Addressing Mental Health Challenges: A Community-Based Survey on Depression, OCD, Eating Disorders, and Psychosis Risk Among 18-44-year-olds in India

Sawant Meenakshi R, Waghachavare Vivek B, Kadam Jitesh H, Gore Alka D, Quraishi Sanjay R

Bharati Vidyapeeth Medical College and Hospital, Sangli, Maharashtra, India

ABSTRACT

INTRODUCTION: Mental health is a complex issue with high prevalence but poor health facilities and health-seeking behaviour. The age group of 18-44-year-olds is socio-economically crucial, however, their mental health is largely neglected. This research was conducted to study mental health problems among the 18–44-year-old age group. **MATERIALS AND METHODS**: This cross-sectional study was conducted among 1700 participants, aged 18-44 years old, from the urban and rural areas of Sangli district (Maharashtra state), India, using stratified random sampling. All ethical considerations were adhered to during data collection. Pre-validated tools namely, WHO-5 Well-Being Index, OCI-R, CAPE, etc., were used in data collection interviews. Statistical analysis was done using frequency (%) and the chi-squared test. **RESULTS**: The highest number of participants were positive for symptoms of obsessive-compulsive disorder (OCD) (n=336, 19.8%), followed by depression (n=326,19.2%), a high risk of psychosis (n=164, 9.6%) and an eating disorder (n=144, 8.5%). The area of residence (urban/rural) was associated with these mental illnesses. Depression was not significantly associated with any socio-demographic factors. OCD was significantly higher in participants from rural area, females, illiterates, and belonging to socioeconomic class III. Eating disorders were associated with rural areas, widowed status, and illiteracy. Psychosis risk was significantly higher in males, rural areas, joint families, and widower status. **CONCLUSIONS:** A very high proportion of 18-44-year-olds suffer or are at risk of various mental health conditions, requiring the development of targeted preventive and curative services. Rural areas should receive sufficient attention regarding mental health services.

INTRODUCTION

People are in a state of mental well-being when they can successfully manage the challenges and stresses of day-to-day life and contribute positively to society.[1] Mental health issues have escalated into a significant public health challenge, with a staggering estimate of over one billion people affected. This alarming trend, an increasing prevalence over the last few decades, underscores the urgent need for intervention.[2] COVID-19 exacerbated various mental health conditions like stress, anxiety, depressive disorders, suicide ideation, anxiety disorders, and alcohol use.[3,4]

Depression, obsessive-compulsive disorder (OCD), eating disorders, psychosis, etc., are some of the most critical mental health issues. Globally in 2019, depression impacts around 260 million people, with symptoms like loss of interest in activities, poor concentration, and low self-esteem. It could lead to suicide ideation. OCD leads to unwanted thoughts or unwanted repetitive behaviours which hamper the functioning of a person. In 2019, eating disorders experienced by 14 million people, are often paired with anxiety about one's body and significantly increase the risk of substance abuse and suicidal ideation. Psychotic conditions, especially schizophrenia, affect approximately 24 million people and impair their perception and behaviour, resulting in symptoms like hallucinations, delusions, and reduced cognitive functioning.[1]

Mental health in India is a complex subject. There is a

significant burden of mental health issues, the most common being depression, anxiety, substance abuse, and psychosis. The number of individuals experiencing mental health struggles has significantly increased over the past few years. These issues can impact an individual's day-to-day functioning, thus reducing one's productivity, resulting in family strain and, ultimately, the nation's economy. The government and the overall health sector have realized the importance of addressing the issue, and steps have been initiated to provide mental health care. But the demand-supply gap is still enormous.[5] This is further complicated by the stigma surrounding mental health issues and lack of awareness, creating a problematic barrier for help-seeking among the people.[6] Community health workers are required to contribute to this challenge.

Management of health issues begins with understanding the extent of the problem. In India, a mental health survey was conducted in 2015-2016 on 39,532 individuals in 12 states. Findings revealed an overall lifetime prevalence of mental health issues at 13.9%. There were significant interstate variations of these morbidities and the availability of mental health services. Within states, the variation within different geographic and economic regions was staggering.[7] This highlights the need for the availability of local data and partial decentralization in the planning of health services to have the requisite impact on mental health care.

The 18–44-year-old age group is often considered a driver of socio-cultural-economic change. This demographic has a significant impact due to their participation in higher education and contribution to the workforce, especially manual and physically challenging labour. They are at the forefront of innovation and entrepreneurial activities. Similarly, this age group is commonly associated with marriage, childbirth, and transmitting ideas and values to future generations.[8] However, the national suicide statistics show a grim reality of the highest suicide rates among the age group of 18-30-year-olds followed by 30-44-year-olds.[9] Hence, understanding the prevalence of mental health issues in this age group and planning for prevention and management is very important.

As discussed earlier, the availability of local data and decentralization of planning is essential for preventing and managing mental health issues. However, there is an overall scarcity of data, especially from the study area. Whatever data is available is among specific college-going students or senior population.[10,11] Hence, the purpose of this research was to study the prevalence of various crucial mental health issues like depressive disorders, OCD, eating disorders, and psychotic symptoms among the participants of the 18-44-year-old age group in the Sangli district (Maharashtra state), India. It is hoped the study will have some impact on practical, theoretical, social, and research domains. The research aims to fill the gap in current knowledge regarding the extent of the presence of depression, obsessive-compulsive disorder (OCD), eating disorders, and psychotic symptoms in the study area. Findings could be applied in education, healthcare, and community programs, leading to enhanced mental health education, targeted interventions, and community initiatives. Future studies could explore this problem in greater depth propelling societal change, hence improving mental health outcomes.

MATERIALS AND METHODS

This cross-sectional study was conducted in Sangli district (Maharashtra state), India. According to the 2011 census, the district's population was 28,22,143, with 39.3% of the population being 18-44 years old. The calculated sample size (99.99% confidence level, 5% margin of error) was 1444 @ 1500. With 10% buffer, the sample size was 1650 and rounded to 1700. As the rural proportion of the population in Sangli district was 74.47%, it was decided to include 1266 rural and 434 urban samples.[12]

Data was collected using stratified random sampling. Stratification was done as urban and rural samples. All the urban wards (divisions) from the Sangli urban area were listed as urban samples, and all the villages from the Sangli district were listed as rural samples. A single ward from the Sangli urban area and a village from the list were randomly selected using simple random sampling. To collect actual samples, every fifth house in the chosen location was approached for data collection. All the eligible and consenting individuals from the house present at the time of data collection were recruited as study

participants. If a home was locked or people were ineligible/non-consenting, the immediate next house was involved. Data was collected until the requisite sample size was fulfilled. The study was conducted for 3 years until 2015.

It is practically impossible to include screening for every mental health problem in this research. Hence, after considering the most common mental health problems in previous surveys and the feasibility of data collection, it was decided to include depression, OCD, eating disorders and psychotic symptoms in this study.[7] The study tool was a scheduled structured interview. The first part consisted of questions regarding sociodemographic characteristics like age, gender, education, etc. The next consisted of validated, reliable tools for screening various mental health issues namely; i) depression: WHO-5 Well-Being Index,[13] ii) OCD: Obsessive-Compulsive Inventory -Revised (OCI-R),[14] **iii) e**ating disorders: Eating attitude test,[15] iv) detection of individuals with a high risk of psychosis: Community Assessment of Psychic Experiences (CAPE).[16]

It is important to note that the current research was a community screening study, and the persons identified positively by any of the above tools do not necessarily suffer from that disease. The positive outcome only suggests that the person exhibits some symptoms of that disease. The principal author undertook three weeks of training in the Department of Psychiatry at the same medical college and prior to data collection.

The Institutional Ethics Committee (IEC) approval was obtained and adhered to regarding consent, privacy or anonymity, and various other aspects. For people undergoing psychiatric treatment, consent was also taken from their legal caretakers. The inclusion criteria were age 18-44-year-old and present during data collection. The exclusion criteria were non-consenting or debilitated persons and language, physical, or other barriers hampering the data collection.

Microsoft Excel and IBM SPSS were used for data compilation and analysis. Descriptive statistics and chi-squared tests were used to study the associations of

various sociodemographic factors with mental health conditions.

RESULTS

The sociodemographic characteristic of 1700 participants is shown in Table I, whilst Figure I illustrates the proportion of participants with mental health problems.

Table I: Sociodemographic characteristics of the study participants

Sociodemographic characteristics		Residence		Total
		Rural	Urban	
Gender	Male	695 (54.9%)	220 (50.7%)	915 (53.8%)
	Female	571 (45.1%)	214 (49.3%)	785 (46.2%)
Age Group (in years)	18-30	833 (65.8%)	226 (52.1%)	1059 (62.3%)
	31-44	433 (34.2%)	208 (47.9%)	641 (37.7%)
Type of family	Nuclear	289 (22.8%)	98 (22.6%)	387 (22.8%)
	Joint	977 (77.2%)	336 (77.4%)	1313 (77.2%)
Occupation	Skilled	568 (44.9%)	188 (43.3%)	756 (44.5%)
	Unskilled	326 (25.7%)	148 (34.1%)	474 (27.9%)
	Business	242 (19.1%)	68 (15.7%)	310 (18.2%)
	Professional	130 (10.3%)	30 (6.9%)	160 (9.4%)
Marital Status	Married	872 (68.9%)	361 (83.2%)	1233 (72.5%)
	Unmarried	362 (28.6%)	63 (14.5%)	425 (25%)
	Divorce	13 (1%)	4 (0.9%)	17 (1%)
	Widow	19 (1.5%)	6 (1.4%)	25 (1.5%)
Education	Illiterate	112 (8.9%)	31 (7.1%)	143 (8.4%)
	Primary	201 (15.9%)	94 (21.7%)	295 (17.4%)
	Secondary	546 (43.1%)	150 (34.5%)	696 (40.9%)
	Graduate	328 (25.9%)	114 (26.3%)	442 (26%)
	Postgraduate	79 (6.2%)	45 (10.4%)	124 (7.3%)
Socioeconomic classification (Updated B. G. Prasad's classification)	Class-I	43 (3.4%)	10 (2.3%)	53 (3.1%)
	Class-II	693 (54.7%)	298 (68.7%)	991 (58.3%)
	Class-III	334 (26.4%)	85 (19.8%)	419 (24.7%)
	Class-IV	196 (15.5%)	41 (9.2%)	237 (13.9%)
Total		**1266 (74.5%)**	**434 (25.5%)**	**1700 (100%)**

The highest proportion of participants were positive for symptoms of OCD, (19.8%), followed by depression, (19.2%). The association of mental health problems with various sociodemographic characteristics is shown in Table II.
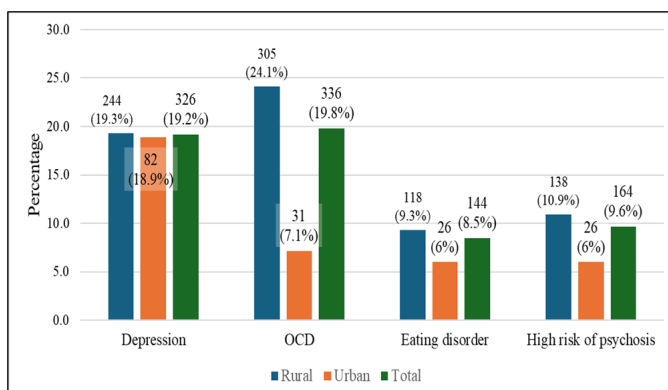

Figure 1: Participants screened positive for mental health problems

Table II: Association of mental health problems with various sociodemographic characteristics

Sociodemographic characters		Depression	OCD	Eating Disorder	High risk of Psychosis
Gender	Male	184 (20.1%)	158 (17.3%)	79 (8.6%)	106 (11.6%)
	Female	142 (18.1%)	178 (22.7%)	65 (8.3%)	58 (7.4%)
		χ^2 =1.1125, P=0.29	χ^2 =7.7905, P=0.005*	χ^2 =0.068, P=0.79	χ^2 =8.5, P=0.003*
Age Group (years)	18-30	206 (19.5%)	202 (19.1%)	93 (8.8%)	105 (9.9%)
	31-44	120 (18.7%)	134 (20.9%)	51 (8%)	59 (9.2%)
		χ^2 = 0.1379, P=0.71	χ^2 = 0.8435, P=0.36	χ^2 = 0.351, P=0.55	χ^2 = 0.231, P=0.63
Residence	Rural	244 (19.3%)	305 (24.1%)	118 (9.3%)	138 (10.9%)
	Urban	82 (18.9%)	31 (7.1%)	26 (6%)	26 (6%)
		χ^2 = 0.03, P=0.86	χ^2 = 58.547, P=0.000*	χ^2 = 4.622, P=0.032*	χ^2 =8.938, P= 0.003*
Type of family	Joint	240 (18.3%)	259 (19.7%)	117 (8.9%)	139 (10.6%)
	Nuclear	86 (22.2%)	77 (19.9%)	27 (7%)	25 (6.5%)
		χ^2 = 2.999, P=0.08	χ^2 = 0.0055, P=0.94	χ^2 = 1.44, P=0.23	χ^2 = 5.839, P= 0.016*
Occupation	Skilled	158 (20.9%)	152 (20.1%)	67 (8.9%)	73 (9.7%)
	Unskilled	80 (16.9%)	89 (18.8%)	36 (7.6%)	38 (8%)
	Business	57 (18.4%)	62 (20%)	23 (7.4%)	32 (10.3%)
	Professional	31 (19.4%)	33 (20.6%)	18 (11.3%)	21 (13.1%)
		χ^2 = 3.1929, P=0.36	χ^2 = 0.43, P=0.93	χ^2 = 2.66, P=0.45	χ^2 = 3.828, P=0.28
Marital Status	Married	222 (18%)	243 (19.7%)	89 (7.2%)	105 (8.5%)
	Unmarried	94 (22.1%)	81 (19.1%)	49 (11.5%)	55 (12.9%)
	Divorce	2 (11.8%)	2 (11.8%)	1 (5.9%)	0 (0%)
	Widow	8 (32%)	10 (40%)	5 (20%)	4 (16%)
		χ^2 Yates = 5.313, P=0.15	χ^2 Yates = 5.609, P=0.13	χ^2 Yates = 10.008, P=0.02*	Fisher's exact test = 8.023, P=0.05*
Education	Illiterate	36 (25.2%)	33 (23.1%)	24 (16.8%)	18 (12.6%)
	Primary	53 (18%)	49 (16.6%)	25 (8.5%)	35 (11.9%)
	Secondary	128 (18.4%)	152 (21.8%)	59 (8.5%)	61 (8.8%)
	Graduate	94 (21.3%)	92 (20.8%)	29 (6.6%)	39 (8.8%)
	Postgraduate	15 (12.1%)	10 (8.1%)	7 (5.6%)	11 (8.9%)
		χ^2 = 9.132, P=0.057	χ^2 = 15.74, P=0.003*	χ^2 = 16.1, P=0.003*	χ^2 = 4.134, P=0.39
Socio-economic classification	Class I	12 (22.6%)	9 (17%)	4 (7.5%)	2 (3.8%)
	Class II	173 (17.5%)	161 (16.2%)	80 (8.1%)	101 (10.2%)
	Class III	94 (22.4%)	123 (29.4%)	40 (9.5%)	39 (9.3%)
	Class IV	47 (19.8%)	43 (18.1%)	20 (8.4%)	22 (9.3%)
		χ^2 = 5.236, P=0.16	χ^2 = 32.69, P=0.000*	χ^2 = 0.887, P=0.83	χ^2 Yates = 1.785, P=0.62
Total		326 (19.2%)	336 (19.8%)	144 (8.5%)	164 (9.6%)

significant

Depression was associated with socioeconomic status, with the highest percentage of Class-I who had signs of depression. OCD was associated with gender, residence, education, and socioeconomic classification. The association of eating disorders with residence, marital status and education was statistically significant. The high risk of psychosis was associated with gender, residence, type of family, and marital status.

The present research also further analysed the rural-urban distribution of mental health problems and their association with various sociodemographic factors. Most of these associations were not significant. Table III shows the sociodemographic factors that had a statistically significant association with the rural-urban distribution of depression and OCD. The rural-urban distribution of eating disorders and high risk of psychosis were not associated with any sociodemographic factor.

Table III: Urban-rural distribution of depression & obsessive-compulsive disorder (OCD) and the associated sociodemographic factors

DEPRESSION				
Sociodemographic characters		Rural	Urban	Total
Marital Status	Married	154 (63.1%)	68 (82.9%)	222 (68.1%)
	Unmarried	82 (33.6%)	12 (14.6%)	94 (28.8%)
	Divorce	2 (0.8%)	0 (0%)	2 (0.6%)
	Window	6 (2.5%)	2 (2.4%)	8 (2.5%)
	Fisher's exact test=12.221, p=0.003			
Socioeconomic Status	Class I	9 (3.7%)	3 (3.7%)	12 (3.7%)
	Class II	117 (47.9%)	56 (68.3%)	173 (53.1%)
	Class III	77 (31.6%)	17 (20.7%)	94 (28.8%)
	Class IV	41 (16.8%)	6 (7.3%)	47 (14.4%)
	χ^2 = 11.111, p=0.011			
Total		244 (100%)	82 (100%)	326 (100%)
OBSESSIVE - COMPULSIVE DISORDERS				
Age Group	18-30	191 (62.6%)	11 (35.5%)	202 (60.1%)
	31-44	114 (37.4%)	20 (64.5%)	134 (39.9%)
	χ^2 =8.644, p=0.003			
Total		305 (100%)	31 (100%)	336 (100%)

DISCUSSION

In this current research, most persons approached in rural areas were willing to participate. However, many from urban areas were apprehensive or sceptical about this mental health survey.

About 19% of participants were screened positive for depression, with no significant rural-urban difference. Similarly, it was not associated with gender, education, occupation, marital status, and type of family. However, based on the descriptive statistics, it was observed that a higher percentage of widowed persons, persons living in nuclear families, persons with skilled labour or professionals, and illiterates were depressed. Depression was not associated with socioeconomic status, but a higher proportion of persons belonging to Class–I was depressed. The rural-urban distribution of depression was significantly associated with marital status and socioeconomic status. A community survey was

conducted in Al-Qunfudah governorate, Saudi Arabia[17] which observed the prevalence of depression in the age group of 18-40-year-olds at 70.3%. This prevalence was over 300% higher than current study. This variation in the prevalence of depression could be attributed to sociocultural differences in the study population. However, both studies observed an increased prevalence of depression among less educated and single persons. In a Nigerian study, the prevalence of depression was observed at 5.2%, with the rural population being more impacted than the urban.[18] Sociocultural differences could explain the lower prevalence of depression in their study compared to our findings. However, in that study, prevalence trend among rural residents compared to urban counterparts mimics the findings of the current research. In a study conducted among rural adult women from Puducherry, India, the prevalence of depression was 15%, whereby it was identified that fewer years of education and being separated/widowed as risk factors for depression.[19] In the current study, 18.1% of women had depression, with a higher proportion of them being illiterate and widowed. The current research looks into 18-44-year-olds; hence the prevalence of depression varies from the India's National Mental Health Survey (NMHS) (2015-16), which stated that prevalence of depressive disorders in 18-29-year-olds, 30-39-year-olds, and 40-49-year-olds were 1.6%, 2.6%, and 3.6% respectively. Depression was higher in rural areas as compared to cities with less than 1 million population. Similarly, it was higher among illiterates, widowed, and lowest earning sections of people.[20] The prevalence observed was much lower than the current findings. The India NMHS used the Mini International Neuropsychiatric Interview (MINI) schedule V.6 as a diagnostic tool to assessed depression. In contrast, in the current study, the WHO-5 Well-Being Index, was used as a screening tool. Hence, the outcomes from both these tools are different, and the current research is expected to have a higher prevalence. However, the trends of the distribution of depression according to sociodemographic attributes are similar in both studies.

It is important to note that in the current study, the presence of OCD does not mean that the person was suffering from OCD; it means the person exhibits some symptoms of OCD. In the current study, the presence of OCD symptoms, was the most reported mental health problem, (19.8%). However, a substantially higher proportion of rural participants (24.1%) had reported OCD as compared to urban participants (7.1%). This difference was statistically significant. OCD was significantly higher in females, illiterates, and those belonging to socioeconomic Class III. In a study from Saudi Arabia, the lifetime prevalence of OCD was observed at 4.2%.[21] Females were at greater odds for lifetime OCD. This prevalence was lower than the current study, as the diagnostic tool used, CIDI 3.0, has better specificity than the OCI-R which was used in the current study. However, the pattern of female preponderance observed in the current study and past research is similar.

In the current research, eating disorders was noted in 8.5% of participants, and statistically significant amongst rural-urban participants, with a higher proportion of rural participants. Similarly patterns for marital status (highest proportion among widowed persons) and education (highest among illiterates). Studies from Indian have found the prevalence of eating disorders at between 25.2-35%.[22,23] However, these studies were conducted among specific groups, such as college students, and not the community, hence comparing their findings with current research will be inaccurate.

Over 9% of participants had a high risk of psychosis. Its association was statistically significant with gender (higher in males), residence (higher in rural areas), type of family (higher in joint family members), and marital status (higher in widowed). In a study among Chinese students, 51.4% of adolescents reported at least one psychotic-like experience.[24] However, these findings during the COVID-19 pandemic are not comparable with current research findings.

CONCLUSION

A substantial proportion of India's 18-44-year-old age group are at risk of mental health problems. The rural population is equally vulnerable to these issues. There is a need for a robust strategy and execution of preventive and curative mental health services targeted at the 18-44-

year-old age group, especially in rural areas. This age group is the backbone of India's economic and social development and must be supported to foster prosperity.

Findings from this research have practical implications for designing and implementing mental health services, especially locally. These should include educational campaigns to raise awareness, early detection initiatives to identify at-risk individuals, and accessible mental health services in urban and rural areas. Training primary healthcare workers to recognize and manage mental health disorders can enhance early intervention and support for affected individuals.

Future research should focus on prospective studies to track the mental health outcomes and effectiveness of mental health services. Researchers should also examine the impact of cultural, socioeconomic, and environmental factors on mental health to develop more tailored and effective interventions. Similarly, the studies should expand to include broader geographic conditions.

LIMITATIONS

The research was a cross-sectional design; hence it was not able to suggest and test effective implantation strategies. Secondly, data was self-reported, hence respondent bias like social desirability and recall bias cannot be avoided. The sample may not fully represent the entire 18–44-year-old population in India, particularly regarding regional, cultural, and socioeconomic diversity. This may affect the generalizability of the findings.

Future research should address these limitations by employing longitudinal designs, multi-centric data collection, corroborating self-reported information using multiple sources, using diagnostic tools following the screening, and ensuring diverse and representative sampling.

ACKNOWLEDGEMENT

CONFLICT OF INTEREST

REFERENCES

1. World Health Organization. World Health Organization. 2022 [cited 2024 Jul 9]. Mental disorders. Available from: https://www.who.int/news-room/fact-sheets/detail/mental-disorders

2. World Health Organization. World Health Organization: Eastern Mediterranean region. 2023 [cited 2024 Jul 9]. WHO EMRO | World Mental Health Day 2023: mental health is a basic human right | News | Media centre. Available from: https://www.emro.who.int/media/news/world-mental-health-day-2023-mental-health-is-a-basic-human-right.html

3. Waghachavare VB, Gore AD, Jailkhani SM, Dhobale R V, Dhumale GB. A study of psychological impact of COVID-19 pandemic and lockdown in India: An online survey. Al Ameen J Med Sci [Internet]. 2021 [cited 2024 Jul 10];14(3):225–35. Available from: http://ajms.alameenmedical.org/ArticlePDFs/10%20AJMS%20V14.N3.2021%20p%20225-235.pdf

4. Winkler P, Formanek T, Mlada K, et al. Increase in prevalence of current mental disorders in the context of COVID-19: analysis of repeated nationwide cross-sectional surveys. Epidemiol Psychiatr Sci [Internet]. 2020 [cited 2024 Jul 9];29:e173. Available from: https://www.cambridge.org/core/journals/epidemiology-and-psychiatric-sciences/article/increase-in-prevalence-of-current-mental-disorders-in-the-context-of-covid19-analysis-of-repeated-nationwide-crosssectional-surveys/1FDE06C80D8CE44526CC016B565D79F5

5. Meghrajani VR, Marathe M, Sharma R, et al. A Comprehensive Analysis of Mental Health Problems in India and the Role of Mental Asylums. Cureus [Internet]. 2023 Jul 27 [cited 2024 Jul 9];15(7). Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10460242/pdf/cureus-0015-00000042559.pdf

6. Raghavan R, Brown B, Horne F, et al. Stigma and mental health problems in an Indian context.

Perceptions of people with mental disorders in urban, rural and tribal areas of Kerala. Int J Soc Psychiatry [Internet]. 2022 [cited 2025 Jan 21];69:362. Available from: https://pmc.ncbi.nlm.nih.gov/articles/PMC9983047/

7. Gururaj G, Varghese M, Benegal V, et al. National Mental Health Survey of India, 2015-16: Mental Health System [Internet]. Bengaluru; 2016 [cited 2024 Jul 9]. Available from: https://main.mohfw.gov.in/sites/default/files/National%20Mental%20Health%20Survey%2C%202015-16%20-%20Mental%20Health%20Systems_0.pdf

8. United Nation Population Fund. UNFPA Worldwide. 2023 [cited 2024 Jul 10]. Demographic dividend. Available from: https://www.unfpa.org/demographic-dividend#NaN

9. Yadav S, Aathavan K, Cunningham S, et al. Changing pattern of suicide deaths in India Comment. www.thelancet.com [Internet]. 2023 [cited 2024 Jul 10]; Available from: https://www.thelancet.com/journals/lansea/article/PIIS2772-3682(23)00125-7/fulltext

10. Waghachavare VB, Dhumale GB, Kadam YR, Gore AD. A Study of Stress among Students of Professional Colleges from an Urban area in India. Sultan Qaboos Univ Med J [Internet]. 2013 [cited 2024 Jul 10];13(3):429. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3749028/

11. Kamble SW, Shirsath AA. A study to assess the prevalence of depression and help-seeking behaviour among depressed elderly individuals. Afr J BioSc. 2024;6(7):253–62.

12. Office of the Registrar General & Census Commissioner I. The Ministry of Home Affairs, Government of India. 2011 [cited 2024 Jul 10]. POPULATION FINDER 2011. Available from: https://censusindia.gov.in/census.website/data/population-finder

13. Topp CW, Østergaard SD, Søndergaard S, Bech P. The WHO-5 well-being index: A systematic review of the literature. Psychother Psychosom [Internet]. 2015 Apr 24 [cited 2024 Jul 11];84(3):167–76. Available from: https://karger.com/pps/article/84/3/167/282903/The-WHO-5-Well-Being-Index-A-Systematic-Review-of

14. Foa EB, Huppert JD, Leiberg S, et al. The obsessive-compulsive inventory: Development and validation of a short version. Psychol Assess. 2002;14(4):485–96.

15. Garfinkel PE, Newman A. The eating attitudes test: Twenty-five years later. Eating and Weight Disorders [Internet]. 2001 Dec 30 [cited 2024 Jul 11];6(1):1–21. Available from: https://link.springer.com/article/10.1007/BF03339747

16. Mossaheb N, Becker J, Schaefer MR, et al. The Community Assessment of Psychic Experience (CAPE) questionnaire as a screening instrument in the detection of individuals at ultra-high risk for psychosis. Schizophr Res [Internet]. 2012 Nov [cited 2024 Jul 11];141(2–3):210–4. Available from: https://www.clinicalkey.com/#!/content/playContent/1-s2.0-S0920996412004641?returnurl=https:%2F%2Flinkinghub.elsevier.com%2Fretrieve%2Fpii%2FS0920996412004641%3Fshowall%3Dtrue&referrer=https:%2F%2Fpubmed.ncbi.nlm.nih.gov%2F

17. Odah M, Ewis A, Alkudaysi FM, et al. Prevalence of Depression Among the Adult Population in Southwestern Saudi Arabia: A Cross-Sectional, Community-Based Study. 2024 [cited 2024 Jul 20]; Available from: https://assets.cureus.com/uploads/original_article/pdf/219321/20240313-26774-1aam0zq.pdf

18. Amoran O, Lawoyin T, Lasebikan V. Prevalence of depression among adults in Oyo State, Nigeria: A comparative study of rural and urban communities. Australian Journal of Rural Health [Internet]. 2007 Jun 1 [cited 2024 Jul 20];15(3):211–5. Available from: https://onlinelibrary.wiley.com/doi/full/10.1111/j.1440-1584.2006.00794.x

19. Srinivasan M, Reddy MM, Sarkar S, Menon V. Depression, Anxiety, and Stress among Rural South Indian Women—Prevalence and Correlates: A Community-Based Study. J Neurosci Rural Pract [Internet]. 2020 Mar 3 [cited 2024 Jul 19];11:78. Available from: https://ruralneuropractice.com/depression-anxiety-and-stress-among-rural-south-indian-women-prevalence-and-correlates-a-community-based-study/

20. Arvind BA, Gururaj G, Loganathan S, et al. Prevalence and socioeconomic impact of depressive disorders in India: Multisite population-based cross-sectional study. BMJ Open. 2019 Jun 1;9(6).

21. Altwaijri Y, Stein DJ, Akkad M, et al. The epidemiology of obsessive-compulsive disorder in the Kingdom of Saudi Arabia: Data from the Saudi National Mental Health Survey. J Anxiety Disord [Internet]. 2024 [cited 2024 Jul 20];103:102856. Available from: http://creativecommons.org/licenses/by/4.0/

22. Raval CM, Bhatt RB, Tiwari DS, Panchal BN. Prevalence and characteristics of eating disorders among college students of a nonmetro city of Gujarat. Ind Psychiatry J. 2022;31(1):74.

23. Muley A, Deshmane A, Mahajan A, Shah J. Eating Disorders: Assessing Its Prevalence and Pattern Among Adults With Type 2 Diabetes. Cureus [Internet]. 2024 [cited 2024 Jul 20];16(1). Available from: https://www.cureus.com/articles/218769-eating-disorders-assessing-its-prevalence-and-pattern-among-adults-with-type-2-diabetes#!/

24. Wang D, Zhou L, Chen C, Sun M. Psychotic-like experiences during COVID-19 lockdown among adolescents: Prevalence, risk and protective factors. Schizophr Res [Internet]. 2023 Feb 1 [cited 2024 Jul 20];252:309. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9868397/pdf/main.pdf