

	ORIGINAL RESEARCH PAPER EVALUATION OF PSYCHOPATHOLOGY IN CHILDREN REFERRED FOR PSYCHIATRIC CONSULTATION	Psychiatry KEY WORDS: Psychiatric Referral, Children, Depression.
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ABSTRACT	Background: Psychiatric disorders among children and adolescents in India are increasingly prevalent ranging from 10-30%, the highest being depressive disorders (3-68%), yet it's highly underdiagnosed in India. Aim: Evaluation of children referred to Psychiatry OPD over a 3 month period at a tertiary health care centre. Methods: This is a prospective observational study evaluating children being referred. Psychiatric clinical interview and mental status examination was done, and diagnosis was made according to DSM-5 criteria. Severity was assessed using rating scales like HAM-A, HAM-D, BPRS and YBOCS. Pharmacotherapy was initiated and patients were followed up. Results: We had 23 children referred to us over 3 months. Children with depressive disorders was found in 73.9% & 23.5% of them reported suicidal ideas and schizophrenia was seen in 8.7% of children. Other diagnosis included OCD, GAD, FNSD, and conduct disorder (4.3% each) respectively. Family history of psychiatric illness was found in 82.6% of children. All the children were treated and a 50% reduction in symptoms was observed after 1 month. Conclusion: An alarming number of 73.9% of children had depressive disorders with suicidal ideas in 23.5% of them. This highlights the need for a regular screening of children in schools for early detection of psychiatric disorders and timely intervention.
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INTRODUCTION Depression in children and teenagers is more common than many people think and is increasingly being recognised as a serious concern among Indian children and adolescents. Depression in young people can be hard to spot, it may appear as sadness, irritability, academic difficulties, unexplained body aches, or changes in sleep and appetite. Common triggers include academic stress, family problems, poverty, and parental mental illness. In 2019 Grover S et al., reviewed Indian studies on depression in children and adolescents. They found that prevalence rates varied widely from 0.1% to 6.94% in community samples and 3% to 68% in clinical settings. It was noted that depression was more common in older adolescents and females. Risk factors included family conflict, parental mental illness, academic stress, peer issues, urban living, and low socioeconomic status. Common symptoms were irritability, somatic complaints, poor school performance, and social withdrawal, with frequent comorbidities like anxiety, conduct problems, and substance use. The authors say that there are not enough studies on depression in Indian children and teenagers. The studies that do exist have different results due to different methods and tools applied. Hospital-based studies show higher depression rates than studies done in the community. Long-term outcomes and treatment results are rarely studied.^[1] Authors Malhotra S and Patra BN in 2014, reviewed 16 community-based studies in children and adolescents with a total of 14,594 participants and 7 school-based studies with 5,687 participants. They found that about 6.46% of children in the community and 23.33% of school-going children had some form of psychiatric disorder. Common disorders included enuresis (6.2%), ADHD (6% in urban slums), conduct disorder (2.7%), oppositional defiant disorder (1.2%), intellectual disability (2.3%), stuttering (1.9%), epilepsy with psychiatric comorbidity (0.4%), and major depression (0.4%).^[2] Child and adolescent mental health in India is significantly impacted by a high burden of psychiatric disorders, with an estimated prevalence of 10–20%. A review by Subramanyam A, Somaiya M, and De Sousa A in 2024 outlines the most commonly reported conditions: depression, anxiety disorders, OCD, ADHD, conduct disorder, ODD, autism spectrum disorder, and intellectual disability. The review also notes increasing trends in substance use, self-harm, and	suicidal behaviour among adolescents. Major risk factors include parental mental illness, family conflict, trauma, academic pressure, and excessive screen time, while protective factors include early identification, supportive home environments, and school-based interventions.^[3] A practice guideline written by Boris Birmaher, David Brent, and the AACAP Work Group on Quality Issues published in 2007 by the American Academy of Child and Adolescent Psychiatry in the United States reports that major depression affects about 2% of children and 4–8% of adolescents, with up to 20% experiencing a depressive episode before age 18. Other diagnosis are in 40–90% of cases, including anxiety, ADHD, conduct disorder, and substance use. Suicidal ideas occurs in 60% and attempts in 30% of children. Risk factors include family history of mood disorders, trauma, abuse, stress, poverty. The chances of getting depressed go up a lot after puberty, and by the time teens turn 18, about 1 in 5 will have experienced at least one episode of depression. Apart from those diagnosed with major depression, 5% to 10% of children and teens show some symptoms of depression that still cause problems in their daily lives. These young people may struggle at school, with friends, or at home, and are more likely to become seriously depressed or even have thoughts of suicide later on. There's also a longer-lasting, milder form of depression called dysthymic disorder. Though the symptoms aren't as intense, they can last for years. This affects about 0.6% to 1.7% of children and 1.6% to 8% of teenagers.^[4] In 2024, Senapati RE et al., in Indian Institute of Public Health, Bhubaneswar, reviewed 62 studies on suicide among Indian adolescents aged 10–19 years. They found that mental health issues were linked to 54.3% of suicides, family problems or past trauma to 34.3%, academic stress and violence to 22.9% each, lifestyle issues to 20%, and relationship or financial problems to 8.8%.^[5] Globally, Merikangas KR et al., in 2009 found that 25% of young people had a mental disorder each year, and 33% during their lifetime.^[6] In a study by Barican JL et al., in 2022 estimated the overall prevalence at 12.7%, with anxiety (5.2%) and ADHD (3.7%) most common.^[7] These are review studies and different studies have used different diagnostic tools and methods for measurements leading to various incidences and prevalences.
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Aims

The present study aimed to evaluate the children who were referred to the Psychiatry OPD over a period of 3 months.

METHODOLOGY

The study was conducted in the Department of Psychiatry at a tertiary health care center in Navi Mumbai following approval by Institutional Ethics Committee. A written informed consent from the parents was taken prior to the study. This was a prospective observational study. A detailed clinical psychiatric interview and a mental status examination was conducted in all the children referred to the psychiatry OPD for evaluation. Diagnosis was made based on symptomatology according to DSM-5. Appropriate rating scales were administered as per the diagnosis e.g Hamilton Anxiety Rating Scale, Hamilton Depression Rating Scale, Brief Psychiatric Rating Scale & Yale-Brown Obsessive Compulsive Scale. Treatment was advised as per diagnosis of the children. Pharmacotherapy was initiated and the children's progress was documented on follow up.

Tools of Assessment

Hamilton Anxiety Rating Scale

The Hamilton Anxiety Rating Scale (HAM-A) is a clinician-administered scale developed by Max Hamilton in 1959 to assess the severity of anxiety symptoms. It remains one of the most widely used tools in both research and clinical settings. The scale consists of 14 items, each rated on a 5-point scale from 0 to 4, where 0 indicates "not present," 1 is "mild," 2 is "moderate," 3 is "severe," and 4 is "very severe." These items are grouped into two major domains: psychic anxiety, which includes symptoms such as anxious mood, tension, fears, insomnia, cognitive impairment, and depressed mood; and somatic anxiety, encompassing muscular symptoms, sensory symptoms, cardiovascular and respiratory complaints, gastrointestinal and genitourinary disturbances, autonomic symptoms, and observable behavioral signs during the interview. The total score ranges from 0 to 56, with clinical interpretation as follows: 0-7 indicates no anxiety, 8-14 indicates mild anxiety, 15-23 suggests moderate anxiety, > 24 reflects severe anxiety. The HAM-A remains a valuable and widely accepted tool for evaluating anxiety severity and tracking treatment response.^[8]

Hamilton Depression Rating Scale

The Hamilton Depression Rating Scale (HAM-D or HDRS) is a clinician-rated instrument developed by Max Hamilton in 1960 to assess the severity of depressive symptoms in patients already diagnosed with depression. The most widely used version consists of 17 items, although extended forms with 21 or 24 items are also available. Each item evaluates symptom severity over the past week, with ratings on either a 5-point scale (0-4) or a 3-point scale (0-2), depending on the item. Items rated from 0 to 4 include core symptoms such as depressed mood, feelings of guilt, suicide, insomnia (early, middle, late), work and activity, psychomotor retardation, agitation, anxiety (psychic and somatic), and somatic symptoms. Items scored from 0 to 2 include gastrointestinal symptoms, genital symptoms, hypochondriasis, weight loss, and insight. A score of 0 indicates absence of the symptom, 1 reflects mild severity, 2 is moderate, 3 is severe, and 4 indicates very severe intensity (for applicable items). The total score on the 17-item version ranges from 0 to 52, with standard interpretation as follows: 0-7 = normal (no depression), 8-16 = mild depression, 17-23 = moderate depression, ≥24 = very severe depression. The HAM-D remains one of the most extensively validated and utilized tools for assessing depressive symptom severity and tracking response to treatment in both clinical and research settings.^[9]

Brief Psychiatric Rating Scale

The Brief Psychiatric Rating Scale (BPRS) is a clinician-rated instrument developed by John Edward Overall and Donald Gorham in 1962 to assess a broad range of psychiatric symptoms in individuals with major mental illnesses, particularly schizophrenia and other psychotic disorders. The

standard version comprises of 18 items, though variations with 24 items also exist. Each item is rated on a 7-point Likert scale, where 1 = not present, 2 = very mild, 3 = mild, 4 = moderate, 5 = moderately severe, 6 = severe, and 7 = extremely severe. Items cover several symptom domains, including thought disturbance (e.g., conceptual disorganization, hallucinatory behavior, unusual thought content), anxiety-depression (e.g., anxiety, depression, guilt), hostility-suspiciousness (e.g., hostility, suspiciousness), and activation-retardation (e.g., motor hyperactivity, emotional withdrawal, blunted affect). The total score ranges from 18 to 126, with higher scores indicating greater psychiatric severity. While there is no universally accepted clinical cutoff, score ranges can be broadly interpreted as follows: <18 = no illness 18-31 = mild illness, 32-53 = moderate illness, >54 = severe illness. The BPRS is valued for its brevity, multidimensional coverage, and sensitivity to change, making it especially useful in tracking treatment response in both inpatient and outpatient psychiatric settings. Despite requiring trained raters and some subjective clinical judgment, it remains a widely used tool in both research trials and clinical practice for assessing symptom severity across a variety of psychiatric conditions.^[10]

Yale-Brown Obsessive Compulsive Scale

The Yale-Brown Obsessive-Compulsive Scale (Y-BOCS) is a widely used, clinician-rated instrument developed by Wayne Goodman and colleagues in 1989 to assess the severity of obsessive-compulsive symptoms in individuals diagnosed with OCD, independent of symptom content. The standard version includes 10 core items, divided into two subscales: Obsessions (items 1-5) and Compulsions (items 6-10). Each item is rated on a 5-point scale from 0 to 4, where 0 = no symptoms, 1 = mild, 2 = moderate, 3 = severe, and 4 = extreme. The items assess five dimensions for both obsessions and compulsions: time occupied by symptoms, interference with functioning, associated distress, resistance against symptoms, and degree of control over them. For example, a score of 0 reflects no interference or effortlessness in resisting symptoms, whereas a score of 4 indicates constant, incapacitating symptoms with no control. The total score ranges from 0 to 40, with interpretation as follows: 0-7 = no symptoms, 8-15 = mild OCD, 16-23 = moderate OCD, 24-31 = severe OCD, and 32-40 = extreme OCD. The Y-BOCS is designed to measure symptom severity, not diagnostic presence or type, making it a robust tool for tracking treatment progress. Although later revisions like the Y-BOCS-II offer refined scoring and improved sensitivity, the original Y-BOCS remains the gold standard for evaluating symptom burden and therapeutic response in clinical and research setting.^[11]

RESULTS

Over a period of 2 months, 23 childrens were referred to the department of psychiatry for evaluation.

Table 1: Psychiatric Diagnosis in Children

Diagnosis	Children (n=23)	Percentage (%)
Depression	17	73.91%
Schizophrenia	2	8.69%
GAD	1	4.35%
OCD	1	4.35%
FNSD	1	4.35%
Conduct Disorder	1	4.35%

Out of 23 children evaluated, it was observed that 17 children (73.91%) suffered from depressive disorders and 2 children (8.69%) were diagnosed with schizophrenia. The remaining 4 children were each diagnosed with generalised anxiety disorder, obsessive compulsive disorder, focal neurological symptom disorder with major depressive disorder & conduct disorder respectively (4.35%) as described in Table 1.

Table 2:Age and Gender Distribution

Children	Total (n)	Percentage
	23	100%
Age (Years)		
5 – 11	6	26%
12 – 17	17	74%

Gender		
Boys	7	30.5%
Girls	16	69.5%

As noted in Table 2 out of 23 children, 16 were girls (69.5%) and 7 were boys (30.5%). Majority of the children, 74% belonged to the age group of 12-17 years while 6 children (26%) were in the age group of 5-11 years.

Table 3:Symptomatology in 17 Children with Depression

AGE/SEX	EDUCATION	DURATION OF DEPRESSIVE SYMPTOMS	FAMILY HISTORY	DELIBERATE SELF HARM ATTEMPTS	DIAGNOSIS	HAM-D SCORE	HAM-D (after 1 month)
13/F	8th std	2 years	Not significant	None	PDD with MDD	30	20
15/F	9th std	6 years	TUD in father	2 attempts in 4 years	PDD with MDD	22	15
16/F	10th std	5 years	Demise of 1 older brother and 2 elder sisters, TUD and depression in father	4-5 attempts in 5 years	PDD with MDD	26	20
14/F	7th std	4 years	Parents divorced 9 yrs back, mother remarried, father expired 3 years back (AUD, ALD, CKD), depression in mother	None	PDD with MDD	19	13
13/F	8th std	2 years	Not significant	None	PDD with MDD	15	12
16/F	10th std	3 years	TUD and depression in father	None	PDD with MDD	23	14
17/F	12th std	3 years	Demise of father due to lung infection 5 years ago	None	PDD with MDD	21	15
8/M	3rd std	6 years	TUD in father and grandfather, depression in mother	None	PDD with MDD	18	12
14/M	9th std	1 month	AUD and TUD in father, depression in mother	None	MDD	23	18
17/M	10th std	2 years	AUD in father, parents separated	None	MDD	22	18
16/F	6th std	4 years	Not significant	3-4 DSH attempts in 4 years	PDD with MDD	32	25
10/M	5th std	8 months	Cerebral palsy in eldest sibling depression in paternal uncle	None	MDD	23	13
6/F	1st std	2 months	Depression in mother, BMD in father	None	MDD	21	18
17/F	12th std	2 years	Not significant	4-5 DSH attempts in 2 years)	PDD with MDD	35	27
6/F	1st std	1 year	Depression in mother, AUD TUD in father	None	PDD with MDD	20	16
11/F	6th std	6 months	Not significant	None	MDD	16	12
8/M	3rd std	6 years	Depression in mother, TUD in father	None	PDD with MDD	17	13

Out of all 23 children, 17 children and adolescents (12 girls and 5 boys), aged between 6 and 17 years, presented with depressive symptoms of varying durations as elaborated in Table 3. Most were school-going, with educational levels ranging from 1st to 12th standard. The duration of symptoms ranged from 2 months to 6 years. All 17 patients reported sadness of mood, loss of interest in previously pleasurable activities, thinking that life is not worth living, loss of appetite, lack of concentration, irritability and 4 children had reported history suicidal ideas. Those 4 adolescents had depressive symptoms for more than 2 years and also had prior multiple suicidal attempts in the form of self strangulation with dupatta, slashing of wrists and self overdosing on medications.

We found that 70 % of the children had a family history of psychiatric illness (12 out of 17). The fathers of 7 children (41.18%) had tobacco use disorder (TUD), and fathers of 4 children (23.43%) had alcohol use disorder (AUD). Mothers of 6 (35.3%) children and fathers of 2 children (11.8%) were

noted to have depression. The father of 1 child (5.9%) had bipolar mood disorder. Serious life events such as bereavement and demise of father, parental separation, or mental illness in siblings were noted in 5 children (29.41%). Mental status examinations of all 17 children revealed a depressed mood and affect. Thoughts revealed ideas of hopelessness, helplessness and worthlessness and 4 children (23.5%) reported suicidal ideas.

We observed that 12 children had Persistent Depressive Disorder (PDD) with symptoms lasting for longer than 2 years with major depressive episodes, and 5 children were diagnosed with Major Depressive Disorder (MDD). Hamilton Depression Rating Scale (HAM-D) scores ranged from 15 to 35, with 5 children (29.41%) falling in the mild range, 7 (41.18%) in the moderate range, and 5 (29.41%) in the severe category at the baseline.

At the time of assessment, most of the children and

adolescents had moderate to severe depression, with HAM-D scores ranging from 13 to 35. The children were started on pharmacotherapy- antidepressants Tab Escitalopram (5-10 mg/day) or Tab Amitriptyline (25mg/day), antianxiety medications, and Tab Oxcarbazepine (150mg/day) as indicated in the individual child. Children and relatives were counselled and supportive psychotherapy was administered. After 1 month of follow-up, the children had a 50% reduction in symptoms and HAM-D scores, with the severity declining from severe to moderate, and from moderate to mild. Better response was observed in children with a negative family history.

Table 4: Symptomatology in Other 6 Children

AGE/SEX	EDUCATION	DURATION OF SYMPTOMS	CHIEF COMPLAINTS	FAMILY HISTORY	DIAGNOSIS	RATING SCALE SCORE	RATING SCALE SCORE AT 1 MONTH
14 F	10th std	1 year	Suspiciousness fearfulness , hearing voices muttering and gesticulating to self, lack of self care self care, abusive outbursts, sleep disturbances since 1 year	Depression in mother, TUD in both parents	Schizophrenia	BPRS- 58	BPRS-40
17 F	11th std	8 months	Suspiciousness, fearfulness, hearing of voices, muttering to herself, irritability, since 8 months	Depression in mother and BMD in father, AUD in grandfather	Schizophrenia	BPRS- 54	BPRS-33
13 F	9th std	5 months	Patient kept worrying everyday about academics and famil, feeling restless, uneasy, unable to concentrate, and fatigue since 5 months	AUD in father, parents separated, currently residing with step father, depression in mother	Generalised Anxiety Disorder	HAM-A 30	HAM-A 19
15 M	9th std	2 1/2 years	Repetitive intrusive thoughts thinking something bad will happen to him and his family members, repetitively taking Gods name secondary to distress caused by thoughts since 2 1/2 years	Not significant	OCD	YBOCS-20	YBOCS- 15
14 M	12th std	4 years	Hitting brother, mother, hurting animals, breaking utensils, lying, stealing money from home since 4 years	AUD in grandfather	Conduct Disorder		
12 F	6th std	3 months	Episodes of unresponsiveness lasting 10-15 mins not associated with incontinence, tongue bite, injury or confusion or disorientation, since 3 months	Marital discord between parents, AUD in father	FNSD		

As elaborated in Table 4, 6 adolescents (5 females, 1 male; age range: 12–17 years) presented with varied psychiatric disorders. The children had symptoms for a duration ranging from 3 months to 4 years and were between ages 12–17 years.

Schizophrenia was seen in 2 cases (33.3%). Both children reported suspiciousness, fearfulness and hearing voices lasting 8 months to 1 year. One patient each (4.35%) was diagnosed with obsessive compulsive disorder who reported complaints of repetitive intrusive thoughts that something bad will happen to family, generalised anxiety disorder with complaints of constant worrying about academics and family and restlessness since 5 months, functional neurological symptom disorder having episodes of unresponsiveness which was not associated with any injuries, incontinence or tongue bite since 3 months, and 1 child with conduct disorder with detailed symptomatology as mentioned in Table 4.

Out of the 6 adolescent patients, 5 (83.3%) had a family history of psychiatric illness or substance use. Family history of alcohol use disorder (AUD) was reported in 4 cases (66.7%), 2 fathers had AUD, and in the other 2, the grandfathers had AUD. Depression in one or both parents was noted in 3 cases (50%). In one child of schizophrenia, both parents had tobacco use disorder (TUD) and the mother had depression.

Mental status examination of the children suffering from schizophrenia revealed a fearful mood and affect, delusions of persecution and reference and auditory hallucinations. The child suffering from GAD was found to have constant worrying thoughts regarding her exams and family. The child with OCD had anxious mood and affect and thoughts revealed obsessions and compulsions. The children diagnosed with FNSD and conduct disorder had an anxious mood and affect. Rating scales were applied as per diagnosis. The 2 children with schizophrenia had BPRS scores of 58 and 54 respectively which was in the moderate category. The child with GAD had a HAM A score of 30 which signified severe anxiety. The child with OCD scored 20 on YBOCS which was moderate.

The two patients with schizophrenia were treated with Tab Olanzapine 10mg/day. The 14 year old girl had a 31% reduction in BPRS score from 58 to 40, and the 17year old showed a 38.9% reduction from 54 to 33 at the end of 1 month. The child diagnosed with generalised anxiety disorder was started on anti-anxiety medications and showed a 36.7% reduction in anxiety symptoms, with her HAM-A score improving from 30 to 19, indicating moderate clinical improvement. The 15 year old boy with obsessive compulsive disorder was treated with Tab Fluoxetine (20mg)/day and demonstrated a 25% reduction in symptom severity in one month, with her YBOCS score decreasing from 20 to 15. The child with FNSD was started on Tab Escitalopram (5mg)/day and the child with conduct disorder was started on Tab Risperidone (2mg)/day.

DISCUSSION

Our department of Psychiatry had 23 children being referred to us over a period of 3 months. In our study, 73.91% (17 of 23) of the referred children and adolescents were diagnosed with depressive disorders, and moderate to severe depression was seen in 12 (70.6%) patients. Other diagnoses included

schizophrenia (2 cases; 8.7%), OCD (1 case; 4.3%), generalised anxiety disorder (1 case; 4.3%), functional neurological symptom disorder (1 case; 4.3%), and conduct disorder (1 case; 4.3%). We had 4 patients (23.5%) who reported suicidal ideas. A family history of psychiatric illness was noted in 19 cases (82.6%), including depression (6 mothers, 2 fathers), bipolar disorder (1 father), and substance use disorders (TUD in 41.2% & AUD in 23.5% of fathers) indicating a strong genetic loading. Treatment response after one month showed a 50% reduction in symptom scores.

Literature search revealed only one study using similar tools as ours. A study by Shafi et al., in 2023 assessed 349 school-going adolescents aged 13–19 years in Kashmir, using DSM-5 criteria. They found an overall psychiatric morbidity of 27.8% (n = 97), major depressive disorder was present in 13.7%, OCD in 4.0%, generalised anxiety disorder in 2.5%, panic disorder in 1.4%, social anxiety in 2.2%, dysthymia in 1.7%, and adjustment disorder in 0.8% (n = 3) and self-harm was reported in 2.5%. Family history of psychiatric illness was present in 26.2% in their study.^[12]

CONCLUSION

In our study, of all the children presenting to the psychiatry OPD in a duration of 3 months, a majority, 73.9% of the children were diagnosed with depressive disorders, of which 70.3% were of the moderate to severe category and 23.5% of children reported suicidal ideas. An equal number of children, 73.9% had a family history psychiatric illness. Majority of the children had symptoms for over 2 years before seeking help, indicating a severe delay in recognition and treatment. These findings are alarming and point to a critical gap in early detection of psychiatric illness among children. This highlights the need to implement routine screening of children at schools to identify and pick up symptoms at an earlier stage for timely intervention and treatment.

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