controlled substances, including stimulants and sedatives.

Obstetrician–gynecologists should know that some medications can affect menses and that selective serotonin reuptake inhibitors (SSRIs) may be associated with sexual dysfunction (Table 1). Antiepileptic drugs used for bipolar disorder may affect circulating levels of oral contraceptives and also can affect the efficacy of the medication being prescribed (eg, lamotrigine and valproic acid) (23). Additional information on the safety and efficacy of specific contraceptive methods for those with certain characteristics or medical conditions is provided by the Centers for Disease Control and Prevention’s *Medical Eligibility Criteria for Contraceptive Use*, available online at www.cdc.gov/reproductivehealth/contraception/usmec.htm (23).

As noted by the Centers for Disease Control and Prevention’s *Medical Eligibility Criteria for Contraceptive Use*, a woman being treated with teratogenic drugs is at increased risk of poor pregnancy outcomes and, as such, long-acting, highly effective contraceptive methods

Table 1. Psychopharmacologic Medications Used for Adolescents ↵

Medication	Comments and Gynecologic Adverse Effects
Antianxiety Drugs	
<i>SSRIs (First-line medications for anxiety)</i>	
Sertraline*	Approved for children and adolescents Decreased libido Sexual dysfunction
Fluoxetine*	Approved for children and adolescents Long half-life Sexual dysfunction Heavy menstrual bleeding
Duloxetine*	Approved for generalized anxiety disorder in children and adolescents
<i>Benzodiazepines (OCPs may increase or decrease levels; abrupt discontinuance causes severe withdrawal. All result in decreased libido)</i>	
Diazepam	Long acting
Lorazepam	Short acting
Alprazolam	Sexual dysfunction
Antihistamines	
Hydroxyzine	Avoid in early pregnancy
Antidepressants	
<i>SSRIs (First-line medications for depression)</i>	
Fluoxetine*	Approved for children and adolescents Long half-life Sexual dysfunction Heavy menstrual bleeding
Sertraline*	Indication for premenstrual dysphoric disorder Decreased libido
Citalopram*	Sexual dysfunction
Escitalopram*	Approved for children and adolescents Decreased libido Sexual dysfunction
<i>Tricyclics (No proven efficacy in adolescents; risks outweigh benefits)</i>	
<i>Other (Second-line medications for depression)</i>	
Bupropion*	May be used as adjunct to SSRI
Venlafaxine*	Sexual dysfunction

(continued)

Table 1. Psychopharmacologic Medications Used for Adolescents (*continued*)

Medication	Comments and Gynecologic Adverse Effects
Mood Stabilizers	
Lithium carbonate	Only mood stabilizer approved for pediatric bipolar disorder Associated with thyroid dysfunction, which may cause menstrual dysfunction Metronidazole may potentiate toxicity
Carbamazepine	May affect hormonal contraceptive efficacy
Valproic acid	May affect hormonal contraceptive efficacy
Lamotrigine	May affect hormonal contraceptive efficacy
Antipsychotic Drugs	
<i>Second generation</i>	
Risperidone [†]	Decreased libido, irregular menses, weight gain, and hyperprolactinemia are common
Olanzapine [†]	Decreased libido, irregular menses, weight gain, and hyperprolactinemia are common
Aripiprazole [†]	Decreased libido, irregular menses, weight gain, and hyperprolactinemia are common
Quetiapine [†]	Decreased libido, irregular menses, weight gain, and hyperprolactinemia are common
Asenapine [†]	Decreased libido, irregular menses, weight gain, and hyperprolactinemia are common
<i>First generation</i>	
Haloperidol	Same as second generation
Psychostimulants	
Methylphenidate	Short acting (3–5 hours) Intermediate acting (6–8 hours) Altered liver function Long acting (12 hours)
Amphetamines	Short acting (4–6 hours) Long acting (10–12 hours)
Lisdexamfetamine	Long acting
Atomoxetine	Dysmenorrhea
Adjuvants	
Clonidine	Incontinence Hypotension
Guanfacine	Incontinence Hypotension

Abbreviations: OCPs, oral contraceptive pills; SSRIs, selective serotonin reuptake inhibitors.

*Clinical trials indicate a twofold increase in suicide ideation and attempts by adolescents and young adults taking antidepressants and anti-anxiety drugs particularly SSRIs, bupropion, venlafaxine, and duloxetine. These drugs have a “black box” warning. However, results of clinical pediatric trials suggest that benefits of these medications likely outweigh the risks to adolescents with major depressive and anxiety disorders.

[†]Approved in children and adolescents for schizophrenia and bipolar disorder.

(eg, implant, intrauterine devices) may be her best contraceptive option (23). During pregnancy, close collaboration between the obstetrician and the prescribing psychiatrist is essential to provide adequate treatment to balance the benefits with potential maternal and fetal harms (24). The U.S. Food and Drug Administration is phasing out the use of product letter categories—A, B, C, D, and X—to classify the risks of using prescription drugs during pregnancy. These categories are being replaced with three detailed subsections that describe risks within the real-world context of caring for pregnant women who may need medication. For more information, see www.fda.gov/ForConsumers/ConsumerUpdates/ucm423773.htm.

More than one third of those who are prescribed antidepressant and anti-anxiety medications discontinue use within the first 3 months of drug initiation; another 25% stop use between 3 months and 6 months because of unacceptable adverse effects, most commonly continued drowsiness, decreased sexual libido, and anxiety (25). The obstetrician–gynecologist, when reviewing current medications, may be the first health care provider to learn that a patient is no longer taking her medication and, therefore, has the opportunity to refer the patient back to her mental health care professional. Additionally, some data report higher rates of contraceptive nonuse, misuse, and discontinuation among women with symptoms of mental health disorders (eg, depression and anxiety) compared with asymptomatic women (26). Proactive counseling about long-acting, highly effective contraceptive methods may be beneficial in this population.

The General Role of the Obstetrician–Gynecologist

Obstetrician–gynecologists should ask about any mental illness diagnoses and treatments, especially medications and family history, and coordinate care with the patient’s mental health care providers. Obstetrician–gynecologists who care for minors should be aware of federal and state laws that affect confidentiality, state statutes on the rights of minors to consent to health care services, and the regulations that apply to their practice. 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) by asking questions such as those listed in **Box 3**. The Patient Health Questionnaire (PHQ-9), validated for use with adolescents, is a useful screening tool (**Box 4**). This can be self-completed by the patient or administered by the obstetrician–gynecologist or office staff. The last question screens for suicidal thinking. Many institutions use the PHQ-2, the first two questions, as the initial screen.

Positive responses to screening questions should be investigated further and the patient should be referred to a mental health care specialist or agency for further evaluation and treatment. A list of appropriate health care providers and resources should be made available and can include child and adolescent psychiatrists, adolescent-

friendly psychologists or other psychotherapists, adolescent medicine specialists, and behavioral pediatricians. Adolescents, especially minors, may benefit from having a parent or guardian as part of the process of accessing mental health services. Where it is not possible to involve a parent, an alternative adult relative, family friend, or counselor may be an option. Short-term follow-up (with a visit or telephone call) can determine if recommendations have been followed, provide an opportunity for the obstetrician–gynecologist to offer assistance with any barriers to the referral, and provide support to the patient and her family.

Conclusion

Mental health disorders in adolescence are a significant problem, relatively common, and amenable to treatment or intervention. Whether providing preventive women’s health care or specific obstetric or gynecologic treatment, the obstetrician–gynecologist has the opportunity to reduce morbidity and mortality associated with mental health disorders in adolescents by early identification, prompt referral, and care coordination. An understanding of the obstetric and gynecologic implications of mental health disorders and their treatment is critical. Although mental health disorders should be managed by mental health care professionals or appropriately trained primary care providers, the obstetrician–gynecologist can assist by managing the gynecologic adverse effects of psychiatric medications and by providing effective contraception and regular screening for STIs.

For More Information

The American College of Obstetricians and Gynecologists has identified additional resources on topics related to this document that may be helpful for ob-gyns, other health care providers, and patients. You may view these resources at www.acog.org/More-Info/AdolescentMentalHealth.

Box 3. Useful Questions for Screening for Mental Health Disorders ⇐

- Do you worry a lot or feel overly stressed out? How do you cope with stress?
- Do you feel bored, sad, or irritable most of the time? How do you cope with this?
- Do you have any difficulty with sleeping or appetite?
- Do you find yourself continuing to think about past unpleasant experiences?
- Do you ever feel so upset that you wished you were not alive or wanted to die?

Data from Hagan JF, Shaw JS, Duncan PM, editors. *Bright Futures: guidelines for health supervision of infants, children, and adolescents*. 3rd ed. Elk Grove Village (IL): American Academy of Pediatrics; 2008.

Box 4. Patient Health Questionnaire-9: Screening Instrument for Depression ↩

Instructions: How often have you been bothered by each of the following symptoms during the past 2 weeks? For each symptom put an “X” in the box beneath the answer that best describes how you have been feeling.

	(0)	(1)	(2)	(3)
	Not at All	Several Days	More Than Half the Days	Nearly Every Day
Little interest or pleasure in doing things*				
Feeling down, depressed, irritable, or hopeless*				
Trouble falling asleep, staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself—or that you are a failure, or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead, or of hurting yourself in some way				

Total score Depression severity

0 to 4	Minimal
5 to 9	Mild
10 to 14	Moderate
15 to 19	Moderately severe
20 to 27	Severe

* The first two questions comprise the Patient Health Questionnaire (PHQ)-2. If the PHQ-2 is positive for depression, the PHQ-9 should be administered.

Adapted from patient health questionnaire (PHQ) screeners. <http://www.phqscreeners.com>. Retrieved February 2, 2017.

These resources are for information only and are not meant to be comprehensive. Referral to these resources does not imply the American College of Obstetricians and Gynecologists’ endorsement of the organization, the organization’s website, or the content of the resource. The resources may change without notice.

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