

# TO ASSESS THE LEVELS OF DEPRESSION AMONG THE COLLEGE STUDENTS A CROSS SECTIONAL STUDY

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## **ABSTRACT:**

A cross-sectional descriptive study was conducted to assess the depression levels among 30 male and 30 female college students using a self-administered structured questionnaire. Originally, Beck's Depression Inventory (BDI) was developed by Aron T. Beck (1961) in English having 21 items of varying symptoms intended to assess depression. The objective of the inventory is to assess depression levels and determine the association between depression and socio-demographic variables. The purpose of this study is to assess and compare the depression levels between males and females. All the items of inventory are highly reliable and valid for individuals between the ages 18-25. Research suggests that females are more likely to experience depression, possibly due to hormonal fluctuations, social roles, and greater susceptibility to stress. In contrast, males may exhibit atypical symptoms such as irritability, aggression, or substance abuse, which can lead to underdiagnosis or misdiagnosis. Additionally, societal expectations often discourage men from seeking help, contributing to disparities in treatment outcomes. By analyzing epidemiological data, clinical studies, and psychological theories, this research aims to highlight the importance of gender-sensitive approaches in diagnosis, treatment, and prevention. Understanding these differences can improve mental health interventions and ensure more effective support for individuals struggling with depression.

## **Keywords :-**

Depression, Gender Differences, Mental Health, Males, Females, Prevalence, Symptoms, Diagnosis, Treatment, Psychological Factors, Biological Factors, Social Influences, Help-Seeking Behavior, Mental Health Interventions.

## CHAPTER-1

### INTRODUCTION

A **mental disorder**, also called a **mental illness** or **psychiatric disorder**, is a behavioural or mental pattern that causes significant distress or impairment of personal functioning. Such features may be persistent, relapsing and remitting, or occur as single episodes. Many disorders have been described, with signs and symptoms that vary widely between specific disorders. Such disorders may be diagnosed by a mental health professional, usually a clinical psychologist or psychiatrist.

The causes of mental disorders are often unclear. Theories may incorporate findings from a range of fields. Mental disorders are usually defined by a combination of how a person behaves, feels, perceives, or thinks. This may be associated with particular regions or functions of the brain, often in a social context. A mental disorder is one aspect of mental health. Cultural and religious beliefs, as well as social norms, should be taken into account when making a diagnosis.

Services are based in psychiatric hospitals or in the community, and assessments are carried out by mental health professionals such as psychiatrists, psychologists, psychiatric nurses and clinical social workers, using various methods such as psychometric tests but often relying on observation and questioning. Treatments are provided by various mental health professionals. Psychotherapy and psychiatric medication are two major treatment options. Other treatments include lifestyle changes, social interventions, peer support, and self-help. In a minority of cases, there might be involuntary detention or treatment. Prevention programs have been shown to reduce depression.

In 2019, common mental disorders around the globe include depression, which affects about 264 million, bipolar disorder, which affects about 45 million, dementia, which affects about 50 million, and schizophrenia and other psychoses, which affects about 20 million people. Neurodevelopmental disorders include intellectual disability and autism spectrum disorders which usually arise in infancy or childhood. Stigma and discrimination can add to the suffering and disability associated with mental disorders, leading to various social movements attempting to increase understanding and challenge social exclusion.

The **classification of mental disorders** is also known as **psychiatric nosology** or **psychiatric taxonomy**. It represents a key aspect of [psychiatry](#) and other [mental health professions](#) and is an important issue for people who may be diagnosed. There are currently two widely established [systems](#) for classifying [mental disorders](#):

- [Chapter V of the tenth International Classification of Diseases \(ICD-10\)](#) produced by the [World Health Organization](#) (WHO);
- The [Diagnostic and Statistical Manual of Mental Disorders \(DSM-5\)](#) produced by the [American Psychiatric Association](#) (APA).

Both list categories of disorders thought to be distinct types, and have deliberately converged their codes in recent revisions so that the manuals are often broadly comparable, although significant differences remain. Other classification schemes may be in use more locally, for example the [Chinese Classification of Mental Disorders](#). Other manuals have some limited use by those of alternative theoretical persuasions, such as the [Psychodynamic Diagnostic Manual](#).

#### ICD-10[[edit](#)]

The [International Classification of Diseases](#) (ICD) is an international standard diagnostic classification for a wide variety of health conditions. The ICD-10 states that mental disorder is "not an exact term", although is generally used "...to imply the existence of a clinically recognisable set of symptoms or behaviours associated in most cases with distress and with interference with personal functions." [Chapter V](#) focuses on "mental and behavioural disorders" and consists of 10 main groups:<sup>[12]</sup>

- F0: Organic, including symptomatic, mental disorders
- F1: Mental and behavioural disorders due to use of psychoactive substances
- F2: Schizophrenia, schizotypal and delusional disorders
- F3: Mood [affective] disorders
- F4: Neurotic, stress-related and somatoform disorders
- F5: Behavioural syndromes associated with physiological disturbances and physical factors
- F6: Disorders of personality and behaviour in adult persons
- F7: Mental retardation
- F8: Disorders of psychological development
- F9: Behavioural and emotional disorders with onset usually occurring in childhood and adolescence
- In addition, a group of "unspecified mental disorders".

Within each group there are more specific subcategories. The WHO is revising their classifications in this section as part of the development of the ICD-11 (revision due by 2018) and an "International Advisory Group" has been established to guide this.<sup>[13]</sup>

#### DSM-IV

The [DSM-IV](#) was originally published in 1994 and listed more than 250 mental disorders. It was produced by the [American Psychiatric Association](#) and it characterizes mental disorder as "a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual,...is associated with present distress...or disability...or with a significantly increased risk of suffering" but that "...no definition adequately specifies precise boundaries for the concept of 'mental disorder'...different situations call for different definitions" (APA, 1994 and 2000). The DSM also states that "there is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries dividing it from other mental disorders or no mental disorders."

The DSM-IV-TR (Text Revision, 2000) consisted of five axes (domains) on which disorder could be assessed.

The five axes were:

**Axis I:** Clinical Disorders (all mental disorders except Personality Disorders and Mental Retardation)

**Axis II:** Personality Disorders and Mental Retardation

**Axis III:** General Medical Conditions (must be connected to a Mental Disorder)

**Axis IV:** Psychosocial and Environmental Problems (for example limited social support network)

**Axis V:** Global Assessment of Functioning (Psychological, social and job-related functions are evaluated on a continuum between mental health and extreme mental disorder)

### What is Depression?

Depression is a common illness worldwide, with an estimated 3.8% of the population affected, including 5.0% among adults and 5.7% among adults older than 60 years (1). Approximately 280 million people in the world have depression (1). Depression is different from usual mood fluctuations and short-lived emotional responses to challenges in everyday life. Especially when recurrent and with moderate or severe intensity, depression may become a serious health condition. It can cause the affected person to suffer greatly and function poorly at work, at school and in the family. At its worst, depression can lead to suicide. Over 700 000 people die due to suicide every year. Suicide is the fourth leading cause of death in 15-29-year-olds.

During a depressive episode, the person experiences depressed mood (feeling sad, irritable, empty) or a loss of pleasure or interest in activities, for most of the day, nearly every day, for at least two weeks. Several other symptoms are also present, which may include poor concentration, feelings of excessive guilt or low self-worth, hopelessness about the future, thoughts about dying or suicide, disrupted sleep, changes in appetite or weight, and feeling especially tired or low in energy.

In some cultural contexts, some people may express their mood changes more readily in the form of bodily symptoms (e.g., pain, fatigue, weakness). Yet, these physical symptoms are not due to another medical condition.

During a depressive episode, the person experiences significant difficulty in personal, family, social, educational, occupational, and/or other important areas of functioning.

A depressive episode can be categorised as mild, moderate, or severe depending on the number and severity of symptoms, as well as the impact on the individual's functioning.

There are different patterns of mood disorders including:

- single episode depressive disorder, meaning the person's first and only episode);
- recurrent depressive disorder, meaning the person has a history of at least two depressive episodes; and

• bipolar disorder, meaning that depressive episodes alternate with periods of manic symptoms, which include euphoria or irritability, increased activity or energy, and other symptoms such as increased talkativeness, racing thoughts, increased self-esteem, decreased need for sleep, distractibility, and impulsive reckless behaviour.

### Depression DSM-5 Diagnostic Criteria

The DSM-5 outlines the following criterion to make a diagnosis of depression. The individual must be experiencing five or more symptoms during the same 2-week period and at least one of the symptoms should be either (1) depressed mood or (2) loss of interest or pleasure.

1. Depressed mood most of the day, nearly every day.
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.
3. Significant weight loss when not dieting or weight gain, or decrease or increase in appetite nearly every day.
4. A slowing down of thought and a reduction of physical movement (observable by others, not merely subjective feelings of restlessness or being slowed down).
5. Fatigue or loss of energy nearly every day.
6. Feelings of worthlessness or excessive or inappropriate guilt nearly every day.
7. Diminished ability to think or concentrate, or indecisiveness, nearly every day.
8. Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

To receive a diagnosis of depression, these symptoms must cause the individual clinically significant distress or impairment in social, occupational, or other important areas of functioning. The symptoms must also not be a result of substance abuse or another medical condition.

Article continues below

Do you feel depressed?

Take our 2-minute Depression quiz to see if you may benefit from further diagnosis and treatment.

### Take Depression Quiz

#### Associated Features

- Major depressive disorder is associated with high mortality, much of which is accounted for by suicide. As a result, if you think someone you care about may be suffering from depression it is important to know the warning signs of suicide and to take suicidal statements extremely seriously. An active statement by someone with suicidal ideation might be something like, “I’m going to kill

myself,” but other passive statements such as, “I wish I could just go to sleep and never wake up,” are equally worrying. If someone with depression exhibits these verbal markers, encourage them to consult a mental health professional immediately.

- Depressed individuals also present with irritability, brooding, and obsessive rumination, and report anxiety, phobias, excessive worry over physical health, and complain of pain.

### **New Specifiers for Depression in DSM-5**

The latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the DSM-5, added two specifiers to further classify diagnoses:

- **With Mixed Features** – This specifier allows for the presence of manic symptoms as part of the depression diagnosis in patients who do not meet the full criteria for a manic episode.
- **With Anxious Distress** – The presence of anxiety in patients may affect prognosis, treatment options, and the patient’s response to them. Clinicians will need to assess whether or not the individual experiencing depression also presents with anxious distress.

### **What causes depression?**

The aetiology of mental disorders is best appreciated through a multidimensional integrative approach that disfavours reductionism and encourages models that consider a wide array of biological, psychological, and social forces. Two such models are the biopsychosocial model and the diathesis-stress model. In the biopsychosocial model, biological, psychological, and social factors all play a role in causing depression. There is overlap, and the precise causes vary depending on individual circumstances. The diathesis-stress model posits that depression results when a pre-existing vulnerability, or diathesis, is activated by stressful life events. The predisposition can be either genetic implying an interaction of nature and nurture, or schematic, involving a lasting influence of mental structures formed in childhood. This approach to understanding the causes of depression has garnered empirical support.

### **Psychological factors**

#### **Cognition and depression**

- **Cognitive factors** – Low self-esteem and self-defeating or distorted thinking are connected with depression. Although it is not clear which is the cause and which is the effect, it is known that depressed persons who are able to make corrections in their thinking patterns can show improved mood and self-esteem. Psychological factors related to depression include the complex development of one's personality and how one has learned to cope with external environmental factors such as stress.

### **Early life experience and depression**

• **Early experiences** - Events such as the death of a parent, abandonment or rejection, neglect, chronic illness, and physical, psychological, or sexual abuse can also increase the likelihood of depression later in life. Post-traumatic stress disorder (PTSD) includes depression as one of its major symptoms.

### **Clinical depression and life events**

• **Recent life event** - Job loss, financial difficulties, long periods of unemployment, the loss of a spouse or other family member, divorce or the end of a committed relationship, or other traumatic events may trigger depression. Long-term stress at home, work, or school can also be involved.

### **Personality and depression**

• **Personality variables** - Long standing patterns of thinking, feeling and behaviour that are related or contribute to personality have been linked as causes of depression

Environmental factors

### **Family relationships and depression**

• **Family relationships** - Those living with someone suffering from depression experience increased anxiety and life disruption, increasing the possibility of also becoming depressed.

### **Seasonal affective disorder**

• Seasonal affective disorder (SAD) is a type of depressive disorder that occurs in the winter when daylight hours are short. It is believed that the body's production of melatonin, which is produced at higher levels in the dark, plays a major part in the onset of SAD and that many sufferers respond well to bright light therapy, also known as phototherapy.

### **The social context of depression**

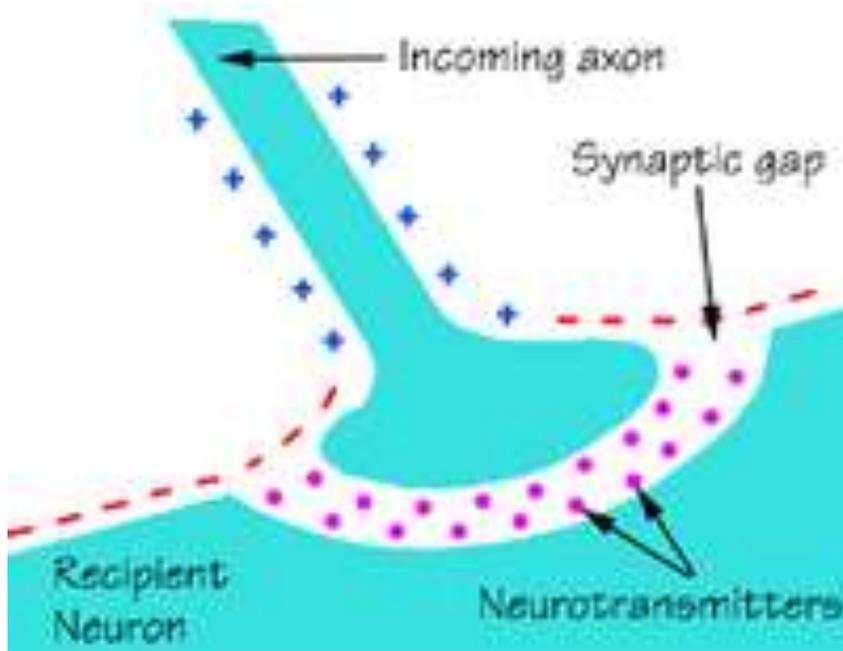
• **Social environment** - Factors such as poverty, unemployment, chronic stress at work have been suggested as causes of depression

Biological causes

### **Genetic factors in depression**

• **Heredity** - The tendency to develop depression may be inherited; there is some evidence that this disorder may run in families. A 2004 press release from the National Institute of Mental Health declares "major depression is thought to be 40-70 percent heritable, but likely involves an interaction of several genes with environmental events."

events."



Brain chemicals called neurotransmitters allow electrical signals to move from the axon of one nerve cell to the neuron of another. A shortage of neurotransmitters impairs brain communication.

### **Neurochemistry of depression**

- **Neurochemical** There may be changes or imbalances in chemicals that transmit information in the brain, called neurotransmitters. Many modern antidepressant drugs attempt to increase levels of certain neurotransmitters, such as serotonin and norepinephrine. Although the causal relationship is unclear, it is known that antidepressant medications can relieve certain symptoms of depression, although critics point out that the relationship between serotonin, SSRIs, and depression usually is typically greatly oversimplified when presented to the public (see [here](#)).

### **Neuroanatomy of depression**

- **Neuroanatomy** Recent research has suggested that there may be a link between depression and neurogenesis of the hippocampus.

## Endocrinology of depression

- **Hormonal factors** The levels of hormones, the chemical messengers in the body that help regulate metabolism, have been linked to depression
- **Postpartum depression** (also known as *postnatal depression*) – Dr. Ruta M Nonacs writes that while many women experience some mood changes after giving birth, "10-15% of women experience a more disabling and persistent form of mood disturbance (eg, postpartum depression, postpartum psychosis). When it occurs, the onset typically is within three months after delivery, and it may last for several months. About two new mothers out of a thousand experience the more serious depressive disorder Postnatal Psychosis which includes hallucinations and/or delusions.
- **Medical conditions** – Certain illnesses, including cardiovascular disease: hepatitis, mononucleosis, hypothyroidism, and organic brain damage caused by degenerative conditions such as Parkinson disease or by traumatic blunt force injury may contribute to depression, as may certain prescription drugs such as birth control pills and steroids. Gender dysphoria can also cause depression.

## Depression and physical illness

### Nutrition and depression

- **Nutrition** – The increase in depression in industrialised societies has been linked to diet, particularly to reduced levels of omega-3 fatty acids in intensively farmed food and processed foods. This link has been at least partly validated by studies using dietary supplements in schools] and by a double-blind test in a prison. An excess of omega-6 fatty acids in the diet was shown to cause depression in rats

### Drug abuse and depression

- **Alcohol and other drugs** – Alcohol can have a negative effect on mood, and misuse of alcohol, benzodiazepine-based tranquilizers, and sleeping medications can all play a major role in the length and severity of depression. The link between frequent cannabis use and depression is also widely documented, although the direction of causality remains in question; Dr. Salynn Boyles writes, "...research has linked pot smoking with depression and schizophrenia ... daily use [of marijuana] was associated with a five-fold increase in later depression and anxiety among young women. But depression and anxiety were not predictive of later marijuana use."

## Adolescent Mental Health

Adolescence is a critical and formative period in which individuals begin their transition from childhood to adulthood. Ensuring that adolescents are fully supported in all facets of life, including their mental health and well-being, is critical for fostering this transition and laying the foundation for healthy and productive adulthoods.

Mental health conditions constitute a major burden of disease for adolescents globally. In 2019, it was estimated that one in seven adolescents experience mental disorders. This amounts to an estimated 166 million adolescents (89 million boys and 77 million girls) boys and girls globally.

About 20 percent of teens will experience teen depression before they reach adulthood.

- Between 10 to 15 percent of teenagers have some symptoms of teen depression at any one time.
- About 5 percent of teens are suffering from major depression at any one time
- As many as 8.3 percent of teens suffer from depression for at least a year at a time, compared to about 5.3 percent of the general population.
- Most teens with depression will suffer from more than one episode. 20 to 40 percent will have more than one episode within two years, and 70 percent will have more than one episode before adulthood. Episodes of teen depression generally last about 8 months.
- Dysthymia, a type of mild, long-lasting depression, affects about 2 percent of teens, and about the same percentage of teens develop bipolar disorder in their late teenage years. 15 percent of teens with depression eventually develop bipolar disorder.
- A small percent of teens also suffer from seasonal depression, usually during the winter months in higher latitudes.

Teen depression can affect a teen regardless of gender, social background, income level, race, or school or other achievements, though teenage girls report suffering from depression more often than teenage boys. Teenage boys are less likely to seek help or recognize that they suffer from depression, probably due to different social expectations for boys and girls – girls are encouraged to express their feelings while boys are not. Teenage girls' somewhat stronger dependence on social ties, however, can increase the chances of teen depression being triggered by social factors, such as loss of friends.

### **Other risk factors that increase the chances of an episode of teen depression include:**

- Previous episodes of depression
- Experiencing trauma, abuse, or a long-term illness or disability

- A family history of depression; between 20 to 50 percent of teens who suffer from depression have a family member with depression or other mental disorders
- Other untreated problems; about two thirds of teens with major depression also suffer from another mental disorder, such as dysthymia, addiction to drugs or alcohol, anxiety, or antisocial behaviours

### **A teen suffering from depression is also at higher risk for other problems:**

- 30 percent of teens with depression also develop a substance abuse problem.
- Teenagers with depression are likely to have a smaller social circle and take advantage of fewer opportunities for education or careers.
- Depressed teens are more likely to have trouble at school and in jobs, and to struggle with relationships.
- Teens with untreated depression are more likely to engage in risky sexual behaviors, leading to higher rates of pregnancy and sexually transmitted diseases.
- Teens with depression seem to catch physical illnesses more often than other teens.
- Untreated depression is the number one cause of suicide, the third leading cause of death among teenagers. 90 percent of suicide victims suffer from a mental illness, and suffering from depression can make a teenager as much as 12 times more likely to attempt suicide.

Less than 33 percent of teens with depression get help, yet 80 percent of teens with depression can be successfully treated if they seek help from a doctor or therapist, and many local health clinics offer free or discounted treatment for teens with depression.

### **Treatment Strategies for Depression**

#### **Cognitive-Behavioral Therapy (CBT)**

Cognitive-behavioral therapy targets current problems and symptoms and focuses on recognizing the relationship between behaviors, thoughts, and feelings and changing patterns that reduce pleasure and interfere with a person's ability to function at his/her best.

#### **Introduction to CBT**

CBT is a psychotherapy treatment that focuses on how thoughts, feelings and behaviors are intertwined in everyday functioning and how changes in any one domain can lead to improvement in the others. For example, altering a person's unhelpful thinking can lead to healthier behavior and improved emotion regulation. CBT targets current problems and symptoms and is typically delivered over six to 16 weekly sessions. CBT is recommended for the treatment of depression in adolescents.

## Using CBT to treat depression in adolescents

Treatment begins with the therapist educating the adolescent, often with his/her parent/guardian, on how thoughts, feelings and behaviors interact with one another. The therapist explains that there are ways the adolescent can modify his/her thinking and behavioral patterns that would benefit him/her emotionally and behaviorally.

Therapists might then ask the adolescent to complete a “mood diary” outside of session, in which he/she will note the situation that triggered the thoughts that then influenced the way they felt and behaved in that situation. For example, a teen who does poorly on an exam [**situation**] and jumps to the conclusion “I will flunk out of school” [**automatic thought**] might then withdraw socially due to perceiving himself as a failure [**behavior**] and end up sad and depressed [**feeling**]. The teen works with the therapist to identify common themes in the diary to begin to identify and address the unhelpful thinking and behavior patterns.

As common themes are identified, the adolescent will be encouraged to apply the behavioral component of CBT by identifying activities that he/she used to enjoy (like playing basketball or hanging out with friends) and then incorporate these into a schedule of pleasant activities (e.g., “When I feel sad or stressed, I will play basketball or hang out with my friend”). Homework is often assigned and encouraged to fully develop new skills and increase confidence in working through stressful situations.

### Interpersonal Psychotherapy for Adolescents (IPT-A)

Interpersonal psychotherapy for adolescents focuses on improving problematic relationships and circumstances that are most closely linked to the current depressive episode.

### Introduction to IPT-A

IPT-A aims to improve the person’s relationships with others by learning strategies to effectively communicate emotions and needs as well as problem-solve within a significant relationship. Therapists using IPT-A emphasize a biopsychosocial explanation of depression, which holds that negative or distressing events people experience can exacerbate feelings of sadness and worthlessness, both common symptoms of depression. As relationships with others improve, the depressive symptoms may subside, and the person will hopefully experience improved functioning in multiple areas of his/her life. On average, adolescents receive 12 to 16 weekly sessions of IPT-A.

IPT-A is recommended for the treatment of depression in adolescents.

### How IPT-A can help treat depression in adolescents

IPT-A focuses on four problem areas that are intrinsic to the original model of IPT for adults:

- **Grief** (e.g., mourning the death of a friend or loved one).
- **Interpersonal role disputes** (e.g., conflict in significant relationships including parents, siblings or friends).

- **Role transitions** (e.g., both expected and unexpected changes such as geographic moves, developmental changes, parental divorce, new school).
- **Interpersonal deficits** (e.g., social isolation).
- IPT-A helps adolescents improve their communication and problem-solving skills so that they will be better at interacting during normal and stressful situations with a friend, relative, teacher or any other relationship. Through psychoeducation and practice, the adolescent gains social confidence. As interpersonal functioning improves, the depressive symptoms will hopefully subside.

### **Using IPT-A to treat depression in adolescents**

Treatment begins with a comprehensive evaluation of the adolescent's social, emotional and academic functioning. The therapist educates both the adolescent and his/her parent/guardian on the theory of IPT. Then, the therapist works with the adolescent on defining his/her close relationships and the quality of those attachments by creating a "closeness circle." This detailed review of significant relationships helps the therapist identify which relationship(s) may be contributing to or maintaining the adolescent's current mood.

In the middle stages of treatment, the therapist and adolescent identify strategies to improve the relationships that will hopefully lead to a reduction in his/her depressive symptoms. This is done through role-playing, affect labeling (e.g., identifying and naming how the adolescent felt when his/her friend said X), effective communication strategies for difficult situations/relationships (e.g., using "I statements"), problem-solving strategies and creating interpersonal experiments for the adolescent to practice the skills outside of the session. The therapist also prepares the adolescent and his/her parent/guardian for the possibility of future depressive episodes by discussing how these strategies may be helpful in upcoming situations, reviewing the warning signs of depression so the adolescent can return to treatment sooner if needed, and offering additional "booster sessions" to prevent relapse or recurrence of depression.

### **Psychodynamic therapy**

Psychodynamic therapists encourage the individual to freely explore his/her current mood and thinking to begin to recognize patterns of behavior and unexpressed feelings. The therapeutic relationship is often used to identify the individual's common verbal and nonverbal patterns and nuances that negatively impact his/her other important relationships as well as view of self. The individual can apply lessons learned in the therapeutic relationship to issues he/she is currently experiencing in his/her personal relationships. Adults generally receive three to 80 weekly sessions of psychodynamic therapy, although the studies the APA guideline development panel reviewed consisted of short-term psychodynamic therapies.

Psychodynamic therapy is recommended for the treatment of depression in adults.

### **Medications**

Medication is often prescribed for the treatment of depression in adults. As each patient varies in his/her response and ability to tolerate a specific medication and dosage, medications must be tailored to the individual.

- Second-generation antidepressants (selective serotonin reuptake inhibitors — SSRIs, serotonin-norepinephrine reuptake inhibitors — SNRIs or norepinephrine/dopamine reuptake inhibitors — NDRI) are recommended but the evidence base is insufficient for recommending any specific medication over another.

The following are common dosage ranges of SSRIs, SNRIs and NDRI for adults with depression. Shared decision-making between the provider and patient is recommended as individual patients may have different responses to the medications or be concerned about different side effect profiles.

- bupropion (Wellbutrin): 150-450 mg once daily
- citalopram (Celexa): 20-40 mg daily
- desvenlafaxine (Pristiq): 50 mg daily
- duloxetine (Cymbalta): 40-60 mg 1-2 times daily
- escitalopram (Lexapro): 10-20 mg daily
- fluoxetine (Prozac): 10-80 mg daily
- fluvoxamine (Luvox): 50-300 mg daily
- levomilnacipran (Fetzima): 40-120 mg daily
- mirtazapine (Remeron): 15-45 mg daily

## CHAPTER-II REVIEW OF LITERATURE

- Furr et al, are suicidal thoughts and depression increasing or decreasing among college students? What life circumstances are the most critical to explore with depressed or suicidal college students? This article focuses on the rate of self-assessed depression and suicide among college students and examines contributing factors and help-seeking behaviour. Results of the study indicated that 53% of the sample stated that they experienced depression since beginning college, with 9% reporting that they had considered committing suicide since beginning college. Suggestions for college mental health practitioners related to programming, prevention, and psychoeducation are described.
- Hokanson et al, Depressed college students were compared with other-psychopathology and normal controls regarding the relationship they developed with dormitory roommates during a 9-month period. Diagnostic status was periodically assessed via SADS interviews, thus also permitting identification of new cases of depression during the year. Psychosocial characteristics found to be uniquely associated with current depression were: (a) low social contact with roommates, (b) low enjoyability of these contacts, and (c) high life-event stress. Roommates of depressives reported low enjoyability of the relationship and high levels of aggressive behaviour

towards the depressive. No features were found to be uniquely associated with new cases before they became depressed; however, several antecedents of general psychopathology were identified.

- **Sarah Naushad et al**, Onset of depression is occurring earlier in life today than in past decades. Adolescence being transitional period from childhood to adulthood is a stage of emotional instability resulting from demand for separation and independence. Evidence suggests that early intervention for depression in children can improve long-term outcomes. This cross-sectional study was done in January 2010 to find out the prevalence of depression among pre university students in Mangalore city. Prevalence of depression was assessed using Beck's Depression Inventory II. Data was collected using a self-administered questionnaire. Out of 308 participants, depression was seen among 79.2% students. A majority (41.2%) were found to be suffering from moderate followed by mild (26.6%) depression. Prevalence of depression ( $P = 0.027$ ) and severity of depression ( $P = 0.0357$ ) was found to significantly increase with age of the participants. Students of commerce were found to be significantly more depressed than students of science stream ( $P = 0.002$ ). No association of depression with gender of participants or with the type of college they were studying in was observed. There is a need for college students to be educated about depression in order to improve recognition and diagnosis.

- **M Ashraf Islam et al**, Depression is a recurrent mental health problem among younger demographics, and university students are particularly susceptible owing to stress, workload and independent living, amongst other factors. This study explores the prevalence of depression and the factors influencing depression among university students in Malaysia. This cross-sectional study involved 1,023 university students (response rate 90.4%). Depression was assessed using the Centre for Epidemiological Studies Short Depression Scale (CESD -10). Binary logistic regression was used to determine predictors of depression based on sociodemographic, physiological, lifestyle, and health characteristics. Approximately 30% of respondents experienced depression, and 4.4% of this category suffered severe depression. This study demonstrates that instances of depression were 2.52 times higher (95% CI: 1.71-3.71) in second year students compared to first year students, and 1.63 times higher (95% CI: 1.08-2.45) in students staying outside campus compared to students staying inside campus. Students from poor, not well-off, and quite well-off family background had 15.26 (95% CI: 2.77-84.88), 4.85 (95% CI: 1.01-23.34) and 5.62 times (95% CI: 1.16-27.25) higher chance for depression than wealthier students respectively. Students with mild, moderate, and severe sleeping problems were 2.50 times (95% CI: 1.61-3.88), 3.34 times (95% CI: 2.18-5.11), and 3.66 times (95% CI: 1.93-6.94) more likely to be depressed than those without sleeping problem, respectively. Students with post-traumatic stress disorder (PTSD) were 1.42 times higher (95% CI: 1.07-2.56) to suffer from depression. This study concludes that higher education institutions need to pay special attention to the mental health of those students especially those in their second year, living off campus, from lower economic backgrounds, with sleeping problem, or suffering PTSD.

• Enrique Ramon- Arbeus et al, To estimate the prevalence of symptoms of depression, anxiety, stress and associated factors in a population of college students. Method: Cross-sectional study of psychological distress measured through the Depression, Anxiety and Stress Scale (DASS-21) in a sample of 1074 college students. Results: We found a moderate prevalence of depression (18.4%), anxiety (23.6%) and stress (34.5%) symptoms in our study population. Being <21, having problematic Internet use behavior, smoking, presenting insomnia and having a low self-esteem were independently associated with symptoms of depression, anxiety and stress. Being a woman, living with their family, having a stable partner, consuming alcohol frequently and having poor nutritional habits were significantly associated with symptoms of stress; lacking a stable partner was significantly associated with depressive symptoms; and frequent consumption of alcohol was significantly associated with symptoms of anxiety. Conclusion: We found a moderate prevalence of depression, anxiety and stress symptoms in our population. Interventions aimed at promoting mental health among college students should be implemented.

• Ye yuan et al, The present study hypothesized that loneliness and interpersonal trust mediate the relationship between depression and social anxiety, with self-esteem playing a moderating role. 1,021 college students completed the interpersonal trust scale (ITS), self-rating depression scale (SDS), UCLA loneliness scale, self-esteem scale (SES), and social avoidance and distress (SAD) scale. And descriptive statistical analysis and correlation analysis, structural equation model analysis were conducted. The results indicated that loneliness and interpersonal trust played mediating roles between depression and social avoidance, and the relationship between interpersonal trust and social avoidance was moderated by self-esteem.

• Jason m nelson et al, This study examined symptoms of anxiety and depression among college students with attention-deficit/hyperactivity disorder (ADHD). Data were collected between March 2011 and March 2016 from 150 college students with ADHD and 150 college students without ADHD. Participants with ADHD were compared to a sex- and ethnicity-matched control group. For the ADHD group, parent and self-report of anxiety and depression were also compared. College students with ADHD self-reported significantly higher anxiety and depressive symptoms than did students without ADHD. Scores on parent-report measures of anxiety and depressive symptoms were significantly higher than scores on self-report measures. Significant sex differences were found for participants with ADHD, with females showing higher depressive and anxiety symptoms than males. Parent-reported anxiety symptoms were higher for those with inattentive type ADHD compared to combined type ADHD.

• Kenneth S. Walters et al, Research on college substance use and mental illness is limited and inconsistent. Measures of substance use, and anxiety and depressive symptoms, were completed by 1,316 undergraduates within a major drug transportation corridor. Hierarchical linear regressions were used to

test associations between anxious and depressive symptoms and substance use (i.e., alcohol, cannabis, tobacco, cocaine, other amphetamines, sedatives, hallucinogens, and designer drugs). Depressive symptoms were associated with use of cannabis, tobacco, amphetamines, cocaine, sedatives, and hallucinogens. Anxiety symptoms were unrelated to substance use. These findings support the need for education and prevention at universities, emphasizing tobacco, cannabis, and certain “harder” drugs

## CHAPTER-III

### METHODOLOGY

**Aim:** The aim of the inventory is to assess the depression among college students using the Beck’s Depression Inventory.

**Hypothesis:**

1. There is no significant difference in the levels of depression among male and female college students.
2. H1: College students experience significant levels of depression due to academic, social, and personal stressors.
3. • H2: Higher academic stress is positively correlated with higher levels of depression among college students.
4. • H3: Students with lower GPA scores are more likely to experience depression compared to those with higher GPAs.
5. H5: Students with low self-esteem are more likely to experience higher levels of depression.
6. H6: College students with poor coping mechanisms exhibit more severe depressive symptoms.
7. H9: Students who report experiencing discrimination or microaggressions have higher depression levels.
8. • H10: Lack of social support is a significant predictor of depression among college students.

Independent Variable: Levels of Depression

Academic stress

- GPA and academic performance
- Course load (number of credits per semester)
- Time management skills

Psychological and emotional variables

- Self-esteem levels
- Anxiety levels
- Resilience and coping mechanisms
- Suicidal thoughts or self-harm tendencies

. Cognitive and Personality Factors

- Rumination and overthinking
- Decision-making skills
- Cognitive flexibility
- Negative automatic thoughts
- Personality traits (e.g., introversion, neuroticism)

Dependent Variable: Male and Female college students.

#### . Depression Severity

- Scores from standardized depression scales (e.g., PHQ-9, Beck Depression Inventory)
- Frequency and intensity of depressive symptoms
- Duration of depressive episodes

#### Lifestyle and Behavioral Changes

- Sleep disturbances (insomnia, hypersomnia)
- Changes in eating habits (overeating, loss of appetite)
- Physical activity levels and sedentary behavior
- Increased or decreased substance use (alcohol, drugs, caffeine)

#### Technology and Digital Behavior Impact

- Social media dependency and comparison effects
- Internet addiction and screen time-related issues

#### **Materials:**

1. Beck's Depression Inventory-1
2. Scoring and norm sheet
3. Writing materials
4. Demographic Detail inventory.

#### **Procedure:**

The subject is seated comfortably and rapport is established. The Instructions are given to the subject followed by the Beck's Depression inventory.

**Instructions:**

Choose one statement from among the group of four statements in each question that describes how you have been feeling during the last 2 weeks.

1. Instructions given should be clear to the subject.
2. Subject is asked to answer all the questions.
3. Subject is asked to choose only one answer per question.

**Scoring:**

The corresponding score of the items checked/circled by the subject is the score of each item. The total score is found by adding up the scores circled/checked by the subject.

The following norms are referred for interpretation:

- \* 1-10- these ups and downs are considered to be normal
- \* 11-16- mild mood disturbances
- \* 17-20- borderline clinical depression
- \* 21-30- moderate depression
- \* 31-40- severe depression
- \* Above 40- extreme depression

**Analysis of Results:**

- \* Individual discussion needs to be made with the help of the norm sheet.

A group table to be interpreted and discussed for the obtained data

**Research Gaps in Levels of Depression Among College Students**

1. Variability in Depression Levels Across Student Subgroups
  - Limited research on how depression levels differ based on factors like academic major, socioeconomic status, and first-generation college students.
  - Insufficient studies on depression disparities between international and domestic students.
2. Longitudinal Studies on Depression Progression
  - Most studies provide cross-sectional data, but long-term studies tracking depression from freshman to senior year are lacking.

- Need for research on how academic stress, financial burden, and social factors contribute to changes in depression levels over time.
3. Impact of COVID-19 and Post-Pandemic Challenges
    - Limited studies on how remote learning, social isolation, and pandemic-related anxiety have affected long-term depression levels.
    - Need for research on how post-pandemic academic and social reintegration impacts mental health.
  4. Effectiveness of College Mental Health Resources
    - Gaps in research on whether university-provided mental health services adequately address varying levels of depression.
    - Need for studies on the barriers (stigma, cost, lack of awareness) that prevent students from seeking mental health support.
  5. Influence of Social Media and Digital Engagement
    - Lack of conclusive research on how excessive social media use influences depression severity among college students.
    - Need for studies on whether digital mental health interventions (e.g., apps, online therapy) effectively reduce depressive symptoms.
  6. Comorbidity with Other Mental Health Issues
    - More research is needed on how depression coexists with anxiety, eating disorders, and substance abuse in college students.
    - Limited understanding of the role of ADHD and learning disabilities in depression among students.
  7. Cultural and Gender Differences in Depression Levels
    - Lack of studies exploring how cultural background influences depression severity and help-seeking behavior.
    - Need for more research on gender differences,

**CHAPTER-IV : RESULTS AND DISCUSSION****Descriptive Statistics****Table 1**

Descriptive Statistics of BDI Scores by Gender

| Gender | N  | Mean  | SD   | Min | Max |
|--------|----|-------|------|-----|-----|
| Male   | 30 | 16.9  | 5.32 | 8   | 28  |
| Female | 30 | 23.23 | 5.60 | 12  | 34  |

Interpretation: Females demonstrated higher mean BDI scores than males

**Severity Distribution****Table 2**

Depression Severity Levels by Gender

| Severity Level     | Male | Female |
|--------------------|------|--------|
| Normal (0–10)      | 5    | 2      |
| Mild (11–16)       | 8    | 4      |
| Borderline (17–20) | 7    | 5      |
| Moderate (21–30)   | 9    | 14     |
| Severe (31–40)     | 1    | 5      |
| Extreme (>40)      | 0    | 0      |

Interpretation: Females were more likely to be in the moderate to severe range.

**Independent Samples t-Test**

**Table 3**

Independent Samples t-Test for Gender Difference in BDI Scores

| Variable       | t     | df | p-value | Cohen's d |
|----------------|-------|----|---------|-----------|
| Male vs Female | -4.52 | 58 | <0.001  | 1.12      |

Interpretation: Females scored significantly higher than males ( $p < .001$ ).

### Correlation Analysis

Table 4

Correlations Between Depression and Associated Variable

| Variable          | r     | p-value |
|-------------------|-------|---------|
| Academic Stress   | 0.45  | <0.01   |
| Self-esteem       | -0.40 | <0.01   |
| Coping Mechanisms | 0.30  | <0.05   |

Interpretation: Academic stress positively correlated with depression; self-esteem negatively correlated.

## DISCUSSION

The findings of this study reveal significant gender-based differences in depression levels among college students. Female participants reported higher mean BDI scores ( $M = 23.23$ ,  $SD = 5.60$ ) compared to their male counterparts ( $M = 16.9$ ,  $SD = 5.32$ ). The independent samples t-test further confirmed that this difference was statistically significant ( $t(58) = -4.52$ ,  $p < .001$ ), with a large effect size (Cohen's  $d = 1.12$ ), indicating that the disparity was not only statistically significant but also practically meaningful.

The higher prevalence of depression in females is consistent with existing literature, which often attributes this difference to multiple factors including hormonal fluctuations, increased vulnerability to psychosocial

stressors, and societal expectations related to gender roles. Additionally, academic stress emerged as a significant predictor of depression ( $r = 0.45$ ,  $p < .01$ ), reflecting the pressures associated with competitive academic environments. Self-esteem showed a significant negative correlation ( $r = -0.40$ ,  $p < .01$ ), highlighting its protective role against depressive symptoms. Students with higher self-esteem tended to experience lower levels of depression, which underscores the importance of self-concept enhancement in mental health promotion.

Coping mechanisms exhibited a weak but statistically significant positive correlation ( $r = 0.30$ ,  $p < .05$ ), suggesting that maladaptive coping strategies may exacerbate depressive symptoms, whereas adaptive strategies could mitigate them. This finding aligns with prior studies suggesting that students employing avoidance-based coping mechanisms tend to report higher levels of psychological distress.

The discussion also acknowledges the sociocultural context in which female students may face additional pressures such as balancing academic demands with societal expectations, which could contribute to their heightened vulnerability. Furthermore, the findings call attention to the role of institutional support systems in addressing gender disparities in mental health.

## CONCLUSION

The present study investigated the prevalence and severity of depression among male and female college students using the Beck Depression Inventory (BDI) and explored the role of associated factors such as academic stress, self-esteem, and coping mechanisms. Depression among college students has become a growing concern due to increasing academic demands, socio-cultural pressures, and transitional life challenges characteristic of late adolescence and early adulthood. By focusing on a sample of 30 male and 30 female students aged 18–25 years, this research sought to highlight gender differences in depression and identify potential predictors to inform preventive and interventional strategies.

The results of this study revealed a significant gender-based disparity in depression levels. Female students reported higher mean depression scores ( $M = 23.23$ ,  $SD = 5.60$ ) compared to male students ( $M = 16.9$ ,  $SD = 5.32$ ). The independent samples t-test confirmed that this difference was statistically significant ( $t(58) = -4.52$ ,  $p < .001$ ) with a large effect size (Cohen's  $d = 1.12$ ), indicating a substantial practical difference. Furthermore, the severity distribution revealed that females were more likely to experience moderate to severe depression, whereas males were predominantly in the normal to mild range. This aligns with prior research that indicates

females tend to report higher depressive symptoms due to a complex interplay of biological factors (e.g., hormonal fluctuations), psychological vulnerabilities (e.g., ruminative coping styles), and sociocultural pressures (e.g., gender role expectations, emotional expressiveness, and societal stigma regarding help-seeking behaviors).

The correlation analysis provided valuable insights into the contributing factors. Academic stress demonstrated a strong positive correlation ( $r = 0.45$ ,  $p < .01$ ) with depression levels, reinforcing the notion that competitive academic environments, excessive workload, and performance-related pressures significantly influence students' mental health. Self-esteem exhibited a negative correlation ( $r = -0.40$ ,  $p < .01$ ), underscoring its protective role against depression. Students with higher self-esteem demonstrated greater resilience and emotional stability, which acted as a buffer against depressive symptoms. Coping mechanisms showed a weak but significant positive correlation ( $r = 0.30$ ,  $p < .05$ ), indicating that maladaptive coping (e.g., avoidance, withdrawal, substance use) may exacerbate depression, whereas adaptive coping (e.g., problem-solving, emotional regulation) could mitigate it.

## **CHAPTER-V SUMMARY, IMPIICATIONS AND RECOMMENDATION, AND LIMITATIONS**

### **IMPLICATIONS OF STUDY**

This research offers several critical implications for mental health interventions and policy development within higher education institutions:

1. **Gender-Sensitive Mental Health Interventions:** The observed gender differences suggest a pressing need for interventions that address the unique psychological and sociocultural challenges faced by female students. Programs that target emotional resilience, self-esteem enhancement, and gender-based stressors may reduce the risk of depression.

2. **Academic Policy Reforms:** Institutions should consider strategies to alleviate academic stress, including flexible deadlines, improved student-teacher communication, mentorship programs, and stress management workshops. Academic policies that balance performance expectations with mental health needs can promote overall well-being.

3. **Early Screening and Prevention:** Routine mental health screening using tools like the BDI could facilitate early detection of depression, particularly among high-risk groups. Preventive counseling sessions and awareness campaigns can encourage students to seek timely help.

4. **Promotion of Adaptive Coping Mechanisms:** Training students in adaptive coping strategies such as mindfulness, cognitive restructuring, and problem-solving skills can empower them to manage stress more effectively and reduce reliance on maladaptive behaviors.

5. **Integration of Mental Health Services in Campus Life:** Establishing easily accessible, confidential, and stigma-free counseling services within colleges can help bridge the gap between mental health needs and service utilization.

## LIMITATIONS

While the study provides valuable insights, several limitations should be acknowledged:

- **Sample Size and Scope:** The study involved only 60 students from a single institution, limiting generalizability across diverse cultural, geographical, and institutional contexts.
- **Cross-Sectional Design:** The study captures a snapshot of depression levels at one point in time and does not establish causal relationships between depression and associated variables.
- **Self-Reported Data:** The reliance on self-administered questionnaires may be prone to response bias, social desirability bias, or underreporting of symptoms.
- **Limited Variables:** Although key factors such as academic stress, self-esteem, and coping were examined, other potentially influential variables (e.g., family history, trauma exposure, sleep quality, and digital behavior) were not extensively analyzed.

## FUTURE SCOPE OF RESEARCH

Future studies can build upon the findings of this research through:

1. **Longitudinal Studies:** Tracking depression levels over time to establish causal pathways between academic pressures, psychological factors, and depression progression.
2. **Larger and Diverse Samples:** Conducting multi-institutional research across different regions and cultural contexts to enhance generalizability.

3. **Qualitative Approaches:** Including in-depth interviews or focus groups to explore students' lived experiences, barriers to help-seeking, and subjective perceptions of depression.
4. **Evaluation of Intervention Programs:** Testing the effectiveness of gender-specific and resilience-based intervention programs in reducing depression prevalence.
5. **Exploration of Digital Behavior:** Investigating the influence of social media use, internet addiction, and online peer support on depression among students in the post-pandemic era.

## CONCLUDING REMARKS

This study underscores the growing mental health burden among college students, with a marked gender disparity favoring higher vulnerability among females. Academic stress, low self-esteem, and maladaptive coping strategies emerged as key contributors, highlighting the multifactorial nature of depression in this population. The findings call for immediate attention from educational institutions, policymakers, and mental health practitioners to create inclusive, supportive, and preventive mental health ecosystems. By integrating gender-sensitive approaches, fostering resilience, and providing accessible counseling services, colleges can play a pivotal role in mitigating depression and promoting holistic well-being among students.

## RECOMMENDATIONS

1. **Gender-sensitive mental health programs:** Develop workshops, peer support groups, and counseling services tailored to address the unique challenges faced by female students.
2. **Stress management and resilience training:** Introduce structured programs focusing on time management, mindfulness, and relaxation techniques to help students cope with academic pressures.
3. **Self-esteem enhancement initiatives:** Provide interventions aimed at improving students' self-worth through mentorship programs, positive feedback systems, and self-development workshops.
4. **Routine depression screening:** Incorporate the Beck Depression Inventory or similar tools in annual health check-ups for students to enable early identification and intervention.
5. **Promotion of adaptive coping strategies:** Facilitate training in problem-solving, emotional regulation, and healthy social engagement to prevent maladaptive coping.

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**ANNEXURE****QUESTIONNAIRE****Beck's Depression Inventory**

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire. 1.

- 0 I do not feel sad.  
1 I feel sad  
2 I am sad all the time and I can't snap out of it.  
3 I am so sad and unhappy that I can't stand it.
- 2.
- 0 I am not particularly discouraged about the future.  
1 I feel discouraged about the future.  
2 I feel I have nothing to look forward to.  
3 I feel the future is hopeless and that things cannot improve.
- 3.
- 0 I do not feel like a failure.  
1 I feel I have failed more than the average person.  
2 As I look back on my life, all I can see is a lot of failures.  
3 I feel I am a complete failure as a person.
- 4.
- 0 I get as much satisfaction out of things as I used to.  
1 I don't enjoy things the way I used to.  
2 I don't get real satisfaction out of anything anymore.  
3 I am dissatisfied or bored with everything.
- 5.
- 0 I don't feel particularly guilty  
1 I feel guilty a good part of the time.  
2 I feel quite guilty most of the time.  
3 I feel guilty all of the time.
- 6.
- 0 I don't feel I am being punished.  
1 I feel I may be punished.  
2 I expect to be punished.  
3 I feel I am being punished.
- 7.
- 0 I don't feel disappointed in myself.  
1 I am disappointed in myself.  
2 I am disgusted with myself.  
3 I hate myself.
- 8.
- 0 I don't feel I am any worse than anybody else.  
1 I am critical of myself for my weaknesses or mistakes.  
2 I blame myself all the time for my faults.  
3 I blame myself for everything bad that happens.

- 9.
- 0 I don't have any thoughts of killing myself.
  - 1 I have thoughts of killing myself, but I would not carry them out.
  - 2 I would like to kill myself.
  - 3 I would kill myself if I had the chance.
- 10.
- 0 I don't cry any more than usual.
  - 1 I cry more now than I used to.
  - 2 I cry all the time now.
  - 3 I used to be able to cry, but now I can't cry even though I want to.
- 11.
- 0 I am no more irritated by things than I ever was.
  - 1 I am slightly more irritated now than usual.
  - 2 I am quite annoyed or irritated a good deal of the time.
  - 3 I feel irritated all the time.
- 12.
- 0 I have not lost interest in other people.
  - 1 I am less interested in other people than I used to be.
  - 2 I have lost most of my interest in other people.
  - 3 I have lost all of my interest in other people.
- 13.
- 0 I make decisions about as well as I ever could.
  - 1 I put off making decisions more than I used to.
  - 2 I have greater difficulty in making decisions more than I used to.
  - 3 I can't make decisions at all anymore.
- 14.
- 0 I don't feel that I look any worse than I used to.
  - 1 I am worried that I am looking old or unattractive.
  - 2 I feel there are permanent changes in my appearance that make me look unattractive
  - 3 I believe that I look ugly.
- 15.
- 0 I can work about as well as before.
  - 1 It takes an extra effort to get started at doing something.
  - 2 I have to push myself very hard to do anything.
  - 3 I can't do any work at all.
- 16.
- 0 I can sleep as well as usual.
  - 1 I don't sleep as well as I used to.
  - 2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
  - 3 I wake up several hours earlier than I used to and cannot get back to sleep.

17.

- 0 I don't get more tired than usual.
- 1 I get tired more easily than I used to.
- 2 I get tired from doing almost anything.
- 3 I am too tired to do anything.

18.

- 0 My appetite is no worse than usual.
- 1 My appetite is not as good as it used to be.
- 2 My appetite is much worse now.
- 3 I have no appetite at all anymore.

19.

- 0 I haven't lost much weight, if any, lately.
- 1 I have lost more than five pounds.
- 2 I have lost more than ten pounds.
- 3 I have lost more than fifteen pounds.

20.

- 0 I am no more worried about my health than usual.
- 1 I am worried about physical problems like aches, pains, upset stomach, or constipation.
- 2 I am very worried about physical problems and it's hard to think of much else.
- 3 I am so worried about my physical problems that I cannot think of anything else.

21.

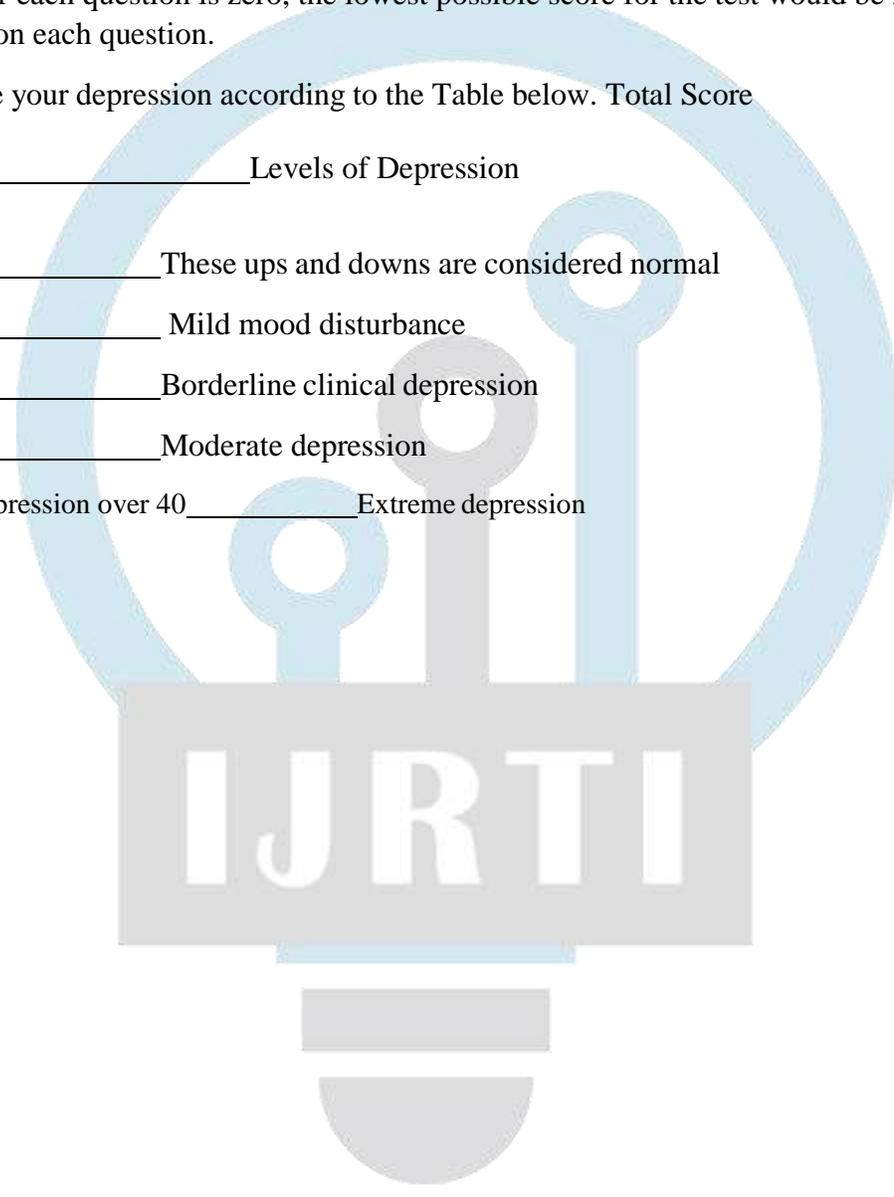
- 0 I have not noticed any recent change in my interest in sex.
- 1 I am less interested in sex than I used to be.
- 2 I have almost no interest in sex.
- 3 I have lost interest in sex completely.

**INTERPRETING THE BECK DEPRESSION INVENTORY**

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question.

You can evaluate your depression according to the Table below. Total Score

| _____ Levels of Depression |  |
|----------------------------|--|
| 1-10 _____                 | These ups and downs are considered normal          |
| 11-16 _____                | Mild mood disturbance                              |
| 17-20 _____                | Borderline clinical depression                     |
| 21-30 _____                | Moderate depression                                |
| 31-40 _____                | Severe depression over 40 _____ Extreme depression |



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