wjpmr, 2025, 11(9), 213-217

SJIF Impact Factor: 6.842

WORLD JOURNAL OF PHARMACEUTICAL AND MEDICAL RESEARCH

www.wjpmr.com

Review Article

ISSN (O): 2455-3301

ISSN (P): 3051-2557

MENTAL HEALTH DISORDER IN YOUNG PEOPLE IN GLOBAL SCENARIO

D. K. Awasthi*[1] and Vivek Mishra[2]

[1]Department of Chemistry Sri Sharda Group of Institutions Lucknow.
[2]Sri Sharda Group of Institutions Lucknow.

***Corresponding Author: D. K. Awasthi**

Department of Chemistry Sri Sharda Group of Institutions Lucknow.

Article Received on 14/07/2025 **Article Revised on 03/08/2025** **Article Accepted on 24/08/2025**

ABSTRACT

Adolescents with psychiatric disorders may be taking psychopharmacologic agents, which can cause menstrual dysfunction, galactorrhea, and unsafe sexual behavior. Pregnant adolescents face challenges in balancing fetal harm risks with inadequate treatment. This Committee Opinion discusses common adolescent mental health disorders, highlighting their implications for gynecologic and obstetric practice, including managing medication adverse effects, providing contraception, and screening for sexually transmitted infections.

KEYWORDS: Adolescent, Gynecologic, Psychiatric, Disorder, Mental, Health.

INTRODUCTION

At least one in five youth aged 9-17 years has a diagnosable mental health disorder, with one in 10 causing significant impairment. Only one third receive necessary treatment. Half of serious adult psychiatric disorders start by age 14, but treatment often takes 6-24 years. Female adolescents are more likely to have anxiety and mood disorders. Obstetricians and gynecologists often see these patients. Adherence to recommended treatment is crucial for certain disorders that affect the hypothalamic-pituitary-gonadal axis, leading to anovulatory cycles and menstrual disturbances. 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.

Fig-1

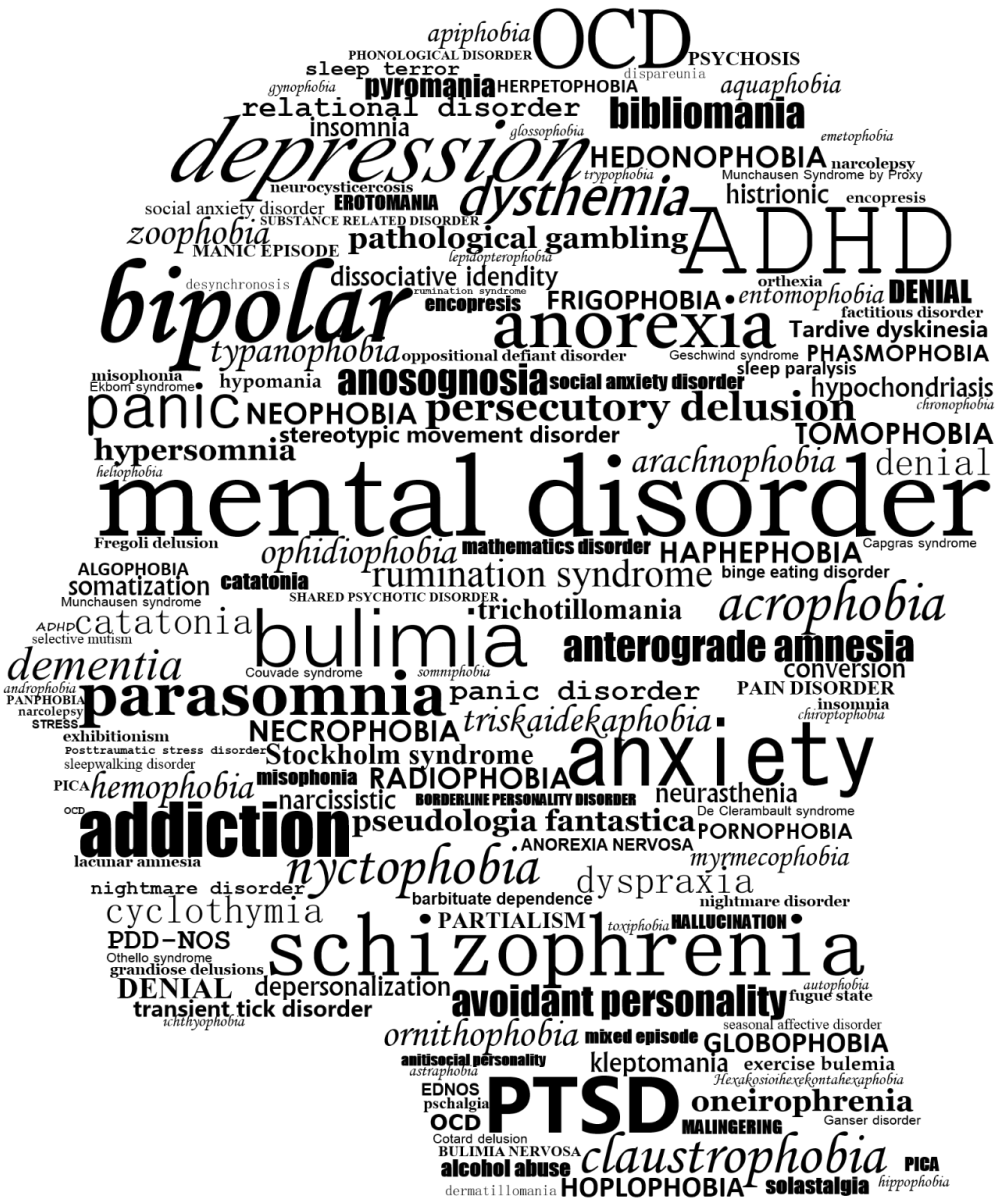

Fig-251

Anxiety Disorders

Anxiety disorders are generally found in young generation, it creates mental problem 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 Anxiety disorders are clinically significant when they interfere with important areas of functioning, such as school, work, or relationships with family and peers. It is related to depressive disorder. If it is increased person can think to sucide.

Mood Disorders and Depression

Mood disorders include adjustment disorder with depressed mood, major depressive disorder, bipolar disorder, and premenstrual dysphoric disorder. Depression generally occurs in female rather than male. mood disorders symptoms are fatigue ,low energy and more irritability.

Depressed mood may interfere with motivation for effective measures to prevent pregnancy and STIs. Weight changes associated with depression or some psycho-pharmacologic agents may be attributed by patients or families to hormonal contraceptives, which may affect adherence to the hormonal contraceptive or the psychiatric medication. Adolescents should be evaluated for co-occurring mood or anxiety disorders. Disruptive behavior disorders frequently coexist with substance use disorder and mood and anxiety disorders. Patients suffering with this order can argue and not follows any advice of any one.

Borderline Personality Disorder
Borderline personality disorder affects 1–3% of adolescents and young adults, mostly females.

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"). These patients often report a history of abuse, neglect, or separation in childhood and 40–70% report a history of sexual abuse.

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).

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.

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. 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 can try to sucide.

Adolescents However, they often feel relieved when the subject is broached. Questions should be asked in a direct, nonthreatening, nonjudgmental manner. 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. 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. 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. 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. *Misuse* was defined as use 228255325without 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. 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. 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. 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. 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). 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.

Adequeate doses of antidepressant and anxiety must be provded, aware of medication another 25% stop use between 3 months and 6 months because of unacceptable adverse effects, most commonly continued drowsiness, decreased sexual libido, and anxiety. 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. 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 to patient for family history Adivise should be given to people suffering from mental disorder. 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. The Patient Health Questionnaire (PHQ-9), validated for use with adolescents, is a useful screening tool.

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

Positive responses must be considered. Parent, friends and other family member should not be involved.

CONCLUSION

Adolescents with psychiatric disorders may be taking psychopharmacologic agents, which can cause menstrual dysfunction, galactorrhea, and unsafe sexual behavior.

- 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.

REFERENCES

1. Smith AB, Wright EP, Rush R, et al. Rasch analysis of the dimensional structure of the Hospital Anxiety and Depression Scale. Psycho-Oncology, 2006; 15: 817–827. [PubMed]
2. Smolders M, Laurant M, Roberge P, et al. Knowledge transfer and improvement of primary and ambulatory care for patients with anxiety. Canadian Journal of Psychiatry, 2008; 53: 277–293. [PubMed]
3. Taylor S. Assessment of obsessions and compulsions: reliability, validity, and sensitivity to treatment effects. Clinical Psychology Reviews, 1995; 15: 261–296.
4. Taylor S, Thordarson DS, Sachting I. Obsessive-compulsive disorder. In: Anthony MM, Barlow DH, editors. Handbook of Assessment and Treatment Planning for Psychological Disorders. New York: Guilford Press, 2002; 182–214.
5. Thomas CM, Morris S. Cost of depression among adults in England in 2000. British Journal of Psychiatry, 2003; 183: 514–519. [PubMed]
6. on Korff M, Shapiro S, Burke JD, et al. Anxiety and depression in a primary care clinic: comparison of Diagnostic Interview Schedule, General Health Questionnaire, and practitioner assessments. Archives of General Psychiatry, 1987; 44: 152–156. [PubMed]
7. Waraich P, Goldner EM, Somers JM, et al. Prevalence and incidence studies of mood disorders:

a systematic review of the literature. Canadian Journal of Psychiatry, 2004; 49: 124–138. [PubMed]
8. Warrilow AE, Beech B. Self-help CBT for depression: opportunities for primary care mental health nurses? Journal of Psychiatric and Mental Health Nursing, 2009; 16: 792–803. [PubMed]
9. Weathers FW, Ford J. Psychometric properties of the PTSD Checklist (PCL–C, PCL–S, PCL–M, PCL–PR) In: Stamm BH, editor. Measurement of Stress, Trauma and Adaptation. Lutherville, MD: Sidran Press, 1996.
10. WHO. The ICD–10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines. Geneva, Switzerland: WHO, 1992.
11. WHO. The World Health Report 2002: Reducing Risks, Promoting Healthy Life. Geneva, Switzerland: WHO, 2002. [PubMed]
12. Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication [published erratum appears in Arch Gen Psychiatry, 2005; 62: 768]. Arch Gen Psychiatry 2005; 62: 593–602.