

Case Report

Observe Everyday Mental Health Signs & Seek Help Before Crisis! Consult a Psychiatrist or Psychologist?

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Abstract

Over the past two decades in India, growing discussion about mental health has also blurred the distinction between everyday emotional experiences such as sadness, stress, and anxiety and mental health conditions such as depression and anxiety disorders.

Deciding whether to meet a psychiatrist or a clinical psychologist depends upon i) the settings in which service is sought ii) the nature and severity and complexity of the problem iii) other medical conditions iv) the needs and preferences of the client and v) The training and practice preference of the professional in proximity vi) Clinical conditions marked by persistent symptoms such as dominant negative thoughts, changes in energy levels, sleep disturbances, appetite changes, and behavioural shifts like social withdrawal or avoidance and the level of interference on day-todays functioning.

A Psychologist is not a medical doctor, but a recognised mental health professional under mental health Act 2017, and trained to evaluate mental health conditions, with working knowledge of treatment approaches, but cannot prescribe medication. S/he may be consulted for i) dealing with everyday stress, worries or life challenges that trigger emotions, ii) Feeling anxious, low or overwhelmed, but can still manage daily activities iii) Facing relationship, family or work-related issues iv) If looking for help with coping skills, behaviour change/self-understanding and v) Symptoms are not disrupting routine life

On the other hand, Psychiatrist is a medical doctor with MBBS and Postgraduate in mental Health or specifically trained in public-sector in-service training and authorised to prescribe medications. Seek a psychiatrist's help if symptoms stay for few days or get worse or Sleep or appetite change, occur or affect work or school or daily routines or there is severe anxiety, depression or mood changes or Paranoia, aggression, or withdrawal & there are suicidal thoughts or self-harm tendencies.

This article is an effort to empower families and general practitioners to observe early signs mental health challenges, as they begin with small shifts in daily routines before they present as crisis.

A general practitioner (GP) or even a family member (FM) need to Observe and note down specific changes noticed in the client over time. For example, GP /FM can say in a low-pressure setting: "I've noticed you haven't been yourself lately and seem a bit overwhelmed. Is anything on your mind? A low-pressure setting may be i) while walking, driving, or doing an activity like cooking, so that the client does not have to maintain direct eye contact. Ask direct but kind questions like "What has been happening for you lately?" or "What helps you feel better when you are stressed?". Be an Active Listener, do not judge or downplay. If they are not ready to talk immediately, let them know you are there whenever they need.

Keywords: stress; sadness; sleep disruption; anxiety; depression; increased worry; needing more efforts to perform normal tasks; appear often; persist for more than 2-3 days

Introduction

In India conversation around mental health started for last 2 decades, the line between every day emotional experiences like sadness, stress, anxiety etc and mental health conditions like depression, and anxiety disorders are blurred. This is due to limited awareness stigma & the tendency to interpret them as passing phase or a reaction to the situations. Therefore, there is still some confusion whom to consult in crisis a psychologist or Psychiatrist? [1,2].

Most mental health challenges don't begin with a crisis, they begin with small daily shifts: less patience, difficulty focusing, poor sleep, or a steady sense of overwhelm. Often, it's the growing mental load-constant problem-solving, remembering details, and juggling responsibilities—that quietly strains people's capacity to think clearly and perform their best. Because these signs can look like "normal" stress, they're easy to dismiss until the impact shows up in productivity, performance quality, and relationships [3].

While deciding whether to meet a psychiatrist or a clinical psychologist depends upon i) the settings in which service is sought ii) the nature and severity and complexity of the problem iii) other medical conditions iv) the needs and preferences of the client and v) The training and practice preference of the professional in proximity However, clinical conditions marked by persistent symptoms such as dominant negative thoughts, changes in energy levels, sleep disturbances, appetite changes,

and behavioural shifts like social withdrawal or avoidance and the level of interference any of these symptoms cause in day-to-day functioning must determine the need for professional help [4].

One must be aware of the perceived divide between therapy and medication even among medical practitioners and mental health care workers, that one does not replace the other. Stigma arises from oversimplified ideas about treatment. Both treatment and medication are complimentary not interchangeable. One should opt an approach tailored to the individual's condition and severity [5]. Medications help management of aspects that cannot be directly controlled through willpower or external efforts, while behavioural changes such as psychotherapy lifestyle adjustments and coping strategies, play an equally important role in recovery and sustenance benefits over long term. In severe cases medication may be necessary at the outset to stabilise a person. For example, a patient with extreme anger issues who is so much agitated that he S/he is breaking home furniture or posing threat to others cannot immediately benefit from therapy. Most people lose the distance between intellectual understanding and emotional change, and such clients struggle with i) Shame and self-criticism ii) Abandonment fears iii) Relationship difficulties iv) Perfectionism and excessive control v) Emotional overwhelm and avoidance vi) People-pleasing & self-sacrifice.

This article is an effort to empower families and general practitioners to observe early signs of i) a sleepless night, ii) increased worry, iii) less patience, or more irritation iv) needing more effort to perform normal tasks, which appear often and persist for more than a day or two before stress starts to feel unmanageable. In workplace settings, those patterns may show up as a shift in someone's typical behaviour or performance level and refer for a combination of Medication and Physiotherapy.

Real life Case Reports

Case 1. Case of Severe Obsessive-Compulsive Disorder (OSD)

A 15-year-old girl our neighbour in 2018, was suffering with severe obsessive compulsive rituals for nearly 2 years. She would clean the pooja room & utensils used for hours every day, keep praying or reciting mantras for hours. Her family took her to a psychologist for months with signs of improvement, instead it started deteriorating and her daily routine life got disrupted over another 6 months. She failed in her class X examination and even attempted to commit suicide. At this stage the family consulted the who referred to a Psychiatrist in VIMHANS - Vidyasagar Institute of Mental Health. Over period of next 4-6 months the girl became almost normal and cleared her X exam in second attempt with flying colours.

Case 2. Case of Paranoid Symptoms

IN 2019 about a year after this author relocated to Bengaluru, a teenager boy was brought for consultation with Paranoid symptoms (intense, irrational mistrust or suspicion of friends and teachers, that he was bullied and discriminated in performance assessment) which interfered with daily functioning. He had unfounded beliefs that his friends were trying to deceive, harm, or persecute him, and teacher did not hear his complaint, though they had found no evidence to his fears. Family had taken him to a counsellor for 3 months showing no improvement. This author referred to Psychiatrist friend in NIMHANS. There a combination of medication and counselling helped him to come over the problem in next 6 months. A proof of how treatment works when therapy /counselling does not work alone.

Case 3. Cognitive Behavioural Therapy (CBT) for Social Anxiety & Substance Abuse:

A 20-year-old male with severe Social Anxiety Disorder, depression, and substance abuse was referred by this author to NIMHANS. Immense success was noticed after 20 sessions of CBT, which focused on cognitive restructuring of dysfunctional thoughts & gradual exposure to crowded malls & social interactions, leading to fewer anxiety attacks & reduced reliance on substances.

Case 4. Interpersonal Psychotherapy (IPT) for Complicated Grief

A female patient with severe grief following a stillbirth reported to this author in December 2025. She showed significant clinical improvement after 12 weeks of IPT focusing on unresolved grief & role transitions.

Case 5. Psychoeducation for Bipolar Disorder during Mania

A patient experiencing a manic episode holding on to grandiose beliefs and altered perceptions was referred to NIMHANS & was treated with Acceptance and Commitment Therapy (ACT) concepts & psychoeducation. This continuous psychotherapeutic support helped her regain family, occupational, and social functioning within 4 months.

Case 6. Tele-psychotherapy for COVID-19 Related Trauma

During the Covid 19 pandemic, in 2021, a 33-year-old female experiencing severe isolation and acute stress. He responded well to rapid tele-psychotherapy by this author, which significantly reduced her symptoms of anxiety, panic, and delusions of death.

Discussions

Burnout and Overwhelm are widespread early, everyday signs of strain that are easily missed but are easy to normalize, until they begin affecting daily routine works. Looking at the reasons of ignoring initial symptoms i) Most people don't ignore the signs on purpose, but they adapt. When strain starts to build, many people compensate quietly, by double-checking tasks, pushing through discomfort, taking fewer breaks, or working late. And in many work environments, the daily signs are easy to normalize, and stress becomes the background noise ii) Some humans hesitate, for example when someone notices a subtle shift in how they're feeling, they keep it to themselves for fear of being seen as vulnerable or less capable in almost all jobs, (working alone, working in shifts, working in the field, serving customers face-to-face, or working on a team), there isn't always time or space to say, "I'm not doing okay," until increasing stress starts showing up in bigger ways of increased friction with others, more mistakes, less patience, or a growing sense of disconnection [5]. One boy who lost his parents admitted he had lost the wish to live and contemplated suicide but never spoke about it fearing bringing "disrepute" to his family iii) Most adolescents accept sadness, hopelessness and suicidal thoughts as "part of life" because they are not aware of professional mental healthcare availability 4. The lack of clarity as to whom seek acre among psychiatrist to Phycologist [3]. The perceived divide between psychotherapy and medication management stems from the historical separation of the mind and body in medicine [1]. While talk therapy focuses on developing coping skills and exploring emotional patterns, medication alters neurochemistry to stabilize physiological symptoms. Today, this divide is increasingly bridged by an integrated care approach. The gap between these two treatment modalities is shaped by 1. The "Nature vs. Nurture" of Mental Health Medication addresses the physiological and chemical or biological imbalances in the brain. It works to quiet severe symptoms like racing thoughts, deep depression, or panic, creating the stability necessary for a patient to engage in daily life. 2. Psychotherapy focuses on emotional processing, identifying negative thought distortions, and building behavioural resilience. While medication addresses the symptoms, therapy provides the lifelong tools needed to address the root causes. Medical Management involves psychiatrists, or primary care doctors in India. Visits are often brief and focused on monitoring side effects, adjusting dosages, and managing biological symptom relief. Psychotherapy led by licensed counsellors, psychologists, or clinical social workers, typically their sessions last 45-50 minutes and are deeply collaborative, exploring a patient's personal history, triggers, and relationship dynamics. However, in recent year we see a shift toward Integrated Care. Historically, providers debated whether therapy or medication was better, sometimes suggesting patients choose one over the other. However, research consistently shows that combining both is often the most effective route, leading to faster progress and reduced risk of relapse. For conditions like severe depression or schizophrenia, integrated treatment where a therapist and a prescribing psychiatrist act as a coordinated care team—is widely considered the gold standard. The divide is also reinforced by patient perception. As some individuals view taking medication as a sign of weakness, a "crutch," or fear dependency. Others find the side effects of medication uncomfortable and prefer natural or strictly talk-based remedies. A combined treatment plan allows patients to discuss their subjective feelings and fears about medication openly within a safe therapeutic space [5].

Table 1: The Difference between Psychologist & Psychiatrist When & Whom to Seek help from?

Domains	Psychologist	Psychiatrist
Who is S/He?	Not a medical doctor, but a recognised mental health professional under mental health Act 2017	Medical Doctor (MBBS+ PG in Mental Health or Psychiatry training)
Skills	Trained to evaluate mental health conditions, with working knowledge of treatment approaches	Can diagnose mental health disorders, trained in psychotherapies
Prescription authority	Cannot prescribe medication	Prescribes Medication
Conusult Under Following Conditions		
1	If dealing with everyday stress, worries or life challenges that trigger emotions	Symptom stay for few days or get worse or Sleep or appetite change
2	Feeling anxious, low or overwhelmed, but can still manage daily activities	Same conditions affecting work or school or daily routines
3	Facing relationship, family or work-related issues	There is severe anxiety, depression or mood changes
4	If looking for help with coping skills, behaviour change/self-understanding	There is Paranoia, aggression or withdrawal
5	Symptoms or mild to moderate and not disrupting routine life	There are suicidal thoughts or self-harm tendencies.

Ideally a treatment works when therapy alone won't do. Treatment consists of medications which stabilise symptoms, improve sleep and focus and reduce severity, while therapy builds coping skills, addresses thoughts & behaviour and supports long-term recovery [1,5].

Choosing between medication and therapy in India, especially given the scarcity of licensed professionals, depends on the severity of your symptoms, biological predisposition, and personal preference. Generally, therapy is ideal for mild-to-moderate issues, while medication is essential for severe, debilitating, or biologically rooted conditions [5].

When to Consider Medication

As medication alters brain chemistry and is highly effective for rapidly stabilizing severe symptoms, if the patient is experiencing psychosis, severe bipolar disorder, or major depressive episodes that impair basic functioning or involve suicidal ideation. It is also recommended for conditions that are recurring and have a strong genetic or physiological component. Medication management requires shorter, less frequent visits after initial stabilization it is better to consult a psychiatrist. Under national mental (GOI) health program NIMHANS is opening mental health units in all district hospitals. Tele MANAS, India's flagship digital mental health platform provides free, 24/7 mental health counselling and video consultations. It operates in multiple languages. Anyone can access it by dialling 14416 or 1800-89-14416. GOI claims that in Ayushman Arogya Mandirs (Health and Wellness Centres) mental health services are integrated directly into primary healthcare across the country, but ground reality is still a distant dream. District Mental Health Programme (DMHP) functions in rural and semi-urban districts to provide outpatient care, counselling, and essential medications through district Hospitals or medical colleges hospitals and local community health centres (CHC), which again is in an initial stage at sub-district level. For specialized care, India hosts premier government-run centres of excellence, such as the National Institute of Mental Health and Neurosciences (NIMHANS) in Bengaluru and the Central Institute of Psychiatry (CIP) in Ranchi [1].

Private Teletherapy & Digital Platforms

The private sector has seen significant growth, offering accessible, on-demand online therapy and psychiatry. Notable platforms operating in India are i) Amaha & ii) Wysa Better Help India. Some NGOs & Grassroots Support focus on raising awareness, reducing stigma, and providing community-based support. Prominent organizations include the Live Love Laugh Foundation, and Vandrevalla Foundation, which runs free mental health crisis helpline platform [1].

When to Consider Therapy

Therapy (such as Cognitive Behavioural Therapy) teaches individuals practical skills to change thought patterns and build long-term resilience. For mild-to-moderate symptoms of generalized anxiety, grief, situational stress, or relationship conflicts where individuals are still functioning day-to-day is advised. long-term coping focuses on root causes and relapse prevention, rather than just suppressing symptoms. Therapy requires a heavier initial time commitment (usually weekly 50-minute sessions) and can be more expensive long-term. Given the limited number of specialists finding a Clinical Psychologist or Therapist with right fit in urban areas is easy but in rural areas it requires resourcefulness and a structured approach [5].

When to Consider a Combined Approach

For many individuals, combining medication to create emotional stability with therapy to learn lifelong coping skills yields the highest success rate. For people who reside outside a major metro, bypass geographic barriers by booking virtual video consultations with top-tier practitioners. Tele-consultations are widely available through platforms like Trijog or Mpower. It is advised to verify that therapist/practitioner holds an M.Phil. in Clinical Psychology and Prescribers psychiatrist holds an M.D. or PG Diploma in Psychiatry. Practitioner validity in India can be verified through the directory on the Rehabilitation Council of India (RCI) [5,8].

Identifying the Signs Earlier by General Practitioner or Family Members

Early signs of i) a sleepless night, ii) increased worry, iii) less patience, or more irritation iv) needing more effort to perform normal tasks often appear and persist for more than a day or two before stress starts to feel unmanageable. In workplace settings, those patterns may show up as a shift in someone's typical behaviour or performance level, and they can precede bigger downstream impacts [6,7].

Systems Help Catch What Individual or Colleagues Miss

Even when we're paying attention, some signs are easy to miss, especially when people are still functioning & pushing through. By flagging small changes in health care patterns or medication usage over time such as medical diagnoses, missed appointments, or delayed refills health benefits data can surface early indicators that stress may be increasing. When appropriate, this can enable earlier outreach and guidance to the right support before concerns escalate

Missed early signs show up later with consequences like downstream in productivity, quality, mistakes, and relationship friction. Early detection is pattern-based, not crisis-based. Integrated benefits can spot non-obvious patterns and route people to the right support earlier, helping reduce escalation and making costs more predictable.

When support begins earlier, people tend to regain stability sooner, which can reduce avoidable escalation, improve outcomes and experience, and make health-related costs more predictable over time.

One in six adolescents in rural north India reported facing a major stressful event within just six months, with academic pressure, poverty, bullying, domestic violence and family conflict emerging as major triggers behind depression, anxiety and suicidal thoughts among teenagers, according to an AIIMS-linked study based on interviews with 583 adolescents across 28 villages in Haryana and paints a disturbing picture of emotional distress, untreated mental illness and silent suffering among adolescents [2]. Most adolescents accepted sadness, hopelessness and suicidal thoughts as “part of life” because they did not even know professional mental healthcare was available.

Mental Health in India

A 2015-16 National Mental Health Survey (NMHS) conducted by the National Institute of Mental Health and Neurosciences (NIMHANS) reported that about 10.6% of Indian adults –were living with a diagnosable mental health disorder. The survey also revealed that 15% of India’s adult population experiences mental health issues requiring intervention. The lifetime prevalence of mental disorders was 13.7%, meaning 137 out of every 1000 people in India have experienced a mental disorder at some point in their lives. Mental health disorders are more prevalent in urban areas (13.5%), compared to rural areas (6.9%). According to a NIMHANS study from 2019, mental health disorders are more prevalent among women (20%) than men (10%). Women in India are found to be particularly more prone to conditions like depression, anxiety, and somatic complaints compared to their male counterparts. According to the 2023 National Crime Records Bureau (NCRB) report ‘Accidental Deaths & Suicides in India’ 171,418 suicides were reported in the country in 2023 which also revealed a significant gender disparity in suicides: males accounted for 72.8% of all suicides, while females accounted for 27.2% [1].

Handling Mental Health Patients in General Practice in India

General practitioners (GPs) face distinct mental health challenges in daily practice, including overlapping symptoms, time constraints, and the absence of definitive biological markers.

When a patient presents with psychological distress, primary care physicians must utilize the 5 Ds to determine if the symptoms meet the threshold for a clinical mental health condition i) Deviation from Cultural Norm: Is the patient's behaviour or mood significantly different from cultural norms? ii) Duration: How long have the symptoms persisted? Persisting for more than 3 days iii) Dysfunction: Is the condition impairing daily life, work, or social relationships? iv) Distress: Is the patient experiencing significant emotional pain? v) Danger: Is there an immediate risk of harm to the patient or others? To confirm a diagnosis, GPs must rely on the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) or the International Classification of Diseases (ICD-11) frameworks, often using brief screening tools like the GAD-7 (for anxiety) or PHQ-9 (for depression). Decision Matrix: To Refer on priority vs Treat, the general rule in primary care is that GPs must handle mild-to-moderate, uncomplicated cases, while severe or complex cases are referred to specialists (psychiatrists or psychologists)- 1. Refer urgently with one dose basic treatment (Specialist Care): i) Acute Crises with Imminent risk of suicide, self-harm, or severe physical neglect or with severe Symptoms of Acute psychosis, mania, bipolar affective disorder, or severe trauma/ post-traumatic stress disorder (PTSD). PTSD is a mental health condition triggered by experiencing or witnessing a terrifying, life-threatening, or deeply distressing event ii) If the patient fails to respond to initial primary care interventions, trials of medication, or standard counselling iii) Complex, overlapping comorbidities (e.g., concomitant substance abuse, eating disorders, or severe personality disorders) [7,1].

Treat confidently at clinic level (Primary Care): Mild-to-moderate Disorders like adjustment disorders, mild depression, or generalized anxiety and Stable patients who have already been stabilized by a psychiatrist and require only basic medication monitoring and prescription refills. Patients strongly preferring holistic care within their established medical home without specialized clinic referrals can also be handled [7].

Common Challenges in General Practice

Many patients present with physical symptoms (e.g., headaches, chronic fatigue, gastrointestinal distress) masking an underlying psychological condition, complicating the initial diagnosis ii) Some Patients may resist referrals due to the perceived stigma of mental illness. Shortage of psychiatrists and therapists especially in Rural India and urban slums often force GPs to treat outside their ideal comfort zone out of necessity. Their approach to a patient must be swift, relying on validated screening tools, clinical interviews, and a clear diagnostic framework to determine whether to treat or refer.

The National Guidelines provide an overall implementation framework to roll out services for the following six groups of MNS disorders and conditions: i) Common Mental Disorders (CMDs): i. depression, anxiety/panic disorders, somatisation/psychosomatic disorders ii) Severe Mental Disorders (SMDs): schizophrenia, bipolar disorder, severe

depression iii Child and Adolescent Mental Health Disorders (C&AMHDs): conduct disorder, attention deficit Hyperactivity disorder (adHd), Oppositional defiant disorder iv) Neurological Conditions: epilepsy and dementia (including Alzheimer's) v) Substance Use Disorder (SUDs): tobacco, alcohol and drug use disorders vi) Suicide ideation/Behaviours [7.]

A recent meta-analysis of various psychological interventions for adolescents with suicidal behaviours, most those presented promising results. However, to summarize results from recent years, dialectical behaviour therapy (DBT) was the most common and the only treatment shown to be effective for adolescents at high risk of suicide and SA. In contrast, empirical evidence for other psychological interventions focusing on deliberate self-harm (SH) was inconclusive. Interventions specifically designed to reduce suicidal risk in adolescents have multiplied significantly in recent years. However, replication and dismantling studies are needed to identify the effects of these interventions and their specific components. An important future challenge is to develop brief and effective interventions to reduce the risk of death by suicide among the adolescent population [5].

Indian Academy of Paediatrics Consensus Guidelines on Prevention and Management of Suicidal Behaviour in Adolescents, recommend that Paediatricians must screen for mental distress, mental disorders and suicidal & para-suicidal (non-suicidal self-injury) behaviour during adolescent health visits. Those with suicidal behaviour must be referred to a psychiatrist after providing emergency healthcare, risk assessment, immediate counselling and formulation of a safety plan. Paediatricians should partner with the community and policymakers for primary and secondary prevention of adolescent suicide [10].

Obsessive-compulsive disorder (OCD)

OCD features a pattern of unwanted thoughts and fears known as obsessions. These obsessions lead the individual to do repetitive behaviours, called compulsions. These obsessions and compulsions get in the way of daily activities and cause a lot of distress. Ultimately, the individual feels driven to do compulsive acts to ease his/her stress. Even if they try to ignore or get rid of bothersome thoughts or urges, they keep coming back. This leads them to act based on ritual. This is the vicious cycle of OCD. OCD often centres around certain themes, such as being overly fearful of getting contaminated by germs or Pooja room or bedroom being far from meticulous clean environment. To ease contamination fears, they keep washing their hands repeatedly or clean the pooja room or bedroom until they're sore and chapped. Such individuals will be ashamed, embarrassed and frustrated about the condition [9].

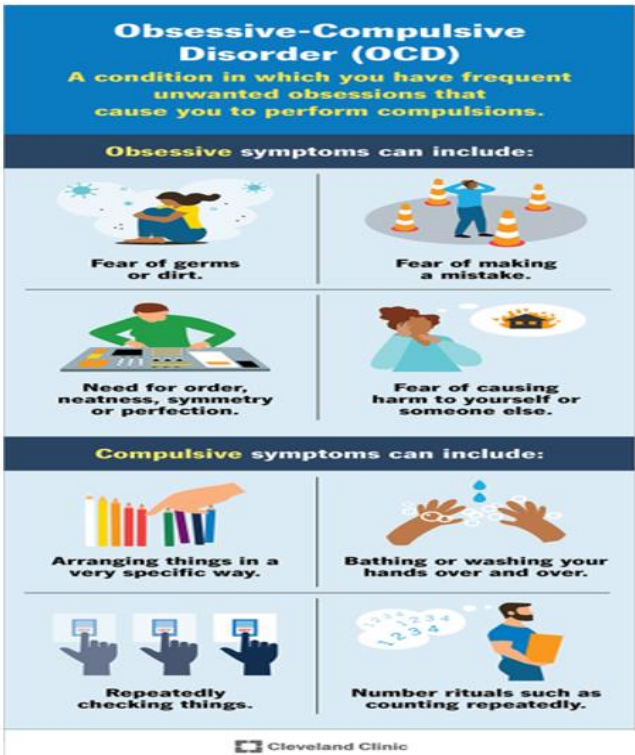


Table I: Evidence Based Strategies for Suicide Prevention

Prevention Strategies	Available evidence
Universal Interventions	
Mitigating unemployment, poverty and inequalities	Implemented Government authorities. Unplanned studies

Restricting access to lethal means of suicide-safer designs of buildings, prisons. stringent firearm rules, limitation to pesticide access. Barriers and safety nets.	Case studies Retrospective observations. Review articles
Public Awareness	
by School based interventions, cyber bullying, monitoring bullying, social media watch, Helplines, Accessible Mental health service	Randomized controlled trials Selective interventions
Selective Interventions	
Gatekeeper training – Health personnel, teachers, priests, volunteers among parents and students	Uncontrolled studies
Vulnerable population interventions- Deaddiction, Evaluating depression, social isolation,	Randomized Controlled trials
Discharge, Contract and follow up for one year minimum,	
Indicated Interventions	
Treatment of mental disorders.	Randomized controlled trials

The common Symptoms usually includes both obsessions and compulsions or have only obsession symptoms or only compulsion symptoms without knowing that their obsessions and compulsions are beyond reason. They take up a great deal of time, reduce their quality of life, and get in the way of their daily routines and responsibilities.

OCD obsessions symptoms are lasting and unwanted thoughts that keeping coming back or urges or images that are intrusive and cause distress or anxiety. One might try to ignore them or get rid of them by acting based on ritual. These obsessions intrude when they are trying to think of or do other things [11].

Obsessions often have themes, such as i) Fear of contamination or dirt ii) Doubting and having a hard time dealing with uncertainty iii) Needing things to be orderly and balanced iv) Aggressive or horrific thoughts about losing control and harming yourself or others v) Unwanted thoughts, including aggression, or sexual or religious subjects. For example i) The individual may fear of being contaminated by touching objects others have touched ii) Doubts that they have locked the door or turned off the stove iii) Intense stress when objects aren't orderly or facing a certain way iv) Images of driving car into a crowd of people v) Thoughts about shouting obscenities or not acting the right way in public vi) Unpleasant sexual images vii) Staying away from situations that can cause obsessions, such as shaking hand.

Conclusion

The lifetime prevalence of mental disorders is estimated to be around 15% in 2026 meaning 15 out of every 100 people in India do experience a mental disorder at some point in their lives. About 11% of Indian adults are living with a diagnosable mental health disorder at any point of time. Most mental health challenges don't begin with a crisis, they begin with small daily shifts like less patience, difficulty focusing, poor sleep, or a steady sense of overwhelm. Often, it's the growing mental load—constant problem-solving, remembering details, and juggling responsibilities—that quietly strains people's capacity to think clearly and perform their best. Because these signs can look like “normal” stress, they're easy to dismiss until the impact shows up in productivity, performance quality, and relationships.

Deciding whether to meet a psychiatrist or a clinical psychologist depends upon i) the settings in which service is sought ii) the nature and severity and complexity of the problem iii) other medical conditions iv) the needs and preferences of the client and v) The training and practice preference of the professional in proximity vi) Clinical conditions marked by persistent symptoms such as dominant negative thoughts, changes in energy levels, sleep disturbances, appetite changes, and behavioural shifts like social withdrawal or avoidance and the level of interference on day-todays functioning.

Both treatment and medication are complimentary and not interchangeable. One should opt an approach tailored to the individual's condition and severity.

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