



PATTERNS OF PSYCHIATRIC DISORDERS IN CHILDREN AND ADOLESCENTS ATTENDING PSYCHIATRY OPD IN A TERTIARY CARE GOVERNMENT HOSPITAL IN DELHI

Chaitanya Sheoran¹, Shivane Kumari², Aprajita Singh³, Siddharth Jagga⁴, Sonali Chaudhary⁵, Avnish Bhargava⁶, Anuj Mittal⁷

¹Senior Resident, Department of Psychiatry, Deen Dayal Upadhyay Hospital, Hari Nagar, Delhi, India

²Senior Resident, Department of Psychiatry, Deen Dayal Upadhyay Hospital, Hari Nagar, Delhi, India

³Senior Resident, Department of Psychiatry, Deen Dayal Upadhyay Hospital, Hari Nagar, Delhi, India

⁴Senior Resident, Department of Psychiatry, Deen Dayal Upadhyay Hospital, Hari Nagar, Delhi, India

⁵Senior Resident, Department of Psychiatry, Deen Dayal Upadhyay Hospital, Hari Nagar, Delhi, India

⁶CMO & Specialist Psychiatry, Department of Psychiatry, Deen Dayal Upadhyay Hospital, Hari Nagar, Delhi, India

⁷HOD & Specialist Psychiatry, Department of Psychiatry, Deen Dayal Upadhyay Hospital, Hari Nagar, Delhi, India

Corresponding Author: Dr. Chaitanya Sheoran

Senior Resident Doctor, Department of Psychiatry, Deen Dayal Upadhyay Hospital, Hari Nagar, Delhi, India

Email: chaitanyasheoran@gmail.com

ABSTRACT

Background: Psychiatric morbidity among children and adolescents is an important public health concern because early-onset mental disorders can affect emotional development, academic performance, social functioning, and long-term adult outcomes. Clinic-based data from tertiary care centres are useful for understanding the pattern of disorders among children and adolescents who seek specialist psychiatric care.

Aim: To evaluate the pattern and distribution of psychopathology among children and adolescents attending the Psychiatry Outpatient Department of a tertiary care government hospital in Delhi.

Materials and Methods: This cross-sectional observational study was conducted in the Psychiatry outpatient clinic of a tertiary care government hospital over a one-year period from 11 August 2024 to 11 August 2025. A total of 612 children and adolescents below 18 years of age were included. Sociodemographic details and clinical diagnoses were collected from OPD records. Diagnoses were categorized according to ICD-10 clinical diagnostic categories. Data were analyzed using descriptive statistics.

Results: The mean age of the study population was 11.53 ± 4.02 years, with an age range of 4-17 years. Males constituted 336 cases (54.9%) and females 276 cases (45.1%). Most patients belonged to the 11-17 years age group, 377 (61.6%), while 235 (38.4%) were in the 4-10 years age group. Among 609 valid diagnostic entries, intellectual disability was the most common diagnosis, 202 (33.2%), followed by conduct disorder, 69 (11.3%), attention-deficit/hyperactivity disorder, 56 (9.2%), anxiety disorder, 35 (5.7%), autism spectrum disorder, 30 (4.9%), specific learning disorder, 26 (4.3%), major depressive disorder, 23 (3.8%), and obsessive-compulsive disorder, 20 (3.3%). Neurodevelopmental disorders were more frequent in younger children, whereas conduct disorder, anxiety disorder, obsessive-compulsive disorder, bipolar affective disorder, dissociative disorder, and depressive disorders were more common among adolescents.

Conclusion: Intellectual disability, conduct disorder, ADHD, anxiety disorder, and autism spectrum disorder were the leading diagnostic categories among children and adolescents attending the Psychiatry OPD. The findings highlight the need for early identification, school-based screening, parental education, and strengthening of child and adolescent mental health services in tertiary care settings.

Keywords: Child Psychiatry, Adolescent Psychiatry, Intellectual Disability, ADHD, Conduct Disorder, Anxiety Disorder, Tertiary Care, ICD-10.

1. INTRODUCTION

Mental health problems in children and adolescents are increasingly recognized as major contributors to morbidity worldwide.



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The World Health Organization estimates that approximately one in seven adolescents aged 10-19 years experiences a mental disorder, and depression, anxiety, and behavioural disorders are among the leading causes of illness and disability in this age group [1]. Childhood and adolescence are critical developmental periods during which biological maturation, cognitive development, family

environment, peer relationships, academic stress, and social transitions interact to influence psychological well-being.

Mental disorders in children differ in presentation from those in adults. Common childhood psychiatric conditions include neurodevelopmental disorders such as intellectual disability, attention-deficit/hyperactivity disorder, autism spectrum disorder and specific learning disorder; behavioural disorders such as conduct disorder and oppositional defiant disorder; emotional disorders including anxiety and depressive disorders; and less commonly, psychotic and bipolar disorders. These conditions may interfere with academic achievement, interpersonal relationships, emotional regulation, and adaptive functioning. If not detected and managed early, childhood psychiatric morbidity may persist into adolescence and adulthood, contributing to long-term functional impairment.

In India, child and adolescent mental health continues to receive inadequate attention due to multiple barriers, including stigma, limited awareness, shortage of trained professionals, lack of school-based mental health screening, poor service accessibility, and financial constraints. Parents may also delay seeking help because behavioural and emotional symptoms are often interpreted as disciplinary problems, academic weakness, or transient developmental issues. Tertiary care hospitals often receive both direct OPD visits and referrals from paediatrics, neurology, medicine, and other specialties, making them important centres for identifying the clinical pattern of psychiatric morbidity in young patients.

Although community-based studies provide estimates of prevalence, clinic-based studies help in understanding the burden and diagnostic pattern among children and adolescents who actually reach mental health services. Such data are useful for service planning, resource allocation, early intervention programmes, and training of healthcare workers. Therefore, the present study was conducted to assess the sociodemographic profile and pattern of psychiatric disorders among children and adolescents attending the Psychiatry OPD of a tertiary care government hospital in Delhi.

Aim and Objectives

Aim

To evaluate the pattern and distribution of psychopathology among children and adolescents presenting to the Psychiatry Outpatient Department of a tertiary care government hospital.

Primary Objective

To assess and categorize the types of psychiatric disorders among children and adolescents below 18 years of age attending the Psychiatry OPD.

Secondary Objectives

To study the age and sex distribution of children and adolescents presenting with psychiatric complaints.

To determine the frequency and distribution of various diagnostic categories in this population. To identify age-wise and sex-wise patterns of psychiatric morbidity among the study participants.

2. MATERIALS AND METHODS

Study Design and Setting

This was a cross-sectional observational study conducted in the outpatient clinic of the Department of Psychiatry at a tertiary care government hospital in Delhi.

Study Duration

The study was conducted over a period of one year, from 11 August 2024 to 11 August 2025.

Study Population

Children and adolescents below 18 years of age attending the Psychiatry OPD, including those directly presenting to the OPD and those referred from other specialty departments, were included.

Sample Size

A total of 612 children and adolescents were included in the final analysis.

Inclusion Criteria

Children and adolescents below 18 years of age.

Patients of either sex attending the Psychiatry OPD during the study period.

Patients with adequate clinical records available for diagnosis and sociodemographic assessment.

Exclusion Criteria

Children with serious acute medical illness interfering with psychiatric assessment.

Patients with impaired consciousness at the time of assessment.

Records with inadequate clinical information for diagnostic categorization.

Data Collection

Sociodemographic details including age and sex were collected from OPD records. Clinical diagnosis was recorded from the psychiatric evaluation notes and categorized according to ICD-10 diagnostic categories. Diagnoses were grouped into clinically meaningful categories such as intellectual disability, ADHD, conduct disorder, autism spectrum disorder, anxiety disorder, depressive disorder, obsessive-compulsive disorder, bipolar affective disorder, dissociative disorder, somatoform disorder, and other less frequent diagnoses.

Statistical Analysis

Data were entered and analyzed using descriptive statistics. Continuous variables were expressed as mean, standard deviation, median, and range. Categorical variables were expressed as frequency and percentage. Diagnostic distribution was analyzed overall and according to sex and age group.

3. RESULTS

Sociodemographic Profile

A total of 612 children and adolescents were included in the study. The mean age was $11.53 \pm$

4.02 years, with a median age of 12 years and an age range of 4-17 years. Among the study participants, 336 (54.9%) were males and 276 (45.1%) were

females. The majority of patients were in the 11-17 years age group, 377 (61.6%), while 235 (38.4%) were in the 4-10 years age group.

Table 1. Sociodemographic profile of the study population

Variable	Frequency	Percentage
Total participants	612	100.0
Sex		
Male	336	54.9
Female	276	45.1
Age group		
4-10 years	235	38.4
11-17 years	377	61.6
Age, years		
Mean $\pm$ SD	11.53 $\pm$ 4.02	-
Median	12	-
Range	4-17	-

Overall Diagnostic Pattern

Among 609 valid diagnostic entries, intellectual disability was the most common psychiatric diagnosis, accounting for 202 cases (33.2%). Conduct disorder was the second most common diagnosis, 69 cases (11.3%), followed by ADHD, 56 cases (9.2%). Anxiety disorder was present in 35

cases (5.7%), autism spectrum disorder in 30 cases (4.9%), specific learning disorder in 26 cases (4.3%), major depressive disorder in 23 cases (3.8%), obsessive-compulsive disorder in 20 cases (3.3%), behavioural problems in 17 cases (2.8%), prodromal symptoms in 17 cases (2.8%), and dissociative disorder in 15 cases (2.5%).

Table 2. Distribution of psychiatric diagnoses among children and adolescents

Diagnosis	Frequency	percentage
Intellectual disability	202	33.2
Conduct disorder	69	11.3
ADHD	56	9.2
Anxiety disorder	35	5.7
Autism spectrum disorder	30	4.9
Specific learning disorder	26	4.3
Major depressive disorder	23	3.8
Obsessive-compulsive disorder	20	3.3
Behavioural problems	17	2.8
Prodromal symptoms	17	2.8
Dissociative disorder	15	2.5
Bipolar affective disorder	13	2.1
Adjustment disorder	13	2.1
Migraine/headache-related presentation	14	2.3
Nocturnal enuresis	10	1.6
Head trauma-related presentation	10	1.6
Panic disorder	7	1.1
Oppositional defiant disorder	5	0.8
Generalized anxiety disorder	4	0.7
Schizophrenia	4	0.7
Global developmental delay	4	0.7
Somatoform disorder	3	0.5
Insomnia	3	0.5
Psychogenic vomiting	2	0.3
Tick disorder	1	0.2
Trichotillomania	1	0.2
Social phobia	1	0.2
Tobacco dependence	1	0.2
Psychogenic cough	1	0.2

Tuberculosis-related presentation	1	0.2
Gaming addiction	1	0.2
Missing diagnosis	3	-

Sex-wise Distribution of Diagnoses

Among females, intellectual disability was the most common diagnosis, 85 (30.8%), followed by conduct disorder, 38 (13.8%), anxiety disorder, 19 (6.9%), ADHD, 17 (6.2%), and dissociative disorder, 14 (5.1%). Among males, intellectual disability was also the most common diagnosis, 117 (35.1%), followed by ADHD, 39 (11.7%), conduct

disorder, 31 (9.3%), autism spectrum disorder, 20 (6.0%), anxiety disorder, 16 (4.8%), and specific learning disorder, 15 (4.5%). ADHD and autism spectrum disorder were proportionately more frequent among males, whereas dissociative disorder and migraine/headache-related presentations were more frequent among females.

Table 3. Major diagnostic categories according to sex

Diagnosis	Female n = 276	Male n = 333
Intellectual disability	85 (30.8%)	117 (35.1%)
ADHD	17 (6.2%)	39 (11.7%)
Conduct disorder	38 (13.8%)	31 (9.3%)
Autism spectrum disorder	10 (3.6%)	20 (6.0%)
Specific learning disorder	11 (4.0%)	15 (4.5%)
Anxiety disorder	19 (6.9%)	16 (4.8%)
Major depressive disorder	9 (3.3%)	14 (4.2%)
Obsessive-compulsive disorder	7 (2.5%)	13 (3.9%)
Dissociative disorder	14 (5.1%)	1 (0.3%)
Bipolar affective disorder	5 (1.8%)	8 (2.4%)
Adjustment disorder	9 (3.3%)	4 (1.2%)
Behavioural problems	9 (3.3%)	8 (2.4%)
Migraine/headache-related presentation	11 (4.0%)	3 (0.9%)

Age-wise Distribution of Diagnoses

Neurodevelopmental disorders were more common in the younger age group. In children aged 4-10 years, intellectual disability was the most frequent diagnosis, 91 (38.9%), followed by ADHD, 41 (17.5%), autism spectrum disorder, 28 (12.0%), and specific learning disorder, 11 (4.7%). In adolescents

aged 11-17 years, intellectual disability remained the most frequent diagnosis, 111 (29.6%), but conduct disorder became the second most common diagnosis, 61 (16.3%). Anxiety disorder, obsessive-compulsive disorder, bipolar affective disorder, dissociative disorder, and depressive disorders were more commonly seen in adolescents.

Table 4. Major diagnostic categories according to age group

Diagnosis	4-10 years n = 234	11-17 years n = 375
Intellectual disability	91 (38.9%)	111 (29.6%)
ADHD	41 (17.5%)	15 (4.0%)
Conduct disorder	8 (3.4%)	61 (16.3%)
Autism spectrum disorder	28 (12.0%)	2 (0.5%)
Specific learning disorder	11 (4.7%)	15 (4.0%)
Anxiety disorder	9 (3.8%)	26 (6.9%)
Major depressive disorder	9 (3.8%)	14 (3.7%)
Obsessive-compulsive disorder	2 (0.9%)	18 (4.8%)
Dissociative disorder	2 (0.9%)	13 (3.5%)
Bipolar affective disorder	0	13 (3.5%)
Prodromal symptoms	2 (0.9%)	15 (4.0%)
Behavioural problems	6 (2.6%)	11 (2.9%)
Nocturnal enuresis	2 (0.9%)	8 (2.1%)
Migraine/headache-related presentation	3 (1.3%)	11 (2.9%)

The graphical distribution of the study population is presented in Figures 1-3. Figure 1 shows sex-wise distribution, Figure 2 shows age-group distribution,

and Figure 3 shows the major diagnostic categories among children and adolescents attending the Psychiatry OPD.

Figure 1. Sex-wise distribution of study participants

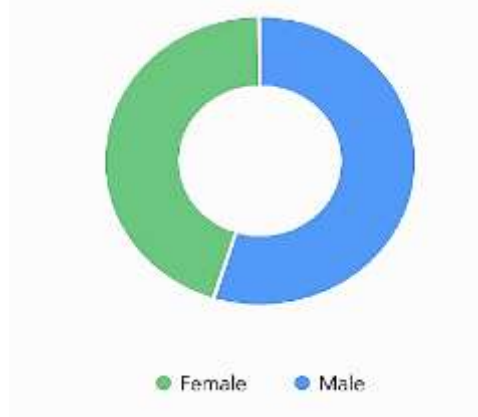


Figure 1: Sex-wise distribution of children and adolescents attending Psychiatry OPD. Males

constituted 336 cases (54.9%) and females constituted 276 cases (45.1%).

Figure 2. Age-group distribution of study participants

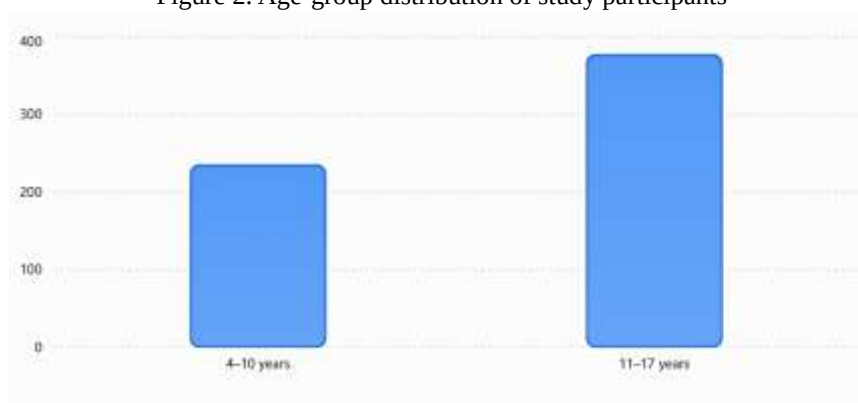


Figure 2: Age-group distribution of the study population. The majority of patients were

adolescents aged 11-17 years, 377 (61.6%), while 235 (38.4%) were aged 4-10 years.

Figure 3. Distribution of major psychiatric diagnoses

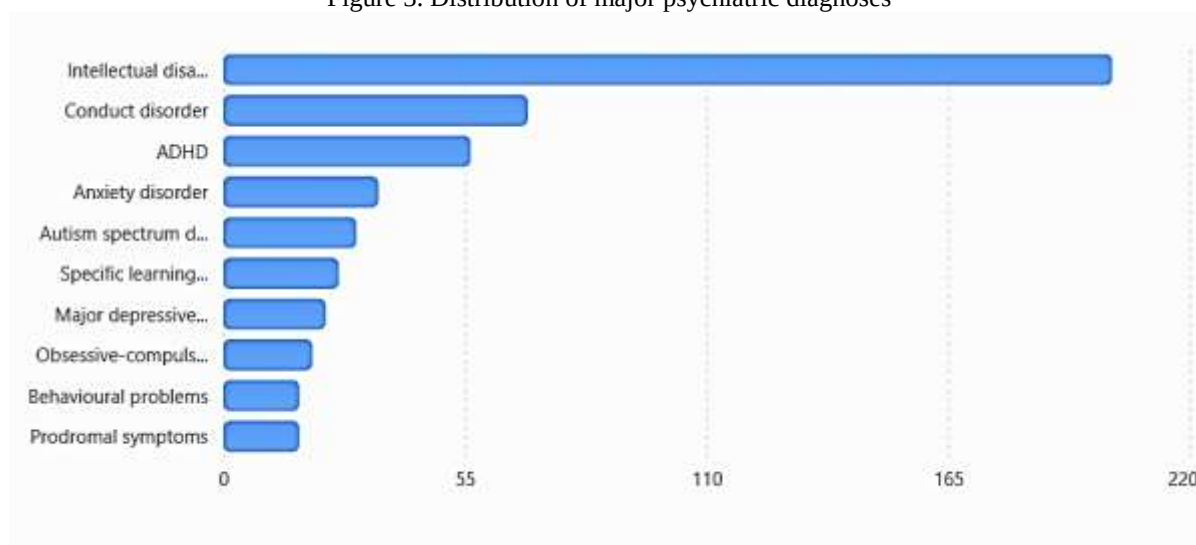


Figure 3: Distribution of major psychiatric diagnoses among children and adolescents attending

Psychiatry OPD. Intellectual disability was the most common diagnosis, followed by conduct disorder,

ADHD, anxiety disorder, autism spectrum disorder, and specific learning disorder.

4. DISCUSSION

The present study assessed the pattern of psychiatric morbidity among children and adolescents attending the Psychiatry OPD of a tertiary care government hospital in Delhi. The study included 612 children and adolescents, with a mean age of 11.53 ± 4.02 years and an age range of 4-17 years. Males constituted 54.9% of the study population, while females accounted for 45.1%. The overall findings indicate that neurodevelopmental disorders, disruptive behavioural disorders, and emotional disorders formed the major diagnostic groups among children and adolescents presenting to the OPD. Intellectual disability was the most frequent diagnosis, followed by conduct disorder, ADHD, anxiety disorder, autism spectrum disorder, specific learning disorder, major depressive disorder, and obsessive-compulsive disorder. These findings are consistent with previous Indian clinic-based studies, which have reported a predominance of developmental, behavioural, and emotional disorders among children and adolescents attending psychiatric services [2-9]. The uploaded results file also shows the same diagnostic distribution, with intellectual disability as the leading category and conduct disorder and ADHD as the next major disorders.

In the present study, males outnumbered females, with a male-to-female ratio of approximately 1.2:1. Male preponderance has been reported in several child and adolescent psychiatry studies from India and other countries [5-8]. This may be due to a true higher occurrence of certain neurodevelopmental and behavioural disorders among boys, especially ADHD and autism spectrum disorder, but it may also reflect sociocultural and referral-related factors. In Indian settings, boys are often brought for medical consultation more readily than girls because behavioural problems, academic difficulties, and developmental delay in boys may receive greater parental attention. Similar male predominance was observed by Malhotra et al. in a long-term clinic-based study from North India and by Bhat et al. in a tertiary care child psychiatry clinic from Kashmir [5,7]. In the present study, ADHD was proportionately higher among males (11.7%) compared with females (6.2%), and autism spectrum disorder was also higher among males (6.0%) compared with females (3.6%). This pattern is supported by earlier literature indicating higher male representation in ADHD and autism spectrum disorder [12].

The mean age of the study population was 11.53 years, and most patients belonged to the adolescent age group. Adolescents aged 11-17 years constituted 61.6% of the study population, while children aged

4-10 years constituted 38.4%. This indicates that psychiatric consultation was more commonly sought during adolescence. Similar findings have been reported by other clinic-based studies, where adolescent patients formed a substantial proportion of child psychiatry OPD attendance [5,7,8]. Adolescence is a biologically and psychosocially vulnerable period characterized by pubertal changes, increased academic pressure, peer influence, identity formation, family conflict, and emotional reactivity. These factors may contribute to the emergence or worsening of psychiatric symptoms. The higher proportion of adolescents in the present study may also be related to increased recognition of academic decline, behavioural disturbances, anxiety, mood symptoms, and social dysfunction during school-going years.

Intellectual disability was the most common diagnosis in the present study, accounting for 202 cases, representing 33.2% of valid diagnostic entries. This was higher than many earlier clinic-based studies, where intellectual disability has been reported as one of the major diagnostic categories but not always the leading diagnosis [5-9]. The high proportion of intellectual disability in the present study may be explained by the tertiary care government hospital setting, where children are frequently referred for developmental assessment, disability certification, scholastic difficulty, behavioural problems, and functional impairment. Children with intellectual disability often present late, especially when academic demands increase and parents recognize persistent deficits in learning, communication, self-care, or social functioning. The finding emphasizes the need for early developmental screening at the primary healthcare and school levels. Srinath et al. highlighted the importance of identifying child and adolescent psychiatric disorders in both urban and rural Indian populations, while Malhotra and Chaturvedi also emphasized that developmental disorders contribute substantially to childhood psychiatric morbidity in India [2,3].

Conduct disorder was the second most common diagnosis in the present study, accounting for 69 cases, or 11.3% of valid diagnoses. Conduct disorder was especially frequent among adolescents, with 61 cases in the 11-17 years age group compared with only 8 cases in the 4-10 years age group. This finding suggests that disruptive and rule-breaking behaviours become more clinically visible during adolescence. Adolescents with conduct disorder may present with aggression, defiance, truancy, lying, stealing, substance experimentation, conflict with authority figures, or poor academic performance. The higher frequency of conduct disorder in adolescents has also been described in previous studies, where behavioural and externalizing disorders were among the common

reasons for referral to child psychiatry clinics [5-8]. In comparison with the younger age group, adolescents have greater exposure to peer influence, social media, academic stress, family expectations, and environmental risk factors, which may contribute to conduct-related symptoms. Early recognition is important because untreated conduct disorder may progress to poor educational outcome, substance use, legal problems, and antisocial behaviour in adulthood.

ADHD was the third most common diagnosis in the present study, observed in 56 cases, representing 9.2% of valid diagnoses. ADHD was more common among younger children and males. In the 4-10 years age group, ADHD accounted for 41 cases, or 17.5%, whereas in the 11-17 years age group it accounted for 15 cases, or 4.0%. This age-wise pattern is expected because ADHD usually begins in early childhood and is often recognized when the child enters school and develops problems with attention, sitting tolerance, impulsivity, and classroom behaviour. The male predominance observed in the present study is consistent with the meta-analysis by Gaub and Carlson, which reported higher identification of ADHD among boys [12]. However, the lower proportion of ADHD among girls may also reflect under-recognition, as girls more often present with inattentive symptoms rather than overt hyperactivity or disruptive behaviour.

Autism spectrum disorder was identified in 30 cases, accounting for 4.9% of valid diagnoses. ASD was much more common among younger children, with 28 cases in the 4-10 years group and only 2 cases in the 11-17 years group. This finding is clinically meaningful because autism is usually recognized in early childhood due to delayed speech, poor social communication, restricted interests, repetitive behaviours, sensory issues, or poor peer interaction. The male predominance in ASD seen in the present study is also consistent with previous literature. The relatively lower number of adolescent ASD cases may reflect earlier identification and referral during childhood, or alternatively, under-recognition of milder ASD phenotypes among older children and adolescents. This finding supports the need for structured developmental surveillance and early intervention services, including speech therapy, occupational therapy, behavioural therapy, and parental training.

Specific learning disorder was seen in 26 cases, accounting for 4.3% of valid diagnoses. The proportion was similar in both age groups, with 11 cases in the 4-10 years group and 15 cases in the 11-17 years group. Learning disorders often become apparent after school entry, when children are expected to acquire reading, writing, spelling, or arithmetic skills. In the Indian context, learning disorders may be missed or misinterpreted as laziness, poor motivation, lack of discipline, or low

intelligence. The presence of SLD in this OPD-based study highlights the need for collaboration between psychiatry services, schools, special educators, and parents. Malhotra et al. and Jayaprakash also observed that academic difficulties and developmental problems are important reasons for consultation in child psychiatry and behavioural paediatrics units [7,8].

Anxiety disorder was present in 35 cases, accounting for 5.7% of valid diagnoses. Anxiety was more frequent among adolescents, with 26 cases in the 11-17 years group compared with 9 cases in the 4-10 years group. This is consistent with the developmental pattern of anxiety disorders, which often become more prominent with increasing academic pressure, peer comparison, family expectations, social evaluation, and concerns about future performance. WHO has also identified anxiety disorders as among the leading causes of illness and disability in adolescents [1]. In the present study, anxiety disorders were slightly more common among females than males. This is similar to previous literature showing that internalizing disorders such as anxiety and depression tend to be more commonly reported among adolescent girls [1,10]. However, cultural factors, stigma, and differences in symptom expression may influence clinic attendance and diagnosis.

Major depressive disorder was diagnosed in 23 cases, representing 3.8% of valid diagnoses. Depression was more frequent among adolescents than younger children. This finding is consistent with the established observation that depressive symptoms increase during adolescence, particularly in relation to academic stress, interpersonal problems, family conflict, social comparison, body image concerns, and hormonal changes [1,10]. Although the proportion of MDD in the present study was lower than intellectual disability, conduct disorder, or ADHD, its clinical importance is high because adolescent depression is associated with self-harm, suicide risk, poor academic performance, substance use, and impaired social functioning. The findings emphasize the need for routine screening of mood symptoms, sleep disturbance, irritability, hopelessness, self-harm thoughts, and functional impairment in adolescent OPD patients.

Obsessive-compulsive disorder was observed in 20 cases, accounting for 3.3% of valid diagnoses. OCD was more common in adolescents, with 18 cases in the 11-17 years group compared with only 2 cases in the 4-10 years group. This age-wise pattern is compatible with the usual clinical emergence of obsessive-compulsive symptoms during late childhood and adolescence. Adolescents may present with repeated checking, washing, intrusive thoughts, counting rituals, religious obsessions, symmetry concerns, or excessive reassurance-seeking. The findings are comparable with previous

child psychiatry OPD studies where OCD formed a smaller but clinically important diagnostic category [5-8]. Early diagnosis is important because untreated OCD may lead to significant academic and social impairment.

Dissociative disorder was present in 15 cases, representing 2.5% of valid diagnoses. A striking finding was the higher proportion among females, with 14 female cases compared with only 1 male case. Dissociative disorders were also more frequent among adolescents. This pattern is in agreement with previous clinical literature suggesting that dissociative and conversion symptoms are more common in adolescent girls, particularly in settings where psychological distress may be expressed through somatic or functional symptoms [14]. Leary highlighted that conversion disorder in childhood may be diagnosed late and investigated excessively, reflecting the difficulty in recognizing functional presentations in young patients [14]. In the Indian sociocultural context, dissociative symptoms may be associated with academic stress, family conflict, interpersonal difficulties, trauma, or emotional distress. Therefore, careful psychosocial assessment is essential.

Bipolar affective disorder was found in 13 cases, all of which were in the adolescent age group. This age distribution is clinically expected, as bipolar disorder is uncommon in younger children and more likely to become evident during adolescence. Similarly, schizophrenia was rare, being present in only 4 cases, all in the adolescent group. Psychotic disorders are generally less common than neurodevelopmental, behavioural, and emotional disorders in child psychiatry clinics, but they carry high morbidity and require early recognition. The presence of prodromal symptoms in 17 cases is notable, as early identification of attenuated psychotic symptoms may allow timely intervention and monitoring.

Behavioural problems were recorded in 17 cases, while adjustment disorder was present in 13 cases. These categories reflect clinically significant distress or dysfunction that may not always meet criteria for more severe disorders but still require intervention. Adjustment disorder was more common among females in the present study. Such cases may be related to school stress, family conflict, parental expectations, bereavement, relocation, interpersonal problems, or examination-related stress. The presence of behavioural problems and adjustment disorders reinforces the need for psychosocial interventions, counselling, and family-based management in child psychiatry services.

Nocturnal enuresis was seen in 10 cases, while insomnia was seen in 3 cases. Although these were less frequent diagnoses, they are clinically relevant because sleep-related and elimination-related complaints often cause significant distress to

families and may be associated with anxiety, developmental delay, behavioural problems, or family stress. Somatoform disorder, psychogenic vomiting, psychogenic cough, headache/migraine-related presentations, and dissociative symptoms also indicate that psychological distress in children and adolescents may present with physical symptoms. This highlights the need for coordination between psychiatry, paediatrics, neurology, and general medicine to avoid unnecessary investigations and ensure timely psychological assessment.

When comparing the age-wise pattern, younger children showed a predominance of neurodevelopmental disorders. In the 4-10 years group, intellectual disability, ADHD, autism spectrum disorder, and specific learning disorder together formed the major diagnostic burden. In contrast, adolescents showed a broader diagnostic distribution, including conduct disorder, anxiety disorder, OCD, depressive disorder, dissociative disorder, bipolar disorder, prodromal symptoms, and schizophrenia. This developmental shift is important. Younger children are usually brought for delayed milestones, poor speech, hyperactivity, school readiness problems, and academic difficulty, whereas adolescents are more likely to present with behavioural disturbance, emotional symptoms, mood disorders, anxiety, functional symptoms, and severe mental illness. This pattern has also been described in earlier Indian studies, including those by Malhotra et al., Jayaprakash, and Bhat et al. [5,7,8].

The sex-wise distribution also revealed important findings. Males had higher proportions of ADHD, intellectual disability, autism spectrum disorder, and specific learning disorder. Females had relatively higher proportions of conduct disorder, anxiety disorder, dissociative disorder, adjustment disorder, and migraine/headache-related presentations. This suggests that boys more commonly present with neurodevelopmental and externalizing symptoms, while girls may present more often with internalizing, stress-related, or somatic symptoms. However, these patterns should be interpreted cautiously because OPD attendance is influenced by parental perception, stigma, gender norms, access to care, and referral practices.

The findings of the present study are broadly comparable with previous Indian clinic-based studies but show some differences in the relative ranking of diagnoses. For example, Bhat et al. reported a high burden of neurodevelopmental and behavioural disorders in a child psychiatry clinic in Kashmir [5]. Chaudhury et al. observed that psychiatric morbidity in child guidance clinics commonly included mental retardation, epilepsy-related behavioural problems, ADHD, conduct disorder, and emotional disorders [6]. Malhotra et

al., in a 26-year clinic-based study from North India, also reported that child psychiatry clinics receive a wide range of neurodevelopmental, behavioural, and emotional disorders [7]. The present study differs in showing intellectual disability as the most dominant category, which may be due to the tertiary government hospital setting, referral bias, availability of disability certification services, and higher attendance of children with developmental and scholastic difficulties.

The study has several clinical and public health implications. First, the high burden of intellectual disability, ADHD, autism spectrum disorder, and learning disorder indicates the need for early developmental screening in paediatric OPDs, Anganwadi centres, schools, and primary health facilities. Second, the high frequency of conduct disorder among adolescents suggests the need for school-based behavioural interventions, parental training, substance-use screening, and family counselling. Third, the presence of anxiety, depression, OCD, adjustment disorder, and dissociative disorder among adolescents highlights the importance of routine mental health screening in schools and adolescent health clinics. Fourth, the findings support the establishment of multidisciplinary child guidance clinics involving psychiatrists, clinical psychologists, paediatricians, speech therapists, occupational therapists, special educators, and psychiatric social workers.

Another important implication is the need to reduce stigma and improve mental health literacy among parents and teachers. Many childhood psychiatric symptoms are initially interpreted as laziness, poor discipline, stubbornness, possession states, weakness, or academic failure. Such interpretations delay help-seeking and worsen outcomes. Awareness programmes should emphasize that developmental delay, ADHD, autism, learning disorder, anxiety, depression, and behavioural disorders are treatable or manageable conditions requiring professional evaluation. Early intervention may reduce long-term disability, improve academic functioning, and enhance family coping.

The present study also highlights the importance of strengthening referral pathways between psychiatry and other departments. Children with headache, psychogenic vomiting, psychogenic cough, insomnia, dissociative symptoms, developmental delay, or behavioural problems may initially present to paediatrics, neurology, medicine, or emergency services. Effective liaison services can help reduce unnecessary investigations and improve early psychiatric referral. This is particularly important in tertiary care government hospitals, where patient load is high and many families may come from low-resource backgrounds.

The study has certain limitations. Being a hospital-based OPD study, the findings cannot be generalized

to the community. The pattern reflects service utilization and referral behaviour rather than true population prevalence. Since the data were based on OPD records, detailed information on socioeconomic status, family history, school performance, parental education, urban-rural background, duration of illness, comorbidities, treatment adherence, and outcome may not have been uniformly available. The use of clinical ICD-10 diagnosis rather than structured diagnostic interviews may also introduce diagnostic variability. Despite these limitations, the study provides important insight into the clinical profile of children and adolescents presenting to a tertiary care psychiatry service.

Overall, the present study demonstrates that child and adolescent psychiatric morbidity in tertiary care OPD settings is dominated by neurodevelopmental disorders, especially intellectual disability, followed by disruptive behavioural disorders and emotional disorders. The pattern varies substantially by age and sex. Younger children mainly present with developmental and attention-related problems, whereas adolescents show increasing rates of conduct disorder, anxiety, OCD, mood disorder, dissociative disorder, and early psychotic symptoms. These findings are consistent with previous Indian studies and reinforce the urgent need for early identification, multidisciplinary management, school-based mental health services, and integration of child psychiatry into general healthcare systems [2-10].

5. CONCLUSION

The present study found that intellectual disability, conduct disorder, ADHD, anxiety disorder, autism spectrum disorder, specific learning disorder, depressive disorder, and obsessive-compulsive disorder were the major psychiatric diagnoses among children and adolescents attending the Psychiatry OPD. Neurodevelopmental disorders were more frequent in younger children, while conduct disorder and emotional disorders were more common among adolescents. The findings emphasize the need for early identification, parental education, school-based screening, and multidisciplinary child and adolescent mental health services.

Limitations

This was a hospital-based study and therefore cannot estimate community prevalence. The study was based on OPD records, and detailed psychosocial variables such as family history, academic performance, socioeconomic status, referral pathway, and treatment outcome were not uniformly analyzed. Future studies with structured diagnostic interviews, larger multicentric samples, and longitudinal follow-up are recommended.

Recommendations

Child and adolescent mental health services should be strengthened at tertiary care hospitals through dedicated child guidance clinics.

Screening for developmental delay, ADHD, autism, learning disorder, anxiety, and depression should be incorporated into paediatric and school health services.

Parents and teachers should be trained to recognize early warning signs of psychiatric morbidity.

Multidisciplinary intervention involving psychiatrists, psychologists, paediatricians, special educators, speech therapists, and occupational therapists should be encouraged.

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