



Identification and Assessment of Mental Disorders: A Review of Concepts, Methods and Cultural Considerations

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Abstract

Early identification and accurate assessment of mental disorders are fundamental to effective mental health care. This paper critically examines the processes involved in the identification and assessment of mental disorders, with a particular focus on the Indian context. It emphasizes early recognition of emotional, behavioural and cognitive symptoms using validated screening tools as a preventive gateway rather than immediate diagnostic labelling. The review integrates evidence on diagnostic approaches, highlighting the balance between standardized classification systems (DSM and ICD) and culturally sensitive, dimensional and biopsychosocial perspectives. Key assessment techniques- including psychometric testing, psychiatric interviews, case history taking, mental status examination and physical and neurological evaluation-are discussed as complementary components of comprehensive assessment. Ethical, cultural and developmental considerations are emphasized, particularly the role of family involvement and culturally embedded expressions of distress in India. Overall, the paper underscores that accurate, culturally informed and ethically grounded assessment practices enhance diagnostic clarity, reduce misdiagnosis and stigma and improve mental health outcomes.

Keywords: Mental disorders, Early identification, Mental health assessment, Psychometric tools, Psychiatric interview

I. Introduction

Early detection of emotional, behavioural and cognitive signs that signal the beginning of psychopathology is crucial to the diagnosis of mental disorders. Instead of making a formal diagnosis, it is

a preventive procedure that focuses on identifying symptom patterns. Early detection is crucial for changing the course of mental diseases, lessening their severity and enhancing long-term results because many of them develop slowly. Validated screening tools and symptom-focused identification techniques are critical for reducing diagnostic delays and promoting prompt intervention, as mental health research has repeatedly shown over the last thirty years.

In basic care and community settings, quick, symptom-based screening instruments reliably detect prevalent mental diseases. The PHQ-9 established structured symptom evaluation as a trustworthy technique for early detection in non-specialist health care by demonstrating excellent sensitivity and specificity for depressed symptoms (Kroenke et al., 2001). Early behavioral and cognitive alterations, such as perceptual abnormalities and social disengagement, can be identified before the beginning of schizophrenia-spectrum disorders in the realm of severe mental illness, according to prodromal symptom identification among those at high risk for psychosis. These results made it clear that identification is not a diagnostic conclusion but rather a preventive entry point for examination and monitoring (Miller et al., 2003).

Subclinical symptoms that are often overlooked by conventional clinical examinations were successfully caught by identification instruments that emphasized subjective sensations, supporting dimensional and symptom-continuum models of early mental disease diagnosis (Loewy et al., 2005). Measurable clinical advantages were achieved through early identification and specialized intervention. Early recognition and referral systems are beneficial for public health, as evidenced by the



decreased symptom intensity and relapse rates of individuals getting early assistance during first-episode psychosis (Craig et al., 2004). When symptoms manifest physically, common mental illnesses like anxiety and depression frequently go undiagnosed. The empirical basis for community-level identification procedures in India was established by symptom-based screening conducted by non-specialist health workers, which greatly enhanced the detection of psychological distress (Patel et al., 1998). Brief screening tools that were culturally tailored successfully detected anxiety and depression and reaffirmed that early detection places more emphasis on functional symptom recognition than diagnostic labelling (Patel et al., 2008).

The importance of family and social context in early detection processes is shown by the fact that family members were often the first to recognize mental illness through behavioural changes, mood disorders and social disengagement (Ganguli, 2000).

Therefore, early symptom recognition, family and community awareness and the adoption of basic screening techniques—rather than a prompt clinical diagnosis—are the key to identifying mental diseases. Early identification is a key element of successful mental health services in India since it improves access to care, lowers stigma and limits long-term disability.

II. Approaches to Diagnosis of Mental Disorders

Using defined criteria, psychological symptoms are systematically categorized into clinically recognized diseases in order to diagnose mental disorders. Diagnosis establishes if these symptoms meet predetermined criteria for particular mental diseases, whereas identification stresses early symptom awareness. Strong family participation, cultural manifestations of distress and variation in symptom presentation influence diagnostic procedures in India, necessitating methods that go beyond strict categorical application.

The application of Western diagnostic methods, such as DSM and ICD, in the Indian setting has shown that somatic complaints and culturally patterned experiences, which are not adequately represented by standardized categories, are common ways that psychological distress manifests itself. Therefore, in addition to formal categorization systems, clinical interpretation is necessary for effective diagnosis (Jacob, 2010). With a focus on symptom progression and functional impairment rather than individual symptom counts, long-term clinical observation and methodical integration of

family histories led to a correct diagnosis of schizophrenia (Srinivasan & Thara, 2007).

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When used with contextual modification in low- and middle-income settings, ICD-based diagnostic procedures improved professional communication and dependability, proving that standardized frameworks are still useful when they are in line with regional clinical reality (Loewenthal, 2006). The integration of dimensional symptom evaluation within categorical diagnostic systems was reinforced by population-based diagnostic assessments of depression in South India, which revealed that diagnoses were most accurate when combined with structured clinical interviews (Poongothai et al., 2009).

In order to position diagnosis as a comprehensive clinical process rather than a static label, diagnostic understanding in Indian mental health care further incorporated social stressors, family dynamics and economic conditions as essential elements shaping symptom manifestation and diagnostic outcomes (Patel et al., 2011). Dimensional diagnostic views were reinforced by the recognition of overlapping symptoms and varied intensity across illnesses; this was especially important in situations where comorbidity and symptom continuity are prevalent (Kraemer, 2007).

Therefore, in order to assure diagnostic accuracy and relevance in the Indian context, techniques to diagnosing mental diseases require established classification systems backed by clinical judgment, cultural understanding and dimensional assessment of symptoms.

III. Psychometric Foundations of Mental Health Assessment

The scientific basis of mental health assessment is comprised of psychometric underpinnings. The validity, reliability and standardization of the instruments used determine how accurate identification and evaluation are. The



danger of misidentification, incorrect diagnosis and ineffective intervention is increased by assessment instruments with weak psychometric qualities. Due to linguistic diversity, cultural variances and variations in how psychological discomfort is expressed, psychometric rigor is especially important in the Indian context.

Standardized instruments achieve acceptable reliability and validity when they are culturally adapted and locally evaluated, according to an evaluation of psychiatric diagnostic tools in Indian community settings. These results demonstrated that without contextual validation, psychometric instruments cannot be used worldwide (Alarcón, 2009). Validation studies of depression screening in South India demonstrated that instruments with strong psychometric qualities improve identification accuracy when paired with clinical assessment. Effective community-based evaluation relied heavily on concept validity and sensitivity (Pongothai et al., 2009).

Reliability greatly increases when screening tools are meticulously translated, standardized and administered by qualified staff, according to assessment study conducted in rural Indian settings. Strict standardization methods preserved consistency between assessors and contexts, highlighting the significance of methodological rigor in mental health evaluation (Ganguli et al., 2011). Strong internal consistency and satisfactory validity were found in the psychometric evaluation of the PHQ-9 using Rasch analysis in an Indian population, highlighting the need for empirical testing of commonly used instruments prior to their use in Indian clinical and research contexts (Gothwal et al., 2014).

Strong psychometric soundness has been proven by international validation studies of short screening instruments, including the GAD-7. Similar psychometric assessments in Indian mental health research have been informed and led by the methodological foundation these findings provided (Spitzer et al., 2006).

When taken as a whole, these research confirm the importance of validity, reliability and standardization in mental health assessment. To guarantee that assessment results accurately reflect psychological discomfort rather than just culturally formed manifestations, psychometric evaluation in India must methodically take linguistic, cultural and environmental factors into account. Strong psychometric underpinnings promote moral and efficient mental health practice and bolster the validity of assessment results.

IV. Mental Status Examination in Clinical Assessment

A standardized clinical technique for evaluating a person's present psychological functioning is the Mental Status Examination (MSE). Appearance, behavior, emotion, speech, cognitive processes, perception, cognition, insight and judgment are all methodically assessed. The MSE serves as the psychiatric equivalent of a physical examination in mental health practice, offering a quick and structured picture of a person's mental state at the moment of assessment. Because it enables therapists to comprehend symptoms within cultural expressions of distress and varying levels of education and literacy, the MSE is particularly helpful in India.

In psychiatric assessment, structured application of the MSE decreases personal bias and enhances diagnostic precision. Clinicians are more consistent when they systematically observe speech, affect and mental processes, especially in high-load outpatient settings (Trivedi & Gupta, 2006). The MSE's cognitive components, which include tests of direction, attention and memory, are useful in differentiating between biological brain diseases and functional psychiatric illnesses. In Indian clinical practice, where access to cutting-edge diagnostic tools may be restricted, these elements are particularly beneficial (Grover et al., 2010).

When administered by qualified mental health professionals, the use of standardized MSE formats in community-based psychiatric examinations increased agreement amongst various assessors. This supported the MSE's broader usage in public mental health services and showed that it is still dependable outside of hospital settings (Bhugra et al., 2015). In patients with schizophrenia, the MSE's structured assessment of thinking form, content and perceptual abnormalities made it possible to accurately identify psychotic symptoms and track the severity of the illness over time (Kulhara et al., 2010).

The MSE framework has been further reinforced by cognitive screening techniques. The importance of quick and standardized cognitive examination has been reinforced by the Montreal Cognitive Assessment, which shown excellent sensitivity in identifying moderate cognitive impairment and has affected cognitive assessment techniques within the MSE across Indian clinical settings (Nasreddine et al., 2005).

In conclusion, the Mental Status Examination continues to be a crucial part of clinical evaluation, offering precise, organized and clinically significant data. It is more effective in the Indian context when physicians employ information from



family members, basic cognitive activities and culturally sensitive observation. The MSE therefore plays a vital role in accurate identification, diagnosis and ongoing evaluation of mental disorders.

V. Psychological Assessment Techniques in Mental Health

Standardized tests and inventories are used in psychological evaluation methods to gauge personality traits, emotional functioning, cognitive ability and psychopathological symptoms. In addition to supporting and enhancing clinical interviews and the Mental Status Examination, these methods offer objective, quantitative data. As long as the assessment instruments are psychometrically validated and culturally suitable, psychological testing is crucial for diagnosing mental illnesses in a variety of Indian groups.

When paired with clinical judgment, the use of standardized psychological testing in psychiatric practice increased diagnosis accuracy. Clinical decision-making was reinforced by personality inventories and symptom rating scales and meaningful assessment was found to require adapting Western-developed instruments to Indian socio-cultural contexts (Malhotra et al., 1999). The utility of standardized psychological tools for population-level mental health screening was demonstrated by the successful identification of depressive symptoms in large South Indian populations through community-based assessment of depression using validated screening questionnaires (Poongothai et al., 2009).

Standardized assessments of symptoms and functioning allow for systematic monitoring of illness severity and psychosocial impairment, according to the application of psychological evaluation instruments in people with serious mental disorders. These methods facilitated well-informed clinical planning and treatment outcome assessment (Volkos & Symvoulakis, 2021). The clinical value of widely used assessment instruments was further reinforced by psychometric evaluation. Strong internal consistency and construct validity were confirmed by Rasch analysis of the PHQ-9 in an Indian population, highlighting the significance of empirical testing of psychological instruments prior to clinical implementation (Dadfar et al., 2018).

Psychological evaluation techniques in India have also been impacted by widely used international assessment instruments. Following cultural adaptation, the Beck Depression Inventory-II was successfully used in Indian settings, demonstrating its usefulness for both evaluation and therapy monitoring (Beck et al., 1996).

In conclusion, the objective diagnosis and assessment of mental illnesses depend heavily on psychological assessment methods. Careful standardization, cultural sensitivity and integration with therapeutic techniques are necessary for their efficacy. In India, developmental, social and family-centred methods to mental health assessment are complemented by validated psychological instruments that are crucial for early detection, diagnostic clarity and outcome monitoring.

VI. Physical and Neurological Assessment in Differential Diagnosis of Mental Disorders

Since many medical and neurological illnesses appear with psychiatric symptoms, physical and neurological evaluation is an essential part of differential diagnosis in mental health. Mood swings, psychosis and cognitive impairment are common first symptoms of conditions such as thyroid dysfunction, epilepsy, infections of the central nervous system, malnutrition and neurodegenerative illnesses. Therefore, integrating medical history, physical examination, neurological evaluation and pertinent laboratory tests is necessary for accurate mental health assessment.

A significant percentage of individuals presenting with psychological symptoms had underlying, previously undiagnosed medical illnesses, according to medical screening in psychiatric institutions. Regular physical examinations decreased incorrect psychiatric labelling and misdiagnosis, making medical evaluation a crucial component of mental health evaluation (Vindhya, 2024). Diagnostic boundaries were further clarified by endocrine examination, which revealed a high correlation between depressed symptoms and thyroid problems. Thyroid function tests made it easier to distinguish between medication induced depression and primary mood disorders (El Hayek, 2026).

Through rigorous neurological evaluation and neuroimaging, neurological testing in patients with first-episode psychosis revealed organic brain disorders such as epilepsy and space-occupying lesions. These results validated the need for mandatory neurological screening in early psychiatric presentations, especially in cases of abrupt or unusual symptom onset (Saxena & Srivastava, 2010). Central nervous system illnesses, such as neurocysticercosis and tubercular meningitis, often cause behavioral abnormalities, mood disorders and cognitive deficits, according to neuropsychiatric research conducted in Indian clinical settings. Combined medical and neurological evaluation was necessary for an



accurate diagnosis, particularly in areas where infections were common (Kumar et al., 2021).

Neurological and immunological tests are essential for the accurate diagnosis of autoimmune encephalitis, which has become a significant differential diagnosis in cases of severe psychosis. Acknowledgment of these diseases guided proper medical therapy and avoided misdiagnosis as primary psychiatric disorders (Kayser & Dalmau, 2011).

In conclusion, a thorough assessment of mental health requires a physical and neurological examination. The comprehensive integration of physical and neurological examination promotes correct differential diagnosis, prevents diagnostic mistake and facilitates a complete understanding of mental health issues in the Indian environment, where medical, nutritional and viral illnesses are frequent.

VII. Ethical, Cultural and Developmental Considerations in Mental Health Assessment

A responsible and accurate mental health assessment must take ethical, cultural and developmental factors into account. Instead of being in a vacuum, psychological symptoms are impacted by developmental stage, cultural beliefs, family arrangements and social surroundings. Assessment procedures must go beyond symptom checklists to guarantee moral behaviour, cultural sensitivity and accurate diagnosis of mental problems in India, where cultural diversity and family involvement significantly influence daily life.

Concerns about informed consent, confidentiality in joint family systems and the stigma attached to mental illness were brought to light by ethical difficulties in psychiatric evaluation among culturally varied populations. Respect for family involvement must be balanced with the defense of individual autonomy and rights in an ethical evaluation (Jain et al., 2017). Psychological issues are often manifested through bodily symptoms and culturally particular idioms, according to cultural studies of distress in Indian communities. The necessity for culturally appropriate assessment frameworks was highlighted by the misinterpretation of symptoms caused by the use of culturally insensitive tools (Patel, 2024).

The evaluation of serious mental diseases was significantly influenced by developmental and familial factors. The significance of developmental history and caregiver perspectives in clinical evaluation is demonstrated by the fact that symptom detection and reporting varied across developmental stages and mostly depended on family observation

(Viswanath & Chaturvedi, 2012). Particular ethical issues with assent, confidentiality and parental engagement were brought up by the evaluation of children and adolescents. In collectivist family structures, which are prevalent in India, developmentally sensitive assessment techniques guaranteed the protection of the child's best interests (Kharawala & Dalal, 2011).

Ethical and diagnostic clarity were enhanced by structured methods of culturally aware evaluation. The Cultural Formulation Interview has influenced culturally sensitive assessment procedures in Indian mental health research and clinical settings by offering a methodical approach to comprehending cultural interpretations of symptoms and patient experiences (DeSilva et al., 2018).

In general, effective mental health assessment requires ethical, cultural and developmental sensitivity. Assessment accuracy and acceptability are strengthened in the Indian context by incorporating family viewpoints, honouring traditional expressions of grief and upholding ethical standards. The Human Development and Family Studies perspective, which stresses context, relationships and lifetime development in understanding mental health, is strongly aligned with this method.

VIII. Discussion

This review demonstrates that the identification and evaluation of mental diseases are multifaceted procedures that incorporate many assessment techniques, standardized diagnostic methodologies and early symptom recognition. Research emphasizes how crucial it is to combine dimensional and biopsychosocial viewpoints with categorical systems like DSM and ICD in order to provide an appropriate diagnosis. A thorough understanding of mental problems can be obtained by combining methods such as psychiatric interviews, mental status examination, psychological testing and medical evaluation. In order to increase assessment accuracy and decrease misdiagnosis, Indian studies highlight the importance of cultural sensitivity, family engagement and developmental context

IX. Conclusion

Effective mental health care is built on identification and assessment. Accurate diagnosis is ensured by early symptom recognition backed by credible, trustworthy and culturally relevant assessment methods. A comprehensive understanding of mental disorders results from the integration of clinical, psychological and medical examinations. Improving evaluation procedures can



lower stigma, stop chronicity and enhance mental health results.

References

- [1]. Alarcón RD. (2009) Culture, cultural factors and psychiatric diagnosis: review and projections. *World Psychiatry*. 8(3):131-9
- [2]. Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for the Beck Depression Inventory-II*. San Antonio, TX: Psychological Corporation.
- [3]. Chaturvedi, S. K., & Sarmukaddam, S. (2002). Cultural sensitivity and clinical interviewing in Indian psychiatric practice. *Indian Journal of Psychiatry*, 44(1), 1–6.
- [4]. Craig, T. K. J., Garety, P., Power, P., Rahaman, N., Colbert, S., Fornells-Ambrojo, M., & Dunn, G. (2004). The Lambeth Early Onset (LEO) Team: Randomised controlled trial of the effectiveness of specialised care for early psychosis. *BMJ*, 329(7474), 1067.
- [5]. Dadfar, M., Kalibatseva, Z., & Lester, D. (2018). Reliability and validity of the Farsi version of the Patient Health Questionnaire-9 (PHQ-9) with Iranian psychiatric outpatients. *Trends in psychiatry and psychotherapy*, 40(2), 144-151.
- [6]. DeSilva, R., Aggarwal, N. K., & Lewis-Fernández, R. (2018). The DSM-5 Cultural Formulation Interview: bridging barriers toward a clinically integrated cultural assessment in psychiatry. *Psychiatric Annals*, 48(3), 154-159.
- [7]. Dinesh Bhugra, S., Roger, N., & Takei, N. (2015). *Routledge handbook of psychiatry in Asia*. Abingdon: Routledge.
- [8]. El Hayek, S. (Ed.). (2026). *Addiction and Neurodegenerative Disorders: Unraveling the Nexus*. CRC Press.
- [9]. Ganguli, H. C. (2000). Epidemiological findings on prevalence of mental disorders in India. *Indian Journal of Psychiatry*, 42(1), 14–20.
- [10]. Gothwal, V. K., Bagga, D. K., & Sumalini, R. (2014). Rasch analysis of the Patient Health Questionnaire-9 in an Indian population. *Journal of Affective Disorders*, 158, 1–8.
- [11]. Goyal, G., Kaur, U., Sharma, M., & Sehgal, R. (2023). Neuropsychiatric Aspects of Parasitic Infections—A Review. *Neurology India*, 71(2), 228-232.
- [12]. Grover S, Dutt A, Avasthi A., (2010). An overview of Indian research in depression. *Indian J. Psychiatry*. 52(S1): 178-88.
- [13]. Jacob, K.S. (2010). Indian Psychiatry and classification of psychiatric disorders. *Indian Journal of Psychiatry*, 52, 104-109.
- [14]. Jain, S., Kuppili, P. P., Pattanayak, R. D., & Sagar, R. (2017). Ethics in psychiatric research: Issues and recommendations. *Indian journal of psychological medicine*, 39(5), 558-565.
- [15]. Kayser, M. S., & Dalmau, J. (2011). Anti-NMDA receptor encephalitis in psychiatry. *Current Psychiatry Reviews*, 7(3), 189–193.
- [16]. Kharawala, S., & Dalal, J. (2011). Challenges in conducting psychiatry studies in India. *Perspectives in clinical research*, 2(1), 8-12.
- [17]. Kraemer, H. C. (2007). DSM categories and dimensions in clinical and research contexts. *International journal of methods in psychiatric research*, 16(S1), S8-S15.
- [18]. Kroenke, K., Spitzer, R. L., & Williams, J. B. W. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine*, 16(9), 606–613.
- [19]. Kulhara, P., Shah, R., & Aarya, K. R. (2010). An overview of Indian research in schizophrenia. *Indian Journal of Psychiatry*, 52(Suppl1), S159-S172.
- [20]. Kumar, D., Pannu, A. K., Dhobar, D. P., Singh, R., & Kumari, S. (2021). The epidemiology and clinical spectrum of infections of the central nervous system in adults in north India. *Tropical Doctor*, 51(1), 48-57.
- [21]. Loewenthal, K. (2006). *Religion, culture and mental health*. Cambridge University Press.
- [22]. Loewy, R. L., Bearden, C. E., Johnson, J. K., Raine, A., & Cannon, T. D. (2005). The prodromal questionnaire (PQ): preliminary validation of a self-report screening measure for prodromal and psychotic syndromes. *Schizophrenia research*, 79(1), 117-125.
- [23]. Mahajan, S., Grover, S., & Chakrabarti, S. (2022). Caregiving in Obsessive Compulsive Disorder: A study from North India. *Journal of Psychosocial Rehabilitation and Mental Health*, 9(1), 65-79.
- [24]. Miller, T. J., McGlashan, T. H., Rosen, J. L., Cadenhead, K., Cannon, T., Ventura, J., & Woods, S. W. (2003). Prodromal assessment with the Structured Interview for Prodromal Syndromes and the Scale of Prodromal Symptoms. *Schizophrenia Bulletin*, 29(4), 703–715.
- [25]. Misra, U. K., Kalita, J., & Bhoi, S. K. (2014). Spectrum and outcome predictors of central



- nervous system infections in a neurological critical care unit in India: a retrospective review. *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 108(3), 141-146.
- [26]. Nasreddine, Z. S., Phillips, N. A., Bédirian, V., Charbonneau, S., Whitehead, V., Collin, I., Cummings, J. L., & Chertkow, H. (2005). The Montreal Cognitive Assessment (MoCA): A brief screening tool for mild cognitive impairment. *Journal of the American Geriatrics Society*, 53(4), 695–699.
- [27]. Patel, V. (2024). Social and cultural determinants of mental health. In *Mental Health Care Resource Book: Concepts and Praxis for Social Workers and Mental Health Professionals* (pp. 55-70). Singapore: Springer Nature Singapore.
- [28]. Patel, V., Araya, R., Chowdhary, N., King, M., Kirkwood, B., Nayak, S., Simon, G., & Weiss, H. A. (2008). Detecting common mental disorders in primary care in India: A comparison of five screening questionnaires. *Psychological Medicine*, 38(2), 221–228.
- [29]. Poongothai, S., Pradeepa, R., Ganesan, A., & Mohan, V. (2009). Prevalence of depression in a large urban South Indian population: Psychometric issues in screening. *Journal of the Association of Physicians of India*, 57, 185–190.
- [30]. Sheehan, D. V., Lecrubier, Y., Sheehan, K. H., Amorim, P., Janavs, J., Weiller, E., & Dunbar, G. C. (1998). The Mini-International Neuropsychiatric Interview (MINI): the development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. *J. clin. Psychiatry*, 59(20), 22-33.
- [31]. Shruthi, M. N. (2019). *Cognitive Deficits in Remitted Phase of Major Depressive Disorder* (Doctoral dissertation, Rajiv Gandhi University of Health Sciences (India)).
- [32]. Spitzer, R. L., Kroenke, K., Williams, J. B. W., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine*, 166(10), 1092–1097.
- [33]. Srinivasan, T. N., & Thara, R. (1997). How do men with schizophrenia fare at work? A follow-up study from India. *Schizophrenia research*, 25(2), 149-154.
- [34]. Trivedi, J. K. (2006). Cognitive deficits in psychiatric disorders: Current status. *Indian journal of psychiatry*, 48(1), 10-20.
- [35]. Vindhya, U. (2024). *Feminist Psychologies: Identities, Relations and Well-Being in India*. Routledge India.
- [36]. Viswanath, B., & Chaturvedi, S. K. (2012). Cultural aspects of major mental disorders: A critical review from an Indian perspective. *Indian Journal of Psychological Medicine*, 34(4), 306-312.
- [37]. Volkos, P., & Symvoulakis, E. K. (2021). Impact of financial crisis on mental health: A literature review ‘puzzling’ finding from several countries. *International Journal of Social Psychiatry*, 67(7), 907-919.