A STUDY ON DEPRESSION AND ANXIETY AMONG HATIM COLLEGE STUDENTS
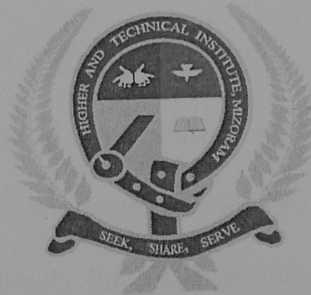
Submitted by:

Jeremy C. Lalfakzuala

Roll no: 2123BA023

Under the supervision of

Lalvenhimi Ralte

Department of Psychology

Higher and Technical Institute, Mizoram

Kawmzawl, Lunglei-796691

DEPARTMENT OF PSYCHOLOGY

HIGHER AND TECHNICAL INSTITUTE, MIZORAM KAWMZAWL, LUNGLEI - 796691

CERTIFICATE

This is to certify that the present piece of research titled 'a study on depression and anxiety among HATIM college students" is a bonafide research conducted by Jeremy C. Lalfakzuala under my supervision He worked methodologically for his dissertation for the Under Graduate Degree in Psychology of Higher and Technical Institute Mizoram, Mizoram University.

This is to further certify that the research conducted by Jeremy C. Lalfakzuala has not been submitted in support of an application to this or any other college or Institution of learning.
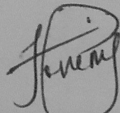
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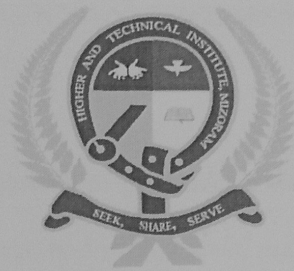
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DEPARTMENT OF PSYCHOLOGY

HIGHER AND TECHNICAL INSTITUTE, MIZORAM KAWMZAWL, LUNGLEI –

796691

DECLARATION

I, Jeremy C. Lalfakzuala, hereby declare that the subject matter of this dissertation is the record of work done by me, that the contents of this dissertation did not form basis for the award of any previous degree to me or to the best of my knowledge to anybody else, and that the dissertation had not been submitted by me for any research degree in any other university or institute.

This is submitted to Higher and Technical Institute, Mizoram, for the undergraduate degree in Psychology.
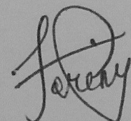
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ACKNOWLEDGEMENT

ABSTRACT

The purpose of this study was to determine whether there is a gender difference in the levels of anxiety and depression among HATIM college students, as well as the relation between the two variables. A total of 296 college students participated in the study (male=143, female=153). It was found that there is a significant relationship between anxiety and depression as well as a mean difference in the levels of anxiety and depression between male and female students.

KEY WORD :College Students,Gender,Anxiety,Depression

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CHAPTER I

INTRODUCTION

College Students.

A college student is an individual who is enrolled in a university on college to a particular course. Typically, the age range of college student is 18-25 (young adult). The college student learns various things during the college days like, discipline, better ways of communication, preparing project reports, hosting gests, etc.

Prevalence

Anxiety disorders are the most prevalent psychiatric problems among college students, with approximately 11.9 % of college students suffering from an anxiety disorder (Arch Gen Psychiatry. 2008). Among the anxiety disorders, social phobia has an early age of onset (median age of onset between 7– 14 years), while panic disorder, generalized anxiety disorders (GAD), and post-traumatic stress disorder (PTSD) have somewhat later onsets. (Arch Gen Psychiatry.2005). Giaconia et al. found that in a community sample of adolescents the peak risk period for developing PTSD was between the ages of 16to 17 years, with approximately one third of the sample developing the disorder by the age of 14 years (J Am Cad Child Adoles Psychiatry.1994).

Another common mental health problem among college students is depression, with prevalence rates incollege students of 7 to 9 % (J Nerv Ment Dis. 2013). Zisook et al. found that over half of all cases of depression had a first onset during childhood, adolescence, or young adulthood (Am J Psychiatry. 2007).

Anxiety

Anxiety is a negative mood state characterized by bodily symptoms of physical tension and by apprehension about the future (American Psychiatric Association, 2013; Barlow, 2002). In humans it can be a subjective sense of unease, a set of behaviors (looking worried and anxious or fidgeting), or a physiological response originating in the brain and reflected in elevated heart rate and muscle tension. Because anxiety is difficult to study in humans, much of the research has been done with animals.

American Psychological Association defined anxiety as "Anxiety is an emotion characterized by feelings of tension, worried thoughts, and physical changes like increased blood pressure.

Psychologist and researcher David Barlow, PhD, defined anxiety as a "future-oriented mood state in which one is ready or prepared to attempt to cope with upcoming negative event

Symptoms of Anxiety

Common anxiety signs and symptoms include:

* Feeling nervous, restless or tense

* Having a sense of impending danger, panic or doom

* Having an increased heart rate

* Breathing rapidly (hyperventilation)

* Sweating

* Trembling

* Feeling weak or tired

* Trouble concentrating or thinking about anything other than the present worry

* Having trouble sleeping

* Experiencing gastrointestinal (GI) problems

* Having difficulty controlling worry

* Having the urge to avoid things that trigger anxiety

Causes of Anxiety

Biological Contributions

Increasing evidence shows that we inherit a tendency to be tense, uptight, and anxious (Barlow et al., 2013; Clark, 2005; Eysenck,1967; Gray & McNaughton, 1996). The tendency to panic also seems to run in families and probably has a genetic component that differs somewhat from genetic contributions to anxiety (Barlow,2002; Craske & Barlow, 2013; Kendler et al., 1995). As with almost all emotional traits and psychological disorders, no single gene seems to cause anxiety or panic. Instead, contributions from collections of genes in several areas on chromosomes make us vulnerable when the right psychological and social factors are in place.

Furthermore, a genetic vulnerability does not cause anxiety and/ or panic directly. That is, stress or other factors in the environment can "turn on" these genes, as we reviewed in Chapter 2 (Gelernter & Stein, 2009; Kendler, 2006; Owens et al., 2012; Rutter, Moffitt, & Caspian, 2006; Smoller, Block, & Young,2009). Anxiety is also associated with specific brain circuits and neurotransmitter systems. For example,

depleted levels of gamma-aminobutyric acid (GABA), part of the GABA-benzodiazepine sys-tem, are associated with increased anxiety, although the relationship is not quite so direct. The noradrenergic system has also been implicated in anxiety (Hermans et al., 2011), and evidence from basic animal studies, as well as studies of normal anxiety in humans, suggests the serotonergic neurotransmitter system is also involved (Lesch et al., 1996; Maier, 1997; Stein, Schork, & Gelernter, 2007).

Psychological causes of anxiety

Behavioral theorists thought anxiety was the product of early classical conditioning, modeling, or other forms of learning (Bandura, 1986). But, new and accumulating evidence supports an integrated model of anxiety involving a variety of psychological factors (see, for example, Barlow, 2002; Suárez, Bennett, Goldstein, & Barlow, 2009). In childhood, we may acquire an awareness that events are not always in our control (Chorpita & Barlow, 1998). The continuum of this perception may range from total confidence in our control of all aspects of our lives to deep uncertainty about ourselves and our ability to deal with upcoming events. If you are anxious about schoolwork, for example, you may worry you will do poorly on the next exam, even though all your grades have been A's and B's. A general "sense of uncontrollability" may develop early as a function of upbringing and other disruptive or traumatic environmental factors. the actions of parents in early childhood seem to do a lot to foster this sense of control or uncontrollability (Barlow et al., 2013; Bowbly, 1980; Chorpita & Barlow, 1998; Gunnar & Fisher, 2006). Generally, it seems that parents who interact in a positive and predictable way with their children by responding to their needs, particularly when the child communicates needs for attention, food, relief from pain, and so on, perform an important function.

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These parents teach their children that they have control over their environment and their responses have an effect on their parents and their environment. In addition, parents who provide a "secure home base" but allow their children to explore their world and develop the necessary skills to cope with unexpected occurrences enable their children to develop a healthy sense of control (Chorpita & Barlow, 1998). In contrast, parents who are overprotective and overintrusive and who "clear the way" for their children, never letting them experience any adversity, create a situation in which children never learn how to cope with adversity when it comes along. Therefore, these children don't learn that they can control their environment. A variety of evidence has accumulated supporting these ideas (Barlow, 2002; Chorpita & Barlow, 1998; Dan, Sagi-Schwartz, Bar-haim, & Eshel, 2011; Gunnar & Fisher, 2006; White, Brown, Somers, & Barlow, 2006). A sense of control (or lack of it) that develops from these early experiences is the psychological factor that makes us more or less vulnerable to anxiety in later life.

Social Contributions

Stressful life events trigger our biological and psychological vulnerabilities to anxiety. Most are social and interpersonal in nature-marriage, divorce, difficulties at work, death of a loved one, pressures to excel in school, and so on. Some might be physical, such as an injury or illness. The same stressors can trigger physical reactions, such as headaches or hypertension, and emotional reactions, such as panic attacks (Barlow, 2002). The particular way we react to stress seems to run in families. If you get headaches when under stress, chances are other people in your family also get headaches. If you have panic attacks, other members of your family probably do also. This finding suggests a possible genetic contribution, at least to initial panic attacks.

Types of anxiety

1. Generalized Anxiety Disorder (GAD): People with anxiety and worry about many different aspects of life (including minor events) becomes chronic, excessive, and unreasonable. In these cases, generalized anxiety disorder (GAD) (formerly known as free-floating anxiety) may be diagnosed. DSM-5 criteria specify that the worry must occur on more days than not for at least 6 months and that it must be experienced as difficult to control (see DSM-5 criteria box).

2. Specific Phobias: A person is diagnosed as having a specific phobia if she or he shows strong and persistent fear that is triggered by the presence of a specific object or situation (see DSM-5 box for diagnostic criteria). When individuals with specific phobias encounter a phobic stimulus, they often show an immediate fear response that often resembles a panic attack except for the existence of a clear external trigger (APA, 2013).

2. Social Phobias: Social phobia (or social anxiety disorder), as the DSM-5 describes it, is characterized by disabling fears of one or more specific social situations (such as public speaking, urinating in a public bathroom, or eating or writing in public). In these situations, a person fears that she or he may be exposed to the scrutiny and potential negative evaluation of others or that she or he may act in an embarrassing or humiliating manner

3. Panic Disorder: Diagnostically, panic disorder is defined and characterized by the occurrence of panic attacks that often seem to come "out of the blue." According to the DSM-5 criteria for panic disorder, the person must have experienced recurrent, unexpected attacks and must have been

persistently concerned about having another attack or worried about the consequences of having an attack for at least a month (often referred to as anticipatory anxiety.

4. <u>Agoraphobia</u>: Historically, agoraphobia was thought to involve a fear of the agora—the Greek word for public places of assembly (Marks,1987). In agoraphobia the most commonly feared and avoided situations include streets and crowded places such as shopping malls, movie theaters, and stores. Standing in line can be particularly difficult.

Depression

Depression is a common mental disorder. It is characterized by persistent sadness and a lack of interest or pleasure in previously rewarding or enjoyable activities. It can also disturb sleep and appetite. Tiredness and poor concentration are common. Depression is a leading cause of disability around the world and contributes greatly to the global burden of disease. The effects of depression can be long-lasting or recurrent and can dramatically affect a person's ability to function and live a rewarding life (WHO)

American Psychiatric association defined Depression as "a common and serious medical illness that negatively affects how you feel, the way you think and how you act."

American Psychological Association defined depression as "extreme sadness or despair that lasts more than days. It interferes with the activities of daily life and can cause physical symptoms such

as pain, weight loss or gain, sleeping pattern disruptions, or lack of energy."

According to Sigmund Freud depression as "mentally characterized by a profoundly painful depression, a loss of interest in the outside world, the loss of the ability to love, the inhibition of any kind of performance and a reduction in the sense of self, expressed in self"

Symptoms

The symptoms of depression can vary slightly depending on the type and can range from mild to severe. In general, symptoms include:

* Feeling very sad, hopeless or worried. Children and adolescents with depression may be irritable rather than sad.

* Not enjoying things that used to bring joy.

* Being easily irritated or frustrated.

* Eating too much or too little, which may result in weight gain or weight loss.

* Trouble sleeping (insomnia) or sleeping too much (hypersomnia).

* Having low energy or fatigue.

* Having a difficult time concentrating,

* making decisions or remembering things.

* Experiencing physical issues like headache, stomachache or sexual dysfunction.

* Having thoughts of self-harm or suicide.

Causes

Depression is probably the most common psychiatric complaint and has been described by physicians since before the time of ancient Greek physician Hippocrates, who called it melancholia. The course of the disorder is extremely variable from person to person; it may be mild or severe, acute or chronic. Untreated, depression may last an average of four months or longer. Depression is twice as prevalent in women than in men. The typical age of onset is in the 20s, but it may occur at any age. Depression can have many causes. Unfavorable life events can increase a person's vulnerability to depression or trigger a depressive episode. Negative thoughts about oneself and the world are also important in producing and maintaining depressive symptoms. However, both psychosocial and biochemical mechanisms seem to be important causes; the chief biochemical cause appears to be the defective regulation of the release of one or more naturally occurring neurotransmitters in the brain, particularly norepinephrine and serotonin. Reduced quantities or reduced activity of these chemicals in the brain is thought to cause the depressed mood in some sufferers. Depression is also associated with disordered rapid eye movement (REM) sleep. A region of the brain known as the amygdala contains neurons that project into the brainstem and appear to be involved in modulating REM sleep. The amygdala is also associated with processing negative thoughts and may be enlarged, hyperactive, or

otherwise dysfunctional in some depressed persons. Although the significance of these associations is yet to be defined, the link between depression, disordered REM sleep, and abnormalities of the amygdala has led to new avenues of research into the neurobiology and treatment of depression.

Research suggests that depression is also linked to physical activity, whereby physical activity may lower a person's risk of developing depression. Individuals who exercise typically report better mental health and are less likely to be depressed, compared with individuals who do not exercise.

Types of Depression

The American Psychiatric Association's Diagnostic Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) classifies depressive disorders as the following:

1. Clinical depression (major depressive Disorder): A diagnosis of major depressive disorder means you've felt sad, low or worthless most days for at least two weeks while also having other symptoms such as sleep problems, loss of interest in activities or change in appetite. This is the most severe form of depression and one of the most common forms.

2. Persistent Depressive Disorder (PDD): Persistent depressive disorder is mild or moderate depression that lasts for at least two years. The symptoms are less severe than major depressive disorder. Healthcare providers used to call PDD dysthymia.

3. Disruptive Mood Dysregulation Disorder (DMDD) DMDD causes chronic, intense irritability and frequent anger outbursts in children. Symptoms usually begin by the age of 10.

4. Premenstrual dysphoric disorder (PMDD): With PMDD, you have premenstrual syndrome (PMS) symptoms along with mood symptoms, such as extreme irritability, anxiety or depression. These symptoms improve within a few days after your period starts, but they can be severe enough to interfere with your life.

The cognitive theories of depression put forward by Beck and his colleagues (1980), Brown & Harris (1978) and Abramson and her colleagues (1978) are described and compared. Although each theory has its strengths, it is argued that an adequate cognitive account of depression is awaited. Such a theory must link specific experiences with each of the cognitive themes of depression, and the links postulated should be specific to depression. Refinements of description and method are required before such a theory can be tested.

THEORIES OF DEPRESSION

Beck is a psychiatrist whose first interest in cognition developed during his psychoanalytical training as a consequence of his dissatisfaction with the belief that people became depressed as a result of a need to suffer. In particular, he noticed that interventions based on this point of view

were not effective. He began to see self-laceration as the result of cognitive distortion, not of masochism. Beck was influenced by his reading of Adler's Individual Psychology, of Kelly's Personal Construct Theory and of Ellis' Rational-emotive Psychotherapy, which all emphasized the significance of the constructions which we place on reality. He states that the major factor in the development of his cognitive model of depression was systematic clinical observation and experimental testing. He has ex- panded his ideas in a series of publications (Beck, 1967, 1976, 1983; Beck et al. 1980).

The first limb of the cognitive triad is the depressive's negative view of himself, that he is defective, inadequate, diseased or deprived. He is therefore worthless, he criticizes himself, and sees himself as lacking the wherewithal to achieve happiness. The depressive also has a negative view of current experience: the world is making exorbitant demands upon him and places insuperable obstacles in his way. All his dealings with it lead to defeat or deprivation. Finally, the depressive has a negative view of the future. His expectations are of continuing difficulties and suffering, of unremitting hardship, a litany of failure.

BROWN & HARRIS' MODEL

The second model to be considered is that described by Brown & Harris in their book Social Origins of Depression, published in 1978. The book is a report of their community study of women in Camberwell, South London. On the basis of this survey, they developed a complex account of the interaction of social factors in the precipitation of depression.

They identified three types of factors: 'provoking factors', such as recent life events and chronic difficulties;' vulnerability factors'; and' symptom formation factors'. There were four vulnerability

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factors: early loss of mother, involvement in the care of young children, the lack of an adequate confidant, and the absence of gainful employment. Vulnerability factors did not of themselves increase the risk of depression but they made the woman more susceptible to the impact of a supervening life event. The description of the precipitation of depression outlined above was based on certain types of statistical relationship. This empirically based account can be termed the' vulnerability model'. However, Brown & Harris developed a further, cognitive, model of depression, in terms of which they sought to explain these findings.

They emphasized that this model was speculative: claims that we make for the causal model cannot be made as yet for the more speculative theory' (Brown & Harris, 1978, p. 233). Nevertheless, the authors quite clearly indicate their support for a cognitive a etiology: 'in most cases, a cognitive appraisal of one's world is primary' (Brown & Harris, 1978, p. 235). Indeed, they go on to emphasize that, unless physiological abnormalities can be shown to predate depression, they may merely form part of the dependent variable - although this obviously also applies to their concept of hopelessness.

THE REFORMULATED LEARNED HELPLESSNESS MODEL

The original helplessness model of depression is described by Seligman (1975) and proposed that events which the organism attempts to control, but cannot, have peculiarly disruptive effects. The resulting deficits fall into three categories: motivational, cognitive and emotional. The motivational deficit is reflected in retarded initiation of voluntary responses; the cognitive deficit involves erroneously pessimistic expectations of the non-contingency of future outcomes; and the emotional deficit takes the form of depressed mood. However, there were a number of inadequacies of this model, developed in animals, when applied to account for depression in humans (Blaney, 1977; Depue & Monroe, 1978). This led to a reformulation of the model by Abramson and her colleagues (1978) and by Miller & Norman (1979). The major innovation was the introduction of

an attributional framework. In other words, when people perceive that they have failed to control an outcome, they immediately ask themselves why this is so. The answers, according to the reformulated model, determine the generality and chronicity of effect and also the effect on the subject's self-esteem. The original model did not distinguish between the perception of a task as impossible and the pere mode rings in as competent us or causality to account for this. It must be emphasized that locus of causality is an attribution the subject makes about an outcome which has already happened. In this it differs from Rotter's (1966) concept of locus of control with which it sometimes appears to be confused. Locus of control, as elaborated by Rotter, concerns the extent to which future outcomes, both positive and negative, are thought to be under the control of the subject. It is therefore more akin to the expectation of future non-contingency. The incorporation of positive outcomes probably accounts for the general empirical finding that depressives show a characteristically external locus of control (see Brewin & Shapiro, 1984).

According to the World Health Organization (WHO), "Gender refers to the socially constructed characteristics of women and men, such as norms, roles, and relationship of and between groups of women and men. It varies from society to society and can be changed." Gender differences are variants between males and females that are based on biological adaptations that are the same for both sexes. Connections between gender and mental health manifest differently for each child and young person, in combination with a wide range of individual, social and structural factors, and in ways that change over the course of childhood and shift over time. The gender gap in the prevalence of diagnosable mental health conditions begins to narrow in adolescence, as emotional problems become more common in girls. By early adulthood, women are more likely to be diagnosed with a mental health condition than men. Girls and young women are more likely than boys and young men to have depressive disorders and anxiety disorders.

Sang Min Lee (2015) study the immediate anxiety and psychological impact experienced by quarantined patients undergoing hemodialysis and university hospital workers who treated patientsMiddle East respiratory syndrome (MERS) during its outbreak. They found that During the initial stages of the MERS outbreak, healthcare workers who performed MERS-related tasks scored significantly higher on the total IES-R and its subscales. In the second assessment of the high-risk group, the sleep and numbness subscale scores from the IES-R differed depending on the implementation of home quarantine, and the intrusion subscale scores differed depending on the performance of MERS-related tasks.

Louise Lindberg (2020) study whether obesity increases the risk of anxiety or depression independently of other risk factors in a large cohort of children and adolescents, using robust measures with regard to exposure and outcome. Children aged 6–17 years in the Swedish Childhood Obesity Treatment Register. The main outcome was a diagnosis of anxiety or depression identified through ICD codes or dispensed prescribed medication within 3 years after the end of obesity treatment. Hazard ratios (HRs) with 95% confidence intervals (CIs) from Cox proportional models were adjusted for several known confounders. Obesity remained a significant risk factor for anxiety and depression in children and adolescents after adjusting for Nordic background, neuropsychiatric disorders, family history of anxiety/depression, and socioeconomic status

Julia Martini (2015) study correlates and course patterns of anxiety and depressive disorders duringpregnancy and after delivery in Germany and completed up to seven waves of assessment

from early pregnancy until 16 months postpartum. Anxiety and depressive disorders and potential risk factors/correlates were assessed with the Composite International Diagnostic Interview for Women (CIDI-V), medical records and additional questionnaires. He found that anxiety and depressive disorders appeared to be persistent in some women, others reported major changes with heterogeneous courses and shifts between diagnoses and contents. There was a considerable amount of incident disorders. Strongest predictors for peripartum anxiety and depressive disorders were anxiety and depressive disorders prior to pregnancy, but psychosocial (e.g. maternal education), individual (e.g. low self-esteem), and interpersonal (e.g. partnership satisfaction, social support) factors were also related.

A. Bruggink (2016) investigate the relationship between cognitive emotion regulation and anxiety and depression in adults with autism spectrum disorder (ASD). One hundred and twenty-one adults with ASD were compared to neurotypical adults, matched on age and gender. Cognitive emotion regulation was measured with the Cognitive Emotion Regulation Questionnaire (CERQ). Anxiety and depression were measured using the Symptom Check List (SCL-90). They found that The ASD group reported more use of the strategy "Other-blame" and less use of "Positive reappraisal" than the control group. A significant relationship was found between cognitive emotion regulation strategies and anxiety and depression in the ASD group. There were no differences found in the strength of the relationship between cognitive emotion regulation and anxiety and depression, except for the relationship between "Catastrophizing" and depression, which was more strongly related in neurotypical adults.

Rebecca Beiter & Ryan Nash (2015) investigate correlates of depression, anxiety, and stress in a sample of college students of 374 undergraduate students between the ages of 18 and 24 attending Franciscan University, Steubenville, Ohio. The results indicated that the top three concerns were academic performance, pressure to succeed, and post-graduation plans. Demographically, the most anxious, and depressed students were transfers, upperclassmen, and those living off-campus.

Wenjuan Gao & Xinqiao Liu (2020) Studied gender differences in college students 'depression, anxiety, and stress over the four academic years, and to explore possible anxiety-related factors among first year students. The study analyzed 1892 undergraduate students from 15 universities in China, with 898 females and 994 males. The students have been followed for four years and completed a survey containing the Depression Anxiety Stress Scale-21 questionnaire, students' socio-demographic information, and their educational background, etc. They found out that both female and male college students suffered from mild anxiety in the first three years. Female students scored significantly higher in anxiety than males in the first and second years, and there was no significant gender difference in students' average depression. A significantly larger proportion of female students experienced anxiety above the normal threshold, whereas a higher percentage of male students endured different degrees of depression. Anxiety had a significant positive correlation with introversion. Female freshmen's anxiety levels were also associated with their body image, drinking habits, and academic performance.

Mohamed Fawzy & Sherifa A Hamed (2017) studied estimated the prevalence of depression, anxiety symptoms among medical students who were enrolled in a public university in Upper Egypt

and determine the association of these morbidities with the students' basic socio-demographic variables. This cross-sectional study included 700 students. They reported that high prevalence depression (65%) and anxiety (73%), high scores of DASS 21 subscales and poor sleep quality across the 6 academic years of medical school. In accordance and among medical students using the DASS-21 inventory or different scales other than DASS 21. Study showed that there is a considerable level of symptoms of depression, anxiety and stress among undergraduate medical students.

Louise M Farrer (2016) studied psychosocial and demographic risk factors for major depression and generalised anxiety disorder (GAD) in a sample of Australian university students. A total of 611 students completed the survey. The prevalence of major depression and GAD in the sample was 7.9 and 17.5 %, respectively. In terms of demographic factors, the risk of depression was higher for students in their first year of undergraduate study, and the risk of GAD was higher for female students, those who moved to attend university, and students experiencing financial stress. In terms of psychosocial factors, students with experience of body image issues and lack of confidence were at significantly greater risk of major depression, and feeling too much pressure to succeed, lack of confidence, and difficulty coping with study was significantly associated with risk of GAD.

Md Akhtarul Islam & Sutapa Dey Barna (2020) studied prevalence of depression and anxiety among Bangladeshi university students during the COVID-19 pandemic. They found that 392 (82.4%) students were found to have mild to severe depressive symptoms, and 389 (87.7%) students were found to have mild to severe anxiety symptoms. More than 60% of the students were male (67.2%), and the rest were female. Bangladeshi university students have been suffering from depression

Fernanda Brenneisen Mayer (2016) studied personal and institutional factors related to depression and anxiety prevalence of students from 22 Brazilian medical schools. The authors performed a multicenter study (August 2011 to August 2012), examining personal factors (age, sex, housing, tuition scholarship) and institutional factors (year of the medical training, school legal status, location and support service) in association with scores of Beck Depression Inventory (BDI) and State Trait Anxiety Inventory (STAI). Of 1,650 randomly selected students, 1,350 (81.8 %) completed the study. The depressive symptoms prevalence was 41 % , state-anxiety 81.7 % and trait-anxiety in 85.6 %. Symptoms were positively associated with female sex and students from medical schools located in capital cities of both sexes. Tuition scholarship students had higher state-anxiety but not trait-anxiety or depression scores. Medical students with higher levels of depression and anxiety symptoms . The factors associated with the increase of medical students' depression and anxiety symptoms were female sex, school location and tuition scholarship. It is interesting that tuition scholarship students showed state-anxiety, but not depression and trait-anxiety symptoms.

CHAPTER II

STATEMENT OF THE PROBLEM

Research on Anxiety and depression in adolescents is important both this condition is a serious issue in today's world as they have a significant impact on the mental and physical health of adolescents. Adolescents with depression are at risk for— increased hospitalization, recurrent low self-esteem, psychological impairment, etc. Research on stress and depression is not a limited topic as there are already various researchers who conducted researches on this specific topic and we can infer from it. Women are more likely to experience depression, stress and anxiety disorders, etc. Researchers have known for years that women are about twice as likely to be diagnosed with depression as men, with depression being the leading cause of disease among women. Anxiety and depression can impact the academic performance and success of a college student. Poor mental health contributes to lack of motivation and problems focusing which can lead to failing grades. Campus-wide mental health resources for students to seek support could be the key to their academic success.

Operational Definition

Anxiety

American Psychological Association defined anxiety as "Anxiety is an emotion characterized by feelings of tension, worried thoughts, and physical changes like increased blood pressure."

Depression

American Psychological Association defined depression as "extreme sadness or despair that lasts more than days. It interferes with the activities of daily life and can cause physical symptoms such as pain, weight loss or gain, sleeping pattern disruptions, or lack of energy."

Gender

Gender refers to the characteristics of women, men, girls and boys that are socially constructed. This includes norms, behaviours and roles associated with being a woman, man, girl or boy, as well as relationships with each other. As a social construct, gender varies from society to society and can change over time (World Health Organization).

Gender differences

Gender differences are variants between males and females that are based on biological adaptations that are the same for both sexes. Connections between gender and mental health manifest differently for each child and young person, in combination with a wide range of individual, social and structural factors, and in ways that change over the course of childhood and shift over time.

College Students

A college student is an individual who is enrolled in a university or college for a particular course. Theyare a part of the institution while they pursue the course and then become the part of the alumni association once they complete the course.

Objectives of the Study

1.   To determine the gender difference in level of anxiety and depression among the HATIM college student.

2.   To determine the correlation between anxiety and depression

Hypothesis

1. There will be significant gender difference in level of anxiety and depression among HATIM

    college students.

2. It is hypothesized that there will be positive correlation between anxiety and depression

CHAPTER III

METHOD AND PROCEDURE

A population study was utilized among HATIM college students. For the research, a total population of 296 students participated in the study. Among them 143 were male (M=48.31) and 153 were female(M=51.69). The participants in the study age ranges between 18-25 years with a mean age of 21.5.

Research Design

To achieve the objectives of the study, a quantitative exploratory design had been utilized. The studyincorporated a two-way classification of variables of 'gender' (male and female) as depicted below:
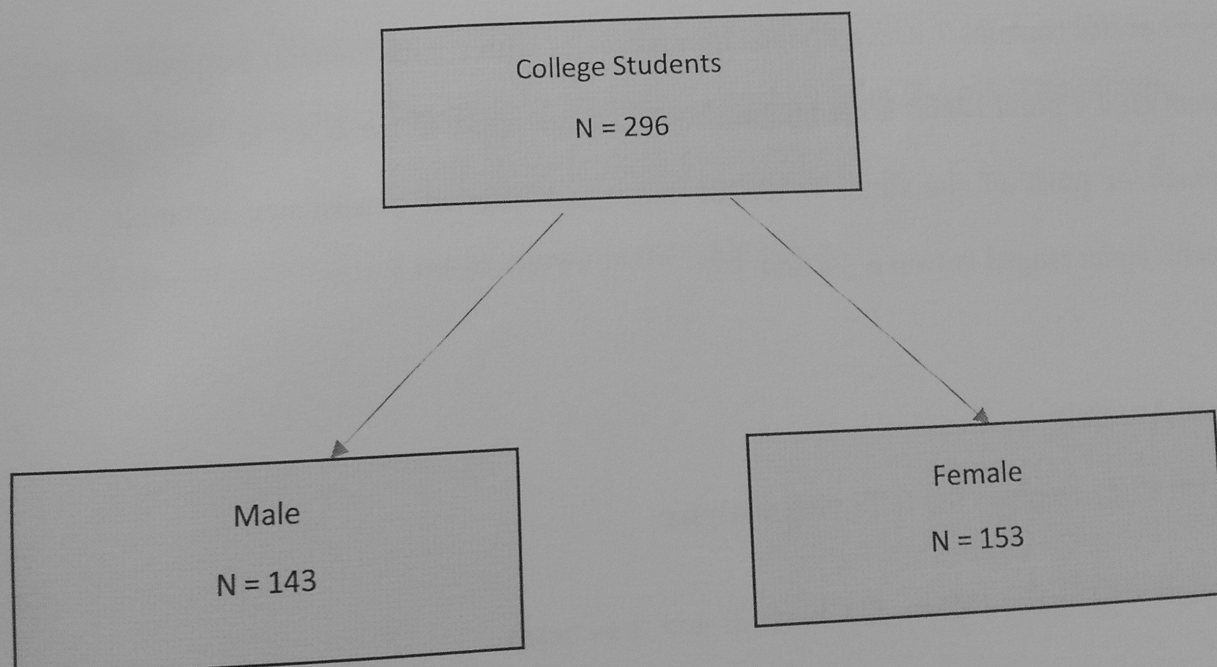

Figure I: Showing the classification of gender.

Procedure

Permission was sought from the authorities of the colleges by the researcher, prior to the conduction of data collection from its students. The researcher ensured that a good rapport was established between students and the researcher. Proper instruction was given as to assure honest and independent responses are given. With permission from the participants through informed consent form, the researcher providedany necessary information about the study and purpose of the study, any doubts raised were clarified. Proper instruction was given about the scoring of the scale, then the researcher thoroughly checked the scoring sheets to ensure that proper responses are answered completely. Finally, the collected data werestored for further analysis.

Psychological Tools

Depression, Anxiety and Stress Scale -21 Items (DASS) (Lovibond et al,1995): The Depression, Anxiety and Stress Scale-21 Items (DASS 21) is a set of three self-report scales designed to measure theemotional states of depression, anxiety, and stress. Each of the three DASS-21 scales contains 7 items, divided into subscales with similar content. Respondents rate each item on a 4 point Likert scale rangingfrom 'Did not apply to me at all' to 'Applied to me very much or most of the time. DASS-21 has good internal consistency reliability with Cronbach's alpha ranged between .74 and .93.

Statistical Analysis

The current study employs the following analysis:

1) Descriptive Statistics (Mean, SD, kurtosis and skewness)

2) T-test

3) Pearson's Correlation

CHAPTER IV

RESULT AND DISCUSSION

It may be reiterated that the objectives of the study were to highlight the nature of gender differences and the relationship between anxiety and depression among HATIM college students, and it was hypothesized that there would be a statistical difference in gender as well as an association between the two variables.

Statistical analysis was done in stepwise to obtain the result, such that

1. checking the assumption of parametric statistics for the purpose of the selection of appropriate statistics (Levene's test for homogeneity of variance, skewness, and kurtosis)

2. An independent sample t-test was analyzed to determine the gender difference in levels of anxiety and depression

3. Checking the relationship between dependent variables using Pearson's correlation

Statistical analysis was carried out as shown in the table below.

Descriptives			Statistic	Std. Error
Depression	Mean		7.19	.241
	95% Confidence Interval for Mean	Lower Bound	6.71	
		Upper Bound	7.66	
	5% Trimmed Mean		7.06	
	Median		7.00	
	Variance		17.212	
	Std. Deviation		4.149	
	Minimum		0	
	Maximum		20	
	Range		20	
	Interquartile Range		6	
	Skewness		.359	.142
	Kurtosis		-.309	.282
Anxiety	Mean		7.44	.235
	95% Confidence Interval for Mean	Lower Bound	6.98	
		Upper Bound	7.91	
	5% Trimmed Mean		7.36	
	Median		7.00	
	Variance		16.349	
	Std. Deviation		4.043	
	Minimum		0	
	Maximum		19	
	Range		19	
	Interquartile Range		6	
	Skewness		.224	.142
	Kurtosis		-.594	.282

As we can see from Table 1, the mean in anxiety is 7.44 and SD is 4.043. For Depression, the mean is 7.19 and the SD is 4.149. The skewness and kurtosis were within an acceptable range of the Normal probability curve. The data were normally distributed with skewness of .224;-.594 and kurtosis of .359; -.309 for anxiety and depression respectively.
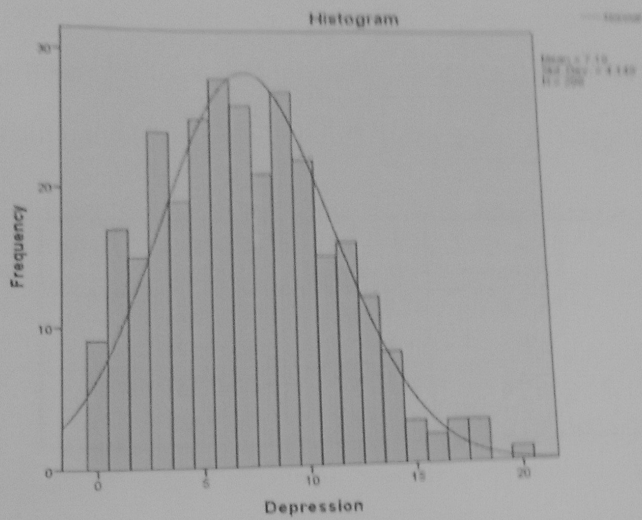
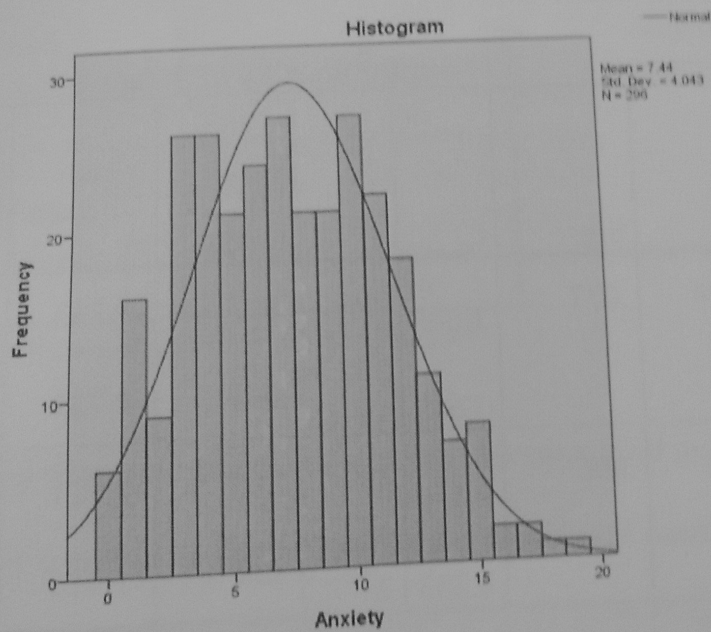**Figure 2:** *Showing score distribution of Depression*

Figure 3: *Showing score distribution of Anxiety*

T-TEST

An independent sample t-test was employed for the comparison of the mean.

Table 2: Result showing mean value of Depression and anxiety.

Group Statistics

	Gender	N	Mean	Std. Deviation	Std. Error Mean
Depression	Male	143	6.29	4.331	.362
	Female	153	8.03	3.797	.307
Anxiety	Male	143	6.45	3.528	.295
	Female	153	8.37	4.281	.346

Table 3: Result showing the t-statistic for anxiety and depression.

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means					95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Depression	Equal variances assumed	3.144	.077	-3.665	294	.000	-1.732	.473	-2.663	-.802
	Equal variances not assumed			-3.649	282.916	.000	-1.732	.475	-2.667	-.798
Anxiety	Equal variances assumed	7.623	.006	-4.176	294	.000	-1.911	.458	-2.812	-1.011
	Equal variances not assumed			-4.203	289.524	.000	-1.911	.455	-2.807	-1.016

A Levene's test for equality of variance was employed to check whether assumptions for the test were met. the Levene's statistics showed non-significance for depression (.077) showing that there is equal variance, while Levene's statistics for anxiety is significant (.006), so equal variance cannot be assumed. However, as it is not too far from normality we proceed with the t-test for further analysis.

From table 2 and 3,There was a significant difference in depression with a higher mean score in females (M =8.03, SD = 3.79) than males (M = 6.29, SD = 4.33).

It also analyzed that there was a significant difference in gender in anxiety with females (M = 8.37, SD = 4.28) having a higher mean than males (M= 6.45, SD= 3.52) (p =0.01), t-value (-3.665; -4.203) for depression and anxiety respectively.

CORRELATION

The results were analysed to see any significant relationship between the dependent variables.

Table 4: Result showing correlations of Depression and anxiety.

Correlations

		Depression	Anxiety
Depression	Pearson Correlation	1	.595**
	Sig. (2-tailed)		.000
	N	296	296
Anxiety	Pearson Correlation	.595**	1
	Sig. (2-tailed)	.000	
	N	296	296

**. Correlation is significant at the 0.01 level (2-tailed).

The correlation between the two dependent variables was calculated using Pearson's correlation. Results of correlational analysis in Table 4 showed a significant positive relationship between the two variables i.e. anxiety and depression {r= .595**, p<0.01 level (2-tailed)}

CHAPTER V
SUMMARY AND CONCLUSION

Summary

The present study entitled 'a study on depression and anxiety among HATIM college students" aimed to study the the gender difference in level of anxiety and depression among the HATIM college student and correlation between anxiety and depression.

To achieve the objectives and hypothesis of the study, 296 participants from the college students of HATIM, comprising 153 males (M=48.31) and 143 female (M=51.69) of the age group 18-25 years (young adult) were selectedto serve as samples by employing sample random sampling procedure.A quantitative exploratory design had been utilized to achieve the objectives of the study. The study incorporated a two-way classification of variables of "gender' (male and female). Depression, Anxiety and Stress Scale -21 (DASS-21) was employed for psychological evaluation of the samples, all prescribedinstructions are given in the manual, and APA guidelines for research were followed.

It was found that there was a significant difference in gender in anxiety with females (M = 8.37, SD = 4.28) having a higher mean than males (M= 6.45, SD= 3.52) (p =0.01), t-value (-3.665; -4.203) for depression and anxiety respectively and The correlation between the two dependent variables was calculated using Pearson's correlation. Results of correlational analysis in showed a significant positive relationship between the two variables i.e. anxiety and depression {r= .595**, p<0.01 level (2-tailed)}.

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Implications

Many researchers had research on Anxiety and depression on college level. But there is few research on district of Lunglei especially among college students.

Research on prevalence of Anxiety and depression among college students is important. Research is key to transforming the next generation of treatments for anxiety and depression disorders. The present study gives us information about what disorder are most prevalent among genders. This can enable any awareness programs to provide the most relevant information among the population, regarding the anxiety and depression.

Limitations

This research was done in the light of some limitations.

Firstly, as the sample size is small, it cannot represent the whole population of young adult in Lunglei.

Secondly, since it was conducted only in 1 college, therefore, it cannot represent the whole students of Lunglei college.

Thirdly, some of the students, even after giving them a clear instruction, they still tend to answer the questionnaire not so seriously and also there are always some students who were absent and therefore the are also not returning the questionnaire as well.

Fourthly, since the time given to us was less and also due to the insufficient of the system like laptops or computers, the work progress was slowed.

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APPENDIX I

PURPOSE OF THE RESEARCH:

This academic research is conducted for partial fulfillment of B.A. Psychology 5th semester course at HATIM. All the information given will be kept with full confidentiality.

(Name of the student/researcher)

APPENDIX II

CONSENT OF THE PARTICIPANT

I have gone through the purpose of this research, and I am willing to participate in it to help the researcher/student in the fulfillment of their course.

(Name of participant)

SOCIO DEMOGRAPHIC PROFILE:

1. NAME: _____

2. AGE: _____

3. SEX: Male ( )   Female ( )

4. SUBJECT/COURSE: _____

5. SEMESTER: _____

6. NAME OF COLLEGE: _____

7. CITY/TOWN: _____

DASS21

Name: _____   Date: _____

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree or a good part of time
3 Applied to me very much or most of the time

		0	1	2	3
1 (s)	I found it hard to wind down	0	1	2	3
2 (a)	I was aware of dryness of my mouth	0	1	2	3
3 (d)	I couldn't seem to experience any positive feeling at all	0	1	2	3
4 (a)	I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5 (d)	I found it difficult to work up the initiative to do things	0	1	2	3
6 (s)	I tended to over-react to situations	0	1	2	3
7 (a)	I experienced trembling (e.g. in the hands)	0	1	2	3
8 (s)	I felt that I was using a lot of nervous energy	0	1	2	3
9 (a)	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10 (d)	I felt that I had nothing to look forward to	0	1	2	3
11 (s)	I found myself getting agitated	0	1	2	3
12 (s)	I found it difficult to relax	0	1	2	3
13 (d)	I felt down-hearted and blue	0	1	2	3
14 (s)	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15 (a)	I felt I was close to panic	0	1	2	3
16 (d)	I was unable to become enthusiastic about anything	0	1	2	3
17 (d)	I felt I wasn't worth much as a person	0	1	2	3
18 (s)	I felt that I was rather touchy	0	1	2	3
19 (a)	I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat)	0	1	2	3
20 (a)	I felt scared without any good reason	0	1	2	3
21 (d)	I felt that life was meaningless	0	1	2	3

DASS-21 Scoring Instructions

The DASS-21 should not be used to replace a face to face clinical interview. If you are experiencing significant emotional difficulties you should contact your GP for a referral to a qualified professional.

Depression, Anxiety and Stress Scale - 21 Items (DASS-21)

The Depression, Anxiety and Stress Scale - 21 Items (DASS-21) is a set of three self-report scales designed to measure the emotional states of depression, anxiety and stress.

Each of the three DASS-21 scales contains 7 items, divided into subscales with similar content. The depression scale assesses dysphoria, hopelessness, devaluation of life, self-deprecation, lack of interest / involvement, anhedonia and inertia. The anxiety scale assesses autonomic arousal, skeletal muscle effects, situational anxiety, and subjective experience of anxious affect. The stress scale is sensitive to levels of chronic non-specific arousal. It assesses difficulty relaxing, nervous arousal, and being easily upset / agitated, irritable / over-reactive and impatient. Scores for depression, anxiety and stress are calculated by summing the scores for the relevant items.

The DASS-21 is based on a dimensional rather than a categorical conception of psychological disorder. The assumption on which the DASS-21 development was based (and which was confirmed by the research data) is that the differences between the depression, anxiety and the stress experienced by normal subjects and clinical populations are essentially differences of degree. The DASS-21 therefore has no direct implications for the allocation of patients to discrete diagnostic categories postulated in classificatory systems such as the DSM and ICD.

Recommended cut-off scores for conventional severity labels (normal, moderate, severe) are as follows:

NB Scores on the DASS-21 will need to be multiplied by 2 to calculate the final score.

	Depression	Anxiety	Stress
Normal	0-9	0-7	0-14
Mild	10-13	8-9	15-18
Moderate	14-20	10-14	19-25
Severe	21-27	15-19	26-33
Extremely Severe	28+	20+	34+

Lovibond, S.H. & Lovibond, P.F. (1995). Manual for the Depression Anxiety & Stress Scales. (2nd Ed.)Sydney: Psychology Foundation.