WORLD JOURNAL OF PHARMACEUTICAL AND MEDICAL RESEARCH

A STUDY TO ASSES THE PREVALENCE OF SIGN AND SYMPTOMS OF DEPRESSION AMONG COLLEGE STUDENTS (17-22 AND ABOVE 22 YEARS) IN SELECTED URBAN COMMUNITY OFMETROPOLITAN CITY

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ABSTRACT

Research Statement
A study to assess the prevalence of sign and symptoms of depression amongcollege students (17-22 and above 22 years) in selected urban community ofmetropolitan city.

Objectives of the Study
1. To identify sign and symptoms of depression among college students
2. To find out number of suffering from sign and symptoms of depression in selected community in metropolitan city.
3. To assess the prevalence of depression among college students at different levels of education and find about their stressors.

Research Approach
A descriptive evaluative approach was used

Setting
This study was conducted in College of Nursing Sir JJ Group of HospitalMumbai-08.

Sample and Sampling Technique
The sample consisted 100 college students, who fulfilled the required criteria.

Techniques and Tools
The data gathering technique used was nonprobable and convenient and the tools used for the study was Questionnaire.

Validity and Reliability
The tool was given to the expert for scrutinizing its adequacy and relevance suggestion were incorporated in the tool.

The reliability of the measuring instrument is a major criterion for assessing it's quality and adequacy. In order to determine the reliability, practicability and feasibility a try out was done on II year BBsc nursing students of College ofNursing Sir JJ Group Of Hospital.

Pilot Study
In order to pre test and refine the tool and technique and check the feasibility of the study a pilot study was done on 5 B Bsc Nursing Students who fulfilled the predetermined criteria a few necessary modifications made in the toolafter the pilot study.

Data Gathering Process
The data collection was done on 21 April 2022.The students were given questionnaire at 2pm-4pm.All subjects were explained purpose of the study after establishing rapport. The confidentiality of their responses was assured.

Analysis and Interpretation
- The data obtained was analysed and interpreted using frequency distributionand percentage.
- The data was presented in the form of table, graph and pie charts.

Major Findings of the Study
38(38%) of students have mild depression, 25(25%) of students have moderate depression, whereas 7(7%) of students have severe depression.

Conclusion
This study findings conclude that there were majority of students present in the community who were suffering from sign and symptoms of depression. Out of 100

students 70 students are suffering from sign and symptoms depression. The stressors were related to admissions, assignments, submissions, exams etc.

INTRODUCTION

Depression is a common psychiatric condition that negatively affects feeling, thinking and acting. Depression causes feeling of sadness and or a loss of interest in activities once enjoyed. Depression can leads to multiple emotional and physical problem and can decrease a person's ability to function at work and at home.

Depression as a disorder has always been a focus of attention of researchers in India. Over the last 50-60 years, large number of studies has been published from India addressing various aspects of this commonly prevalent disorder.

The various aspects studied included epidemiology, demographic and psychosocial risk factor, neurobiology, symptomatology. comorbidity, assessment and diagnosis, impact of depression, treatment related issues and prevention of depression in addition to the efficacy and tolerability of various antidepressants. Here, we review data on various aspects of depression, organization from india.

Depression is a widespread mental health problem affecting many people. The lifetime risk of depression in males is 8-12% and in Neurochemical: Rese females it is 20-26%. Depression occurs twice as that depression res frequently in women as in men. The median age norepinephrine and at onset of bipolar disorder is 18 years in men dysregulation of ac and 20 years in women. The highest incidence of depressive symptoms has been indicated in individuals without close interpersonal relationships and in persons who are divorced or separated. Prevalence of suicide shows large peak in the spring and a smaller one in October. Major depressive disorders often co-occur with other psychiatric and substance-related dis orders. Depression often is associated with a variety of medical conditions.

Depression is one of the leading causes of Endocrine disability across the world. The World Health hypothalamic-pit Organization 2006 estimates that depression is a system that will rank second only to heart disease by 2020 However, in so in terms of global disability. An estimated 3-4% of India's 100 crore plus population suffer from thyroid and hor major mental disorders and about 7-10% of the population suffers from minor depressive disorders (Sinha 2011).

Etiology
1) Biological Theories
The etiology of depression has been biologically attributed to alterations in neurochemical, genetic, endocrine and circadian rhythm functions.
Patient with Mood Disorders that depression results when levels of norepinephrine and serotonin decrease and
2) Neurochemical
Patient with Mood Disorders that depression results when levels of norepinephrine and serotonin decrease and dysregulation of acetylcholine and GABA occurs
3) Genetic theories
Major depressive disorders occur more often in first degree relatives than they do in the general population.. . Studies of identical twins show that when one twin is diagnosed with major depression, the other twin has a greater than 70% chance of developing it
4) Endocrine theories
Normally. The hypothalamic-pituitary-adrenal (HPA) axis is a system that mediates the stress response. However, in some depressed people this system malfunctions and creates cortisol, thyroid and hormonal abnormalities.
5) Circadian rhythm theories
Circadian rhythms are responsible for the daily regulation of wake-sleep cycles, arousal and activity patterns, and hormonal secretions. Individuals experiencing circadian rhythm changes are at increased risk for developing depressive symptoms and other mood symptoms. These changes might be caused by medications, nutritional deficiencies, physical or psycho logical illnesses, hormonal fluctuations.
6) Changes in brain anatomy:
Loss of neurons in the frontal lobes, cerebellum and basal ganglia has been identified in depression.
7) Psychosocial Theories
a) Psychoanalytic theory:
According to Freud (1957) depression results due to loss of a loved object, and fixation in the oral sadistic phase of development. In this model, mania is viewed as a denial of depression.
b) Behavioral theory:
This theory of depression connects depressive phenomena to the experience of uncontrollable events. According to this model, depression is conditioned by re peated losses in the past.
c) Cognitive theory:
According to this theory. depression is due to negative cognitions which includes:
- Negative expectations of the environment

- Negative expectations of the self
- Negative expectations of the future.

These cognitive distortions arise out of a defect in cognitive development and cause the individual to feel inadequate, worthless and rejected by others.

d) Sociological theory

Stressful life events, e.g death, marriage, financial loss before the onset of the disease or a relapse probably have at formative effect.

Transactional Model of Stress/ Adaptation

According to transactional model of stress/adaptation, depression occurs as a combination of predisposing factors (family history and biochemical alterations), past experiences (object loss in infancy, defect in cognitive development) and existing conditions (lack of adequate support system, inadequate coping skills, other physiological conditions). Because of weak ego strength, patient is unable to use coping mechanisms effectively. Maladaptive coping mechanisms used are denial, regression, repression, suppression, displacement and isolation. All these factors lead to clinical depression.

Psychopathology

The psychopathology of the affective disorders can most easily be described by reference to the similarity of the abnormal affect with normal emotions of the same kind. In depression, the patients' sadness deepens to a morbid depression, and the difficulty in concentration becomes retardation of all thought and action. Depressive patients may show a complete failure of all insight, deny that they are ill and hold steadfastly to their ideas of guilt and punishment.

Clinical Features

A typical depressive episode is characterized by the following features, which should last for at least two weeks in order to make a diagnosis.

Depressed mood: Sadness of mood or loss of interest and loss of pleasure in almost all activities (pervasive sadness), present throughout the day (persistent sadness).

Depressive cognitions: Hopelessness (a feeling of no hope in future' due to pessimism). helplessness (the patient feels that no help is possible), worthlessness (a feeling of inadequacy and inferiority), unreasonable guilt and self-blame over trivial matters in the past.

Suicidal thoughts: Ideas of hopelessness are often accompanied by the thought that life is no longer worth living and that death had come as a welcome release. These gloomy preoccupations may progress to thoughts of and plans for suicide.

Psychomotor activity: Psychomotor retarda tion is frequent. The retarded patient thinks, walks and acts slowly. Slowing of thought is reflected in the patient's speech; questions are often answered after a long delay

and in a monotonous voice. In older patients, agitation is common with marked anxiety, restlessness and feelings of uneasiness.

Psychotic features: Some patients p delusions and hallucinations (the dis may then be termed as psychotic depress these are often mood congruent, Leh are related to depressive themes and re the patient's dysphoric mood. For nihilistic delusions (beliefs about the existence of some person or thing), delusi of guilt, delusions of poverty, etc. may present. Some patients experience delusions hallucinations that are not clearly relate to depressive theme (mood incongruent) e.g., delusion of control. The prognosis the appears to be much worse.

Somatic symptoms of depression are also termed as 'melancholic features' in DSMIV.

Other Features

- Difficulties in thinking and concentration
- Subjective poor memory
- Menstrual or sexual disturbances
- Vague physical symptoms such as fatigue, aching discomfort, constipation

Diagnosis

- Psychological tests-Beck depression inventory. Hamilton rating scale for depression to assess severity and prognosis.
- Dexamethasone suppression test showing failure to suppress cortisol secretions in depressed patients.
- Toxicology screening suggesting drug induced depression.
- Based on ICD10 criteria.

Symptoms of depression

Common symptoms

- Apathy
- Sadness
- Sleep disturbances
- Hopelessness
- Helplessness
- Worthlessness
- Guilt. AngerOther symptoms
- Fatigue
- Thoughts of death
- Decreased libido
- Dependency
- Spontaneous crying
- Passiveness

Treatment Modalities Psychopharmacology

Antidepressants establish a blockade for the reuptake of norepinephrine and serotonin into their specific nerve terminals. This permits them to linger longer in synapses and to be more available to postsynaptic receptors.

Antidepressants also increase the sensitivity of the postsynaptic receptor sites SSRIs act by inhibiting the

reuptake of serotonin and increasing its levels at the receptor site. Tricyclic antidepressants mode of action is by blocking the reuptake of norepinephrine (NE) and/or serotonin (5-HT) at the nerve terminals. thus increasing the NE and 5-HT levels at the receptor site. MAOIs are responsible for the degradation of catacholamines after reuptake. The final effect is the same, a functional increase In the NE and 5-HT levels at the receptor site. Atypical antidepressants modestly inhibit the reuptake of norepinephrine and dopamine.

Major categories of antidepressants are
1. Selective Serotonin Reuptake Inhibitors (SSRIS) Citalopram (Celexa), Fluoxetine (Prozac), Sertraline (Zoloft).
2. Tricyclic Antidepressants (TCAS) Amitriptyline (Elavil), Clomipramine (Anafranil), Imipramine (Tofranil), Doxepin [Adapin, Sinequan).
3. Morinamine oxidase inhibitors (MAOIs) Isocarboxazid (Morplan), Phenelzine(Nardil).
4. Other Newer Antidepressant drugs Bupropion, MaprotilinePhysical Therapies.

- Electroconvulsive therapy (ECT) Severe depression with sucidal risk isthe most important indication for ECT.
- Fight therapy Sometimes called photo therapy involves exposing the patient to anartificial light source during winter months to relieve seasonal depression. The light source must be very bright, full-spectrumlight, usually 2,500 lux
- Repetitive transcranial magnetic stimulation (TMS) and vagus nerve stimulation (VNS) directly affect brain function by stimulating the nerves that are direct extensions of the brain.
- Psychosocial Treatment
- Psychotherapy: Psychotherapy based on psychoanalytic interventions emphasizes helping patients gain insight into the cause of their depression.
- Cognitive therapy: It aims at correcting the depressive negative cognitions like hopelessness, worthlessness, helplessness and pessimistic ideas, and replacing them with new cognitive and behavioralresponses.
- Supportive psychotherapy: Various techniques are employed to support the patient. They are reassurance, ventilation, occupational therapy, relaxation and other activity therapies.
- Group therapy: Group therapy is useful for mild cases of depression. In group therapy negative feelings such as anxiety, anger, guilt, despair are recognized and emotional growth is improved through expression of their feelings.
- Family therapy: Family therapy is used to decrease intrafamilial and interpersonal difficulties and to reduce or modify stressors, which mayhelp in faster and more complete recovery.
- Behavioral therapy: It includes social skills training, problem-solving techniques, assertiveness training, self-control therapy, activity scheduling and decision making techniques.

According to WHO 13 September 2021
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 olderthan 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.

Background of Study
Affective illnesses may present at any age, but it is becoming clear that patients who suffer from recurrent and severe forms of mood disorder often experience their first episode of illness early in life. The clinical presentation of depression at this stage of life can be atypical and is often complicated by personality difficulties and substance misuse. A significant proportion of young people presenting with recurrent depression will go on to develop a bipolar disorder, with important implications for future pharmacological treatment choices. Abstract Depression, as a heterogeneous collection of disorders, is likely to include subgroups that are more genetic in origin. In common with other neuropsychiatric disorders such as schizophrenia, Alzheimer's disease and Huntington's disease, earlier age at onset in depression is associated with higher genetic loading and poorer long-term outcome. Adolescents and young adults with depression are also at high risk of developing a bipolar illness. This article reviews depressive illnesses that occur for the first time in adolescence and young adulthood. Case studies are used to discuss atypical presentations and the evolving concept of bipolar-spectrum disorders.

Need for Study
- Need to find out no.of suffering from sign and symptoms of depression and need to help with the support of family, friends and health professionals to those who suffering from depression and also identify those who are under risk of depression.
- Need to assess the seriousness of sign and symptoms of depression because depression is serious illnesses which affects lifestyle of people
- Need to reduce the prevalence of sign and symptoms of depression because Depression is the leading cause of disability in the world Depression, also known as major depressive disorder (MDD), is a common illness that causes a persistent feeling of sadness. All ages, ethnicities, and socioeconomic groups are vulnerable to depression, and it has very

high personal, social and economic costs. Depression is also a major cause of death, particularly in young people, through suicide.

Statement of Problem
A study to assess the prevalence of sign and symptoms of depression among college students (17-22 and above 22 years) in selected urban community of metropolitan city.

Objectives of the Study
1. To identify sign and symptoms of depression among college students
2. To find out number of suffering from sign and symptoms of depression in selected community in metropolitan city.
3. To assess the prevalence of depression among college students at different levels of education and find about their stressors.

Operational Definations
Study
As per Oxford English Dictionary, study refers to the devotion of time and attention to gaining knowledge of an academic subject, by means of book.

In this study, the word study refers to asses prevalence of sign and symptoms of depression in selected community of metropolitan city.

Assess
According to Oxford Dictionary, assess means to evaluate the value, importance and quality of something.

In this study, assess means find the prevalence of sign and symptoms of depression among young adults.

College Students
According to oxford dictionary, A person who is studying at university or college.

In this study, college students who are studying in college of nursing sir j.j. group of hospital (first and second year B. bsc nursing students)

Depression
According to Oxford Dictionary, A medical condition in which a person feels very sad and anxious often has physical symptoms as being unable to sleep etc.

In this study, Depression refers to mood disorder that causes a persistent feeling of sadness, loss of interest, helplessness, worthlessness, hopelessness.

Selected area
Community (According to Tylor) the people with common interest living in a particular area.

In this study, we are taking the selected area of urban community of metropolitan city.

Metropolitan city
According to Oxford Dictionary, metropolitan city refers to metro area or metro is a region consisting of densely populated urban area surrounding territories sharing industry, infrastructure housing.
In this study, metropolitan city refers to the same.

Assumptions
• There are people present in community suffering from depression.
• There is increased prevalence of depression in community.

Chapter No ll
REVIEW OF LITERATURE

1. Review related to concept of depression
a. According to Johnathan R T Davidson clinical psychiatry feb 2007.
Atypical depression is defined as a type of depression that responds preferentially to monoamine oxidase inhibitors. In addition to mood reactivity, symptoms of atypical depression include hypersomnia, hyperphagia or weight gain, leaden paralysis, and a long-standing pattern of rejection sensitivity or interpersonal sensitivity. Over the years, atypical depression has been associated with or identified as nonendogenous depression, anxiety, reverse vegetative shift, chronic pain, bipolar disorder, and rejection sensitivity. This presentation discusses the history of the identification of atypical depression, starting with its initial identification in 1959, and describes the important studies of atypical depression and its treatment by various research groups during the past 50 years. The presentation concludes by differentiating between typical and atypical depression and detailing of some of the clinical characteristics of atypical depression.
b. According to Kenneth S Kendker, JAMA Psychiatry in August 2020
The modern concept of depression arose from earlier diagnostic formulations of melancholia over the hundred years from the 1780s to the 1880s. In this historical sketch, this evolution is traced from the writings of 12 authors outlining the central roles played by the concepts of faculty psychology and understandability. Five of the authors, writing from 1780 through the 1830s, including Cullen, Pinel, and Esquirol, defined melancholia as a disorder of intellect or judgment, a "partial insanity" often, but not always, associated with sadness. Two texts from the 1850s by Guislain, and Bucknill and Tuke were at the transition between paradigms. Both emphasized a neglected disorder- melancholia without delusions- arguing that it reflected a primary disorder of mood-not of intellect. In the final phase in the 1860s to 1880s, 5 authors (Griesinger, Sankey, Maudsley, Krafft-Ebing, and Kraepelin) all confronted the problem of the cause of delusional melancholia. Each author concluded that melancholia was a primary mood disorder and argued that the delusions emerged understandably from the abnormal mood. In this 100-year period, the explanation of delusional melancholia in faculty psychology terms

reversed itself from an intellect to mood to a mood to intellect model. The great nosologists of the 19th century are often seen as creating our psychiatric disorders using a simple inductive process, clustering the symptoms, signs, and later the course of the patients. This history suggests 2 complexities to this narrative. First, in addition to bottom-up clinical studies, these nosologists were working top-down from theories of faculty psychology proposed by 18th century philosophers. Second, for patient groups experiencing disorders of multiple faculties, the nosologists used judgments about understandability to assign primary causal roles. This historical model suggests that the pathway from patient observation to the nosologic categories-the conceptual birth of our diagnostic categories-has been more complex than is often realized.

c. According to Kelsey T Laird et al. Am J Geriatr Psychiatry. 2019 Jan.
Objective of study was the Increasing understanding of the neurocognitive correlates of resilience in late-life depression (LLD) could inform interventions to promote more sustained remission. We investigated cross-sectional relations between baseline resilience and domains of neurocognitive functioning in depressed older adults enrolled in one of four trials.

Participants (N = 288) completed neurocognitive tests of memory, language performance, and executive functioning as well as measures of subjective memory performance and components of resilience (grit, active coping self- efficacy, accommodative coping self-efficacy, and spirituality).

Result of study was Medium-sized associations were observed between greater resilience (overall resilience, accommodative coping) and lower frequency of self-reported forgetting. Small positive associations were observed between language performance and total resilience, active coping self-efficacy, and accommodative coping self-efficacy. Small negative associations were observed between spirituality and each objective measure of cognitive performance.Future longitudinal studies will help elucidate the complex relation between resilience and cognitive functioning in LLD. In addition, randomized controlled trials targeting coping self-efficacy may inform the development of more effective and personalized interventions.

2. Review related to prevalence of depression
a. According to Judit Balar's in June 2013.
The objective was to study investigates the characteristics of adolescent depression and anxiety with a focus on suicidal risk. The result of that study was the 32% of the adolescent were subthreshold anxious and 5.8% anxious and 29.2% subthreshold depressed and 10.5% depressed. Both threshold and subthreshold anxiety and depression were related to functional impairment and suicidality.

b. According to mental disorders collaborators Lancet 2021.
Before 2020 mental disorders were leading cause of global health related burden with depressive and anxiety disorders being leading contributors to this burden. The emergence of Covid-19 pandemic has created an environment where many determinants of poor mental health are exacerbated. A systemic review of data reporting the prevalence of major depressive disorder during Covid-19 pandemic. Due to decrease human mobility and daily SARC Co-V-2 infection rate that was increase in prevalence of major depressive disorder and anxiety. They estimated an additional 53.2 million cases of major depressive disorders globally due to Covid-19 pandemic, such that total prevalence was 3152.9 cases per 100000 population.

c. According to Asif Jeelani, Sabira Aalia Dkhar 04 March 2022
The aim of study was The present study was conceptualised to estimate the prevalence of depression and anxiety and its determinants among school-going adolescents in the Kashmir valley of India.
The result of research was The Patient Health Questionnaire for Adolescents and Generalised Anxiety Disorder questionnaire were used to screen for depression and anxiety among school-going adolescents aged between 15 and 19 years during January and February 2021. Out of the 439 adolescents who had responded, 426 (97.03%) were included in final analysis. The adolescents had a mean age of 17.5 + 1.26 years and comprised of 57% males. The overall prevalence of depression was 16% and was associated with a past history of COVID-19 infection. Anxiety was present in 20% of adolescents. The prevalence was 14% for boys and 27.5% for girls. On logistic regression, anxiety was associated with female gender, past history of personal COVID-19 infection, history of COVID-19 diagnosis in family and hospital admission due to COVID- 19 in family

d. According to Indian J Community Med. 2021 Jul-Sep.
The objective is to estimate the prevalence of severe depression among rural adolescents and also to identify few epidemiological determinants causing severe depression.

The result was Only 24 (7%) of adolescents were found to be having severe depression. The subcategories of depression showed mild mood disturbance in 8.8%, borderline depression in 15.2%, and moderate depression in 12% individuals. Almost 267 (78.2%) were between 15 and 19 years of age. The mean age (standard deviation) of the participants was 16 ± 1.9 years. Majority of the participants belonged to joint family and lower middle-class status as per the Modified Kuppuswamy Scale.

e. According to Jinghui Wang, Xiaohang Wu and

Haotian Lin 2017 Aug 23.

Objectives was the Depression and depressive symptoms are common mental disorders that have a considerable effect on patients' health-related quality of life and satisfaction with medical care, but the prevalence of these conditions varies substantially between published studies. The aim of this study is to conduct a systematic review and meta-analysis to provide a precise estimate of the prevalence of depression or depressive symptoms among outpatients in different clinical specialties.

Results of the study was Eighty-three cross-sectional studies involving 41 344individuals were included in this study. The overall pooled prevalence of depression or depressive symptoms was 27.0% (10 943/41 344 individuals; 95% CI 24.0% to 29.0%), with significant heterogeneity between studies (p<0.0001, $\tau 2$=0.3742, I2=96.7%). Notably, a significantly higher prevalence of depression and depressive symptoms was observed in outpatients than in thehealthy controls (OR 3.16, 95% CI 2.66 to 3.76, I2=72.0%, $\chi 2$=25.33). The highest depression/depressive symptom prevalence estimates occurred in studies of outpatients from otolaryngology clinics (53.0%), followed by dermatology clinics (39.0%) and neurology clinics (35.0%). Subgroup analyses showed that the prevalence of depression and depressive symptoms in different specialties varied from 17.0% to 53.0%. The prevalence of depression and depressive symptoms was higher among outpatients in developing countries than in outpatients from developed countries. Moreover, the prevalence of depression and depressive symptoms in outpatients slightly decreased from 1996 to 2010. Regarding screening instruments, the Beck Depression Inventory led to a higher estimate of the prevalence of depression and depressive symptoms (1316/4702, 36.0%, 95% CI 29.0% to 44.0%, I2=94.8%) than the Hospital Anxiety and Depression Scale (1003/2025, 22.0%, 95% CI 12.0% to 35.0%, I2=96.6%).

3. Review related to causes of depression
a. According toVivek Bansal, Sunil Goyal, and Kalpana Srivastava (AFMCpune)in 2009 Jan-Jun;
This study shows that Study of prevalence of depression in adolescent studentsof a public school Three to nine per cent of teenagers meet the criteria for depression at any one time, and at the end of adolescence, as many as 20% of teenagers report a lifetime prevalence of depression. Usual care by primary care physicians fails to recognize 30-50% of depressed patients. Materials and Methods:Cross-sectional one-time observational study using simple screening instruments for detecting early symptoms of depression in adolescents. Two psychological instruments were used: GHQ-12 and BDI. Also socio- demographic data (e.g. academic performance, marital harmony of parents, bullying in school, etc) was collected in a separate semi-structured performa. Statistical analysis was done with Fisher's Exact Test using SPSS17.

The result of study was Results:15.2% of school-going adolescents were foundto be having evidence of distress (GHQ-12 score e14); 18.4% were depressed (BDI score e12); 5.6% students were detected to have positive scores on both the instruments. Certain factors like parental fights, beating at home and inability to cope up with studies were found to be significantly (P < 0.05) associated with higher GHQ-12 scores, indicating evidence of distress.

Economic difficulty, physical punishment at school, teasing at school and parental fights were significantly (P < 0.05) associated with higher BDI scores, indicating depression. The study highlights the common but ignored problem of depression in adolescence. We recommend that teachers and parents be made aware of this problem with the help of school counselors so that the depressed adolescent can be identified and helped rather than suffer silently.
b. According to hong-he zang1Department of Psychiatry, Xiamen Xianyue Hospital, Xiamen, In 07 July 2020
This study shows that Depressive symptoms are common in empty-nest elderly in China, but the reported prevalence rates across studies are mixed. This is a meta-analysis of the pooled prevalence of depressive symptoms (depression hereafter) in empty-nest elderly in China.

The result of study was total of 46 studies with 36,791 subjects were included. The pooled prevalence of depression was 38.6% (95%CI: 31.5–46.3%).

Compared with non-empty-nest elderly, empty-nest elderly were more likely to suffer from depression (OR=2.0, 95%CI: 1.4 to 2.8, P<0.001). Subgroup and meta-regression analyses revealed that mild depression were more common inempty-nest elderly than moderate or severe depression (P<0.001). In addition, living alone (P=0.002), higher male proportion (β=0.04, P<0.001), later year of publication (β=0.09, P<0.001) and higher study quality score (β=0.62, P<0.001) were significantly associated with higher prevalence of depression.In this meta-analysis, the prevalence of depression in empty-nest elderly was high in China. Considering the negative impact of depression on health outcomes and well-being, regular screening and appropriate interventions need to be delivered for this vulnerable segment of the population.

4. Review related to sign and symptoms of depression
a. According to Héctor J Pérezcano in 2021.
The objective of the study was to determine the state of anxiety, depression, and stress present in the society during the development of the 2019 coronavirus pandemic.

The result of that research shows More than 40% of the subjects presented some degree of anxiety and 41.3% depression; the proportion of stress was < 30%. Of the

subjects who experienced anxiety shows some moderate to severesymptoms of depression and stress.

b. According to ORIGINAL RESEARCH article Front. Psychiatry, 27 September2019
This study shows that. Low Self-Esteem and Its Association With Anxiety, Depression, and Suicidal Ideation in Vietnamese Secondary School Students: A Cross-Sectional Study There is a correlation between self-esteem in adolescents and risks and protective factors for their health and welfare. The study was conducted to determine the prevalence of low self-esteem and sociodemographic features related to anxiety, depression, educational stress, and suicidal ideation in secondary school students in Vietnam.

The method was A cross-sectional design was employed for this study with participation of 1,149 students in Cantho City in Vietnam. A structured questionnaire was applied to ask about self-esteem, depression, anxiety, educational stress, and suicidal ideation. The result was Students with low self- esteem were detected at a prevalence of 19.4%. High educational stress and physical and emotional abuse by parents or other adults in the household weremajor risk factors correlated to low self-esteem, while a protective factor for low self-esteem was attending supplementary classes. An association among lower self-esteem and increased anxiety, depression, and suicidal ideation was detected. Self-esteem is associated with anxiety, depression, and academic stress, which significantly affect students' quality of life and links to suicidal ideation. These results therefore suggested the need for a school-based or web-based provision aimed at proactively increasing students' self-esteem andskills for dealing with academic stress.

C. According to Arda Karagöl. Psychiatr Danub. In July 2021 The study shows relation between levels of depression and quality of medical students The background of study was Medical education is amongst the educational processes with the highest stress load. This study was conducted to determine levels of depression, anxiety and quality of life of medical students in a university hospital. Subjects and methods was third year and sixth year medical students which accepted to be participate to the study and sign informed consent form are included in the study. Data was evaluated by descriptive statistics.

The Result was Totally 81 students of which 41 are third year, and 40 are sixth year students are included to the study. 79% of participants are women and 100% are unmarried. Accordingly, Beck Depression Inventory, ratio of those who have (any level of) depression are 58.5% in third year students and 55% in sixth year students. Ratio of those who have moderate to severe anxiety is 34.1% in third year students and 25% in sixth year students. Differences between them are not statistically significant. Regarding subscales of life quality; sixth year students have higher scores on general health perception then third year students. Medical students have lower scores in; difficulty in physical role, difficulty in emotional role, energy, mental health, social functioning and perception on general health when compared to the average scores of general public In this study medical students are having a lower quality of life regarding most of the subscales when compared to normal population and both third year and sixth year students are found to be having high depression and anxiety levels. As medical training is a hard and long road to go, it is important to encourage medical students to get Psychiatric support when needed. This is important for them to maintain their mental health.

D. According to K S Kendler. Mol Psychiatry. 2017 Nov.
This study shows that genealogy of major depression : symptoms and signs of melancholia How deep are the historical roots of our concept of major depression (MD)? I showed previously that psychiatric textbooks published in 1900-1960 commonly described 18 characteristic depressive symptoms/signs that substantially but incompletely overlapped with the current DSM (Diagnostic and Statistical Manual of Mental Disorders) MD criteria. I here expand that inquiry to the key years of 1880-1900 during which our major diagnostic categories of manic-depressive illness (MDI) and dementia praecox were developed. I review the symptoms of depression/melancholia in 28 psychiatric textbooks and 8 other relevant documents from this period including monographs, reviews and the first portrayal of melancholia Kraepelin in 1883. Descriptions of melancholia in the late nineteenth and twentieth century textbooks closely resembled each other, both reporting a mean of 12.4 characteristic symptoms, and emphasizing core features of mood change and alterations in cognitive content and psychomotor behavior. The detailed monographs, reviews and the early description of Kraepelin were more thorough, reporting a mean of 16.6 of these characteristic symptoms. These nineteenth century texts often contained phenomenologically rich descriptions of changes in mood and cognition, loss of interest and anhedonia and emphasized several features not in DSM including changes in volition/motivation, posture/facial expression and derealization/depersonalization. In the early nineteenth century, melancholia was often defined primarily by delusions or as the initial phase of a unitary psychosis transitioning to mania and then dementia. By 1880, the concept of depression as an independent mood disorder with characteristic symptoms/signs and a good prognosis had stabilized. Kraepelin incorporated this syndrome into his diagnostic concept of MDI, changing its name to 'Depressive States', but did not alter its underlying nature or clinical description.

e. According to Matthieu Hein et al. BMC Psychiatry. 2017.
Our aim is to verify empirically the existence of a major depressed subgroup with a similar polysomnographic pattern as primary insomnia, including at rapid eye

movement sleep level. The Methods was The polysomnographic data from 209 untreated individuals (30 normative, 84 primary insomnia sufferers, and 95 major depressed patients with objective insomnia) who were recruited retrospectively from the Erasme hospital database were studied for the whole night and thirds of the night. The result was Primary insomnia sufferers and major depressed patients with objective insomnia exhibit a similar polysomnographic pattern both for the whole night (excess of wake after sleep onset, deficit in slow-wave sleep/rapid eye movement sleep, and non-shortened rapid eye movement latency) and thirds of the night (excess of wake after sleep onset at first and last third, deficit in slow-wave sleep in first third, and deficit in rapid eye movement sleep in first and last third), including at rapid eye movement sleep level.

In our study, we demonstrated that major depressed patients with objective insomnia showed a similar polysomnographic pattern as primary insomnia, including at rapid eye movement sleep level, which supports the hypothesis of a common pathophysiology that could be hyperarousal. This opens new avenues for understanding the pathophysiology of major depression with objective insomnia.

5. Review related to preventive aspect of depression
a. According to George mommen in November 2013.
The objective of study was to examine whether physical activity is protective against onset of depression. Total 30 studies were included for analysis among these 25 studies demonstrate that physical activity may prevent future depression. Physical activity may serve valuable mental health promotion strategy in reducing risk of developing depression.

Given its high prevalence and impact on quality of life, more research is needed in identifying factors that may prevent depression. This review examined whether physical activity (PA) is protective against the onset of depression. A comprehensive search was conducted up until December 2012 in the following databases: MEDLINE, Embase, PubMed, PsycINFO, SPORTDiscus, and Cochrane Database of Systematic Reviews. Data were analyzed between July 2012 and February 2013. Articles were chosen for the review if the study used a prospective-based, longitudinal design and examined relationships between PA and depression over at least two time intervals. A formal quality assessment for each study also was conducted independently by the two reviewers. The initial search yielded a total of 6363 citations. After a thorough selection process, 30 studies were included for analyses. Among these, 25 studies demonstrated that baseline PA was negatively associated with a risk of subsequent depression. The majority of these studies were of high methodologic quality, providing consistent evidence that PA may prevent future depression. There is promising evidence that any level of PA, including low levels (e.g., walking <150 minutes/weeks), can prevent future depression

b. According to Daniel leubner and Thilo Hinterberger on 17 July 2017.
The objective of study was to music intervention have been shown to be potential alternative for depression therapy. In 26 studies statistically significant reduction in depression level by using passive listening of music(79%) active singing and playing instrument(46%). The elderly participant show impressive improvement in decreasing level of depression when they are listening music or participate in music therapy projet.

C. According to Tina Ljungberg, Emma Bondza, and Connie Lethin in 2020 Mar This study shows that effect of pro inflammatory diet and depression. Evidence of the Importance of Dietary Habits Regarding Depressive Symptoms and Depression Pro-Inflammatory Diet and Depression.

Several studies showed an association between dietary intake with inflammatory potential and risk of depression in different populations.[17,18,20,22,33] Products associated with less impact on systemic, the relationship was strongest in people with overweight and obesity.[17] An increased risk of depression was associated with a high proportion of inflammation have been found to be vegetables, whole grains, olive oil, and fish. Products such as sweets; refined flour; high-fat products; red and processed meat were associated with a greater impact on systemic inflammation.[17]

The result of study was showed that a pro-inflammatory diet was associated with a significantly increased risk of depression in the subgroup of women; middle-aged adults; and people with overweight and obesity. Thus processed foods in the diet, and for each 10% increase of the proportion of processed foods.[18] High intake of pro-inflammatory food was associated with significantly increased risk of depressive symptoms.[17,18,20,22] In subgroups of men, smokers and physically inactive, a diet consisting of a higher proportion of pro-inflammatory foods, significantly increased the risk of depressive symptoms.[20] Associations between food with inflammatory effect and increased risk of depression were calculated with significance in a cross-sectional study performed in USA.[22] A high intake of inflammatory diet was significantly associated with the occurrence of frequent anxiety in the same study. In another study from USA, the results indicated a significant association between inflammatory diet and risk of depression in women.[33]

D. According to Tina Ljungberg, Emma Bondza, and Connie Lethin in 2020 Mar
This study shows that dietary intake of micronutrients linked to depression.Micronutrients in the diet have been associated with an increased risk of mental illness.[17,19,23,28,29,32,38] Magnesium intake through diet was significantly associated with the risk of developing depression in middle- aged men.[38] Calculations were made between three statistical models regarding the

content of magnesium in the diet, and the lowest intake of magnesium was associated with a significantly increased risk of depression.

When all three models in the study were compared, it was found that those with the highest magnesium intake had a protective effect against depression.[38] Relationships between intake of B12, folic acid, and magnesium emergedas side effects in the result where the main purpose was to investigate adherence to healthy dietary advice.[19] Those with the highest adherence to healthy dietary advice in the same study had thus less risk of depressive symptoms and a significantly higher intake of magnesium, folic acid, and B12 in the diet. In another study, high intake of processed food increased the risk of depression, and those with high intake of processed food had significantly lower intake of B12, magnesium, and folic acid in their diet, compared to the group that had the lowest intake of processed foods.[18] Significant associations in both genders have been calculated regarding vitamin B intake and the risk of depression.[29] In women, those with the highest intake of B6 had a reduced risk and among men, the ones with the highest intake of B12 had a reduced risk. Low levels of B6 and B12, respectively were associated with an increased risk of depression in the same study. Intake of fatty acids in the diet was investigated as mediators on risk of inflammation and associations with depression in older people.[32] Inflammation markers in the study were measured with C-reactive protein (CRP) and interleukin-6 (IL-6).

The rIL-6t of study was showed that omega 3 and polyunsaturated fatty acids had protective effects for depression in men, and CRP was the marker that was significantly affected. Furthermore, the total intake of fat, saturated fatty acids, and monounsaturated fatty acids had a significantly increased impact on both CRP and IL-6 in women. Dietary intake of flavonoid subclasses had in one study, a significant protective effect against risk of depression among women. Futhermore, the highest intakes of flavonols, flavones, and flavanones were significantly associated with a 7%–10% lower risk of depression compared with the lowest intakes in a study from USA [23]. In a study by Godos et al. [28], dietary intakes of total polyphenols, their classes, subclasses, and compounds were assessed in relation to depressive symtoms. In their result, no significant association with depressive symptoms was found with the total polyphenol intake. In subclasses, this study assessed significance, indicating that higher flavonoids intake may be inversely associated with depressive symptoms.

E. According to Sarah D. Pressman(PhD), in 2009 Jul 10.
This study shows that Association of Enjoyable Leisure Activities With Psychological and Physical Well-being objective is to examine whether engaging in multiple enjoyable activities was associated with better psychological and physiological functioning. Few studies have examined the health benefits of the enjoyable activities that individuals participate in voluntarily in their free time. Participants from four different studies (n = 1399total, 74% female, age = 19–89 years) completed a self-report measure (Pittsburgh Enjoyable Activities Test (PEAT)

The result was Higher PEAT scores were associated with lower blood pressure, total cortisol, waist circumference, and body mass index, and perceptions of better physical function. These associations withstood controlling for demographic measures. The PEAT was correlated with higher levels of positive psychosocial states and lower levels of depression and negative affect.

6. Review related to management of depression
a. According to Mathew J Bair, Rebecca L., Robinson M in November 2003.
The objective was to determine the prevalence of both depression and pain and effects of co morbidity on diagnosis and treatment. Several studies have reported association between depression and pain. Specifically addressing how the risk of depression increased as function of different aspect of pain. Patient with multiple pain symptoms are 3 to 5 times more likely to be depressed thanpatient without pain.
b. According to Rhys Bevan Jones (Patient Education Couns) in 2018 May.
This study shows that positive effect of Psychoeducational interventions in adolescent depression. Fifteen studies were included: seven targeted adolescents with depression/depressive symptoms, eight targeted adolescents 'at risk' e.g. with a family history of depression. Most involved family/group programmes; others included individual, school-based and online approaches. PIs may affect understanding of depression, identification of symptoms, communication, engagement, and mental health outcomes
The conclusion of study was PIs can have a role in preventing/managingadolescent depression, as a first-line or adjunctive approach.
C. According to Thomas M Penders et al(Prim Care Companion CNS Disord.)in2016.
This study shows that effect of Bright Light Therapy as Augmentation of Pharmacotherapy for Treatment of Depression bright light therapy has demonstrated efficacy and is an accepted treatment for seasonal depression. Ithas been suggested that bright light therapy bright light therapy $\geq$ 5,000 lux for $\geq$ 30 minutes to may have efficacy in non seasonal depressions. Also, there is evidence that bright light therapy may improve responsiveness to antidepressant pharmacotherapy

The result of study was 10 studies involving 458 patients showed improvement using bright light therapy augmentation versus antidepressant pharmacotherapy alone.

D. According to Jojo Y Y Kwok et al. JAMA Neurol.in 2019**.**

This study shows the comparison between effects of Mindfulness Yoga vs Stretching and Resistance Training Exercises on Anxiety and Depression for People With Parkinson Disease To compare the effects of a mindfulness yoga program vs stretching and resistance training exercise (SRTE) on psychological distress, physical health, spiritual well-being, and health-related quality of life (HRQOL) in patients with mild-to-moderate PD.Mindfulness yoga was delivered in 90-minute groups and SRTE were delivered in 60-minute groups for 8 weeks Among patients with mild-to-moderate PD.

The result of study was that the mindfulness yoga program was found to be as effective as SRTE in improving motor dysfunction and mobility, with the additional benefits of a reduction in anxiety and depressive symptoms and an increase in spiritual well-being and HRQOL.

E.   According to Martha C Tomson Am Acad Child Adolescent Psychiatry.in 2017Jun.

This study shows the A Randomized Clinical Trial Comparing Family-Focused Treatment and Individual Supportive Therapy for Depression in Childhood and Early Adolescence examined the efficacy of psychosocial treatment for depressive disorders during childhood. Integrating family in treatment could have particularly salutary effects during this developmental period. This trial compared immediate post treatment effects of family-focused treatment for childhood depression (FFT-CD) with those of individual supportive psychotherapy (IP) for children 7 to 14 years old with depressive disorders.

The result of study was Children were randomized to 15 sessions of FFT-CD (n =67) or IP (n = 67) over 4 months Significant improvement was evident across groups for depressive and non-depressive symptoms, global response, and functioning and social adjustment Results support the value of psychosocial intervention, emphasize the important role that families play, and highlight the potential for FFT-CD for supporting recovery in children with depression.

CHAPTER III
RESEARCH METHODOLOGY

Introduction
The research design or methodology is overall plan of investigator for obtaining answer to the question being studied and for handling some of difficulties encountered during the research process
Research approach the focus of the study is to assess signs and symptoms of depression

Setting of the study
• This study was conducted in College of Nursing Sir JJ Group of HospitalMumbai-08.
• -Population sample and sampling techniques
• The sample consisted 100 college students, who fulfilled the required criteria.

Inclusion criteria
College students who are studied in college of nursing , sir j.j group of hospitalCollege students has age between 17 to 22 and above 22years.

Students who those present during data collection

Exclusion criteria
College students who are not studying in college of nursing ,sir j. j. group ofhospital.
Client who are not willing to participate.

Technique and tool
The data gathering technique used was nonprobable and convenient and the tools used for the study was Questionnaire.

Validity and Reliability
The tool was given to the expert for scrutinizing its adequacy and relevance suggestion were incorporated in the tool.
The reliability of the measuring instrument is a major criterion for assessingit's quality and adequacy. In order to determine the reliability, practicability and feasibility a try out was done on II year BBsc nursing students of College ofNursing Sir JJ Group Of Hospital.

Pilot Study
In order to pre test and refine the tool and technique and check the feasibilityof the study a pilot study was done on 5 B Bsc Nursing Students who fulfilled the predetermined criteria a few necessary modifications made in the tool after the pilot study.

Data Collection Procedure
The data collection was done on 21 April 2022.The students were given questionnaire at 2pm-4pm.All subjects were explained purpose of the study after establishing rapport. The confidentiality of their responses was assured.

Data collection will be done in selected area on college students age groupafter getting written permission from concern authority.

The purpose of study will be provide questionaries to the selected population which questionaries contain 21 questions verified by the ethical authority.

To assess sign symptoms of depression among college students

College students will be selected based on inclusion and exclusion criteria

Plan For Data Analysis
The data obtained was analyse and interpret using frequency distribution andpercentage It was also planned to organised and present the analysed the data is followingthree parts

Part 1- Description of sample in term of demographic data

Part-2-Findings based on becks depression including 1.Mild depression 2. depression 3.Severe depression

Part 3-Findings based on age group in relation to becks depression scale.

In descriptive technique the frequency distribution technique will be used in form of tables and graphs. percentage will be used to compare two variables.

Summary
This chapter deal with research approach, setting up to the study population of the samples, criteria for selection of samples , technique and tools, validity and reliability , pilot study , procedure of data collection and plan for data analysis

Chapter No IV
Analysis and Interpretation of Data
This chapters deals with analysis and interpretation of the data collected from 100 samples . descriptive technique was used to analyse and interpret the findings in order to meet the objectives of the study

The objectives of the study are:
1. To identify sign and symptoms of depression among college students
2. To find out number of suffering from sign and symptoms of depression in selected community in metropolitan city.
3. To assess the prevalence of depression among college students at different levels of education and find about their stressors

Organization of data
Part 1- Description of sample in term of demographic dataPart-2-Findings based on becks depression including Part-3- Findings based on age group in relation to becks depression scale

Part 1- Description of sample in term of demographic data
The sample was described according to their age , educational status . the details of this information are presented here

Table 1

SR.NO	ITEMS	FREQUENCY	PERCENTAGE
1	AGE: • 17-18 years • 19-20 years • 21-22 years • Above 22 years	13 samples 47 samples 36 samples 4 samples	13% 47% 36% 4%
2	EDUCATIONAL STATUS: • First year basic bscnursing • Second year basic bsc	56 students 44 students	56% 44%
	nursing		

AGE
- 13 samples were in the age group between 17-18 years
- 47 samples were in the age group between 19-20 years
- 36 samples were in the age group between 21-22 years
- 4 samples were in the age group above 22
- Majority of samples were in the age group 19-20 years i.e. 47

Educational Status
- 56 of the samples were first year basic bsc nursing students
- 44 of samples were second year basic bsc nursing students.

Demographic data of age
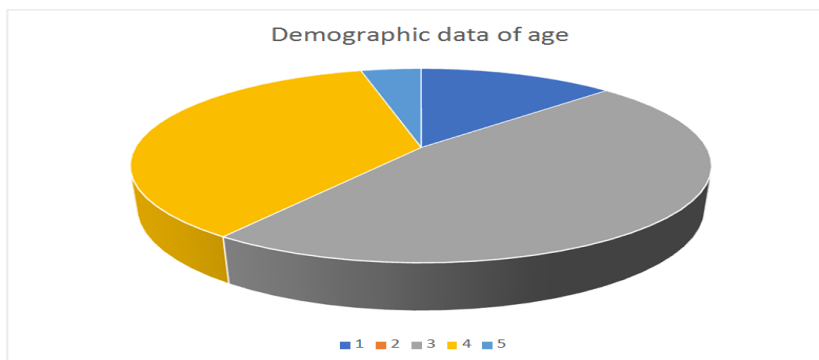
Part-2 – Findings based on becks depression scale including
1. Mild depression
2. Moderate depression
3. Severe depression

	Frequency	Percentage Distribution
Mild	38	38%
Moderate	25	25%
Severe	07	7%

Above table shows the frequency and percentage distribution of mild, moderate and severe depression among college students.38(38%) of students have mild depression, 25(25%) of students have moderate depression, whereas 7(7%) of students have severe depression.
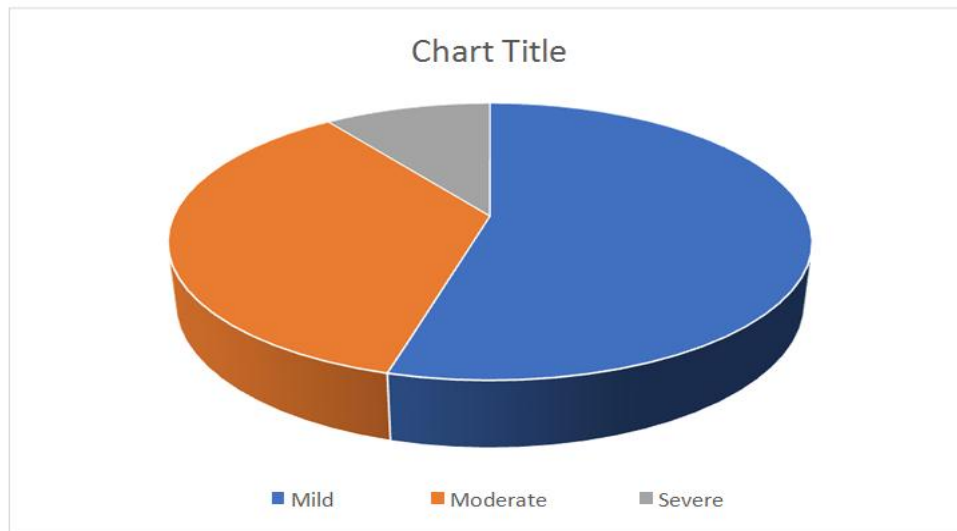
Table 2: Frequency and percentage distribution of students regarding Question no 1.

Options	Score	Frequency	Percentage
I do not feel sad	0	42	42%
I feel sad	1	47	47%
I am sad all the time and can't snap out of it	2	5	5%
I am so sad and unhappy that I can't stand it	3	6	6%

Above table shows that 42(42%) of students do not feel sad, 47(47%) of students feel sad,5(5%) of students feels sad all the time and can't snap out ofit, whereas 6(6%) of students feel sad, unhappy and can't stand it

Table 3: Frequency and percentage distribution of students regarding Question no 2.

Options	Score	Frequency	Percentage
I am not particularly discouraged about the future	0	52	52%
I feel discourage about the future	1	33	33%
I feel I have nothing to look forward to	2	09	9%
I feel the future is hopelessand that things connot improve	3	06	6%

Above table shows that 52(52%) of students feels that they are not particularly discouraged about the future,33(33%) of students feel discouraged about the future,9(9%) of students feel they have nothing to look forward to, whereas 6(6%) of students feels that future is hopeless and that things cannot improve.

Table 4: Frequency and percentage distribution of students regarding Question no 3.

Options	Score	Frequency	Percentage
I do not feel like a failure	0	54	54%
I feel I have failed more than the average person	1	21	21%
As I look back on my life all I can see is a lot of failures	2	24	24%
I feel I am a complete failure as a person	3	01	1%

Above table shows that 54(54%) of students do not feel like a failure,21(21%)students feels that they have failed more than an average person,24(24%) of students feels that as they look back on their life all they can see is a lot of failures, whereas 1(1%) of students feels that they are complete failure as aperson.

Table 5: Frequency and percentage distribution of students regarding Question no 4.

Options	Score	Frequency	Percentage
I get as much satisfaction out of things as I used to	0	51	51%
I don't enjoy things the way I used to be	1	26	26%
I don't get real satisfaction out of anything anymore	2	18	18%
I am dissatisfied or bored with everything	3	05	5%

Above table shows that 51(51%) of students I get as much satisfaction out of things as they used to,26(26%) of students don't enjoy things the way they used to be,18(18%) of students don't get real satisfaction out of anything anymore, whereas 5(5%) of students are dissatisfied or bored with everything.

Table 6: Frequency and percentage distribution of students regarding Question no 5.

Options	Score	Frequency	Percentage
I don't feel particularly guilty	0	23	23%
I feel guilty a good part of time	1	44	44%
I feel quite guilty most of time	2	32	32%
I feel guilty all of the time	3	01	1%

Above table shows that 23(23%) of students don't feel particularly guilty,44(44%) of students feels guilty a good part of time,32(32%) of studentsfeel guilty most of time, whereas 1(1%) of student feels guilty all of the time.

Table 7: Frequency and percentage distribution of students regarding Question no 6.

Options	Score	Frequency	Percentage
I don't feel I am being punished	0	50	50%
I feel I may be punished	1	34	34%
I expect to be punished	2	08	8%
I feel I am being punished	3	08	8%

Above table shows that 50(50%) of students don't feel that they are beingpunished,34(34%) of students feel that they may be punished,8(8%) of students expect to be punished,8(8%) of students feels that they are being punished.

Table 8: Frequency and percentage distribution of students regarding Question no 7.

Options	Score	Frequency	Percentage
I don't feel disappointed in myself	0	51	51%
I am disappointed in myself	1	38	38%
I am disgusted with myself	2	06	6%
I hate myself	3	05	5%

Above table shows that51(51%) of students don't feel disappointed with themselves,38(38%) of students feels disappointed with themselves,6(6%) of students feels disgusted with themselves, whereas 5(5%) of students hate themselves.

Table 9: Frequency and percentage distribution of students regarding Question no 8.

Options	Score	Frequency	Percentage
I don't feel I am any worse than anybody else	0	34	34%
I am critical of myself for my weaknesses or mistakes	1	35	35%
I blame myself all the time for my faults	2	20	20%
I blame myself for everything bad that happens	3	11	11%

Above table shows that 34(34%) of students don't feel that they are any worse than anybody else,35(35%) of students that they are critical of themselves for their weaknesses or mistakes,20(20%) of students blame themselves all the time for their faults,11(11%) of students blame themselves for everything bad that happens.

Table 10: Frequency and percentage distribution of students regarding Question no 9.

Options	Score	Frequency	Percentage
I don't have any thoughts of killing myself	0	73	73%
I have thoughts of killingmyself but I would not carry them out	1	21	21%
I would like to kill myself	2	03	3%
I would kill myself if I had a chance	3	03	3%

Above table shows that 73(73%) of students don't have any thoughts of killing themselves,21(21%) of students have thoughts of killing themselves but they would not carry them out,3(3%) of students would like to kill themselves, whereas 3(3%) of students would kill themselves if they had a chance.

Table 11: Frequency and percentage distribution of students regarding Question no 10.

Options	Score	Frequency	Percentage
I don't cry anymore than usual	0	46	46%
I cry more now than I used to	1	17	17%
I cry all the time now	2	02	2%
I used to be able to cry but now I can't cry even though I want to	3	35	35%

Above table shows that 46(46%) of students don't cry anymore than usual,17(17%) of students cry more than they used to,2(2%) of students cry all the time now, whereas 35(35%) of students used to be able to cry but now they can't cry even though they want to.

Table 12: Frequency and percentage distribution of students regarding Question no 11.

Options	Score	Frequency	Percentage
I am no more irritated by things than I ever was	0	35	35%
I am slightly more irritated now than usual	1	43	43%
I am quite annoyed or irritated a good deal of the time	2	15	15%
I feel irritated all the time	3	07	7%

Above table shows that 35(35%) of students feel no more irritated by thingsthan they ever was,43(43%) of students feel slightly more irritated now than usual,15(15%) of students feels quite annoyed a good deal of the time, whereas 7(7%) of students feel irritated all the time.

Table 13: Frequency and percentage distribution of students regarding Question no 12.

Options	Score	Frequency	Percentage
I have not lost interest in other people	0	24	24%
I am less interested in other people than I used to be	1	50	50%
I have lost most of my interest in other people	2	19	19%
I have lost all of my interest in other people	3	07	7%

Above table shows 24(24%) of students have not lost interest in other people,50(50%) of students are less interested in other people than they used to be,19(19%) of students have lost most of their interest in other people, whereas 7(7%) of students have lost all of their interest in other people.

Table 14: Frequency and percentage distribution of students regarding Question no 13.

Options	Score	Frequency	Percentage
I make decision about as well as I ever could	0	46	46%
I put of making decisions more than I used to	1	22	22%
I have greater difficulty inmaking decisions more than I used to	2	26	26%
I can't make decisions at all anymore	3	06	6%

Above table shows that 46(46%) of students make decisions as well as they ever could,22(22%) of students put of making decisions more than they used to,26(26%) of students have greater difficulty in making decisions more thanthey used to, whereas 6(6%) of students can't make decision at all anymore.

Table 15: Frequency and percentage distribution of students regarding Question no 14.

Options	Score	Frequency	Percentage
I don't feel that I look any worse than I used to	0	63	63%
I am worried that I am looking old or unattractive	1	20	20%
I feel there are permanentchanges in my appearancethat make me look unattractive	2	14	14%
I believe that I look ugly	3	03	3%

Above table shows that 63(63%) of students don't feel that they look any worse than they used to,20(20%) of students are worried that they are looking old and unattractive,14(14%) of students feel that there are permanent changes in their appearance that make them look unattractive, whereas 3(3%)of students believe that they look ugly.

Table 16: Frequency and percentage distribution of students regarding Question no 15.

Options	Score	Frequency	Percentage
I can work about as well as before	0	25	25%
It takes an extra effort toget started at doing something	1	50	50%
I have to push myself very hard to do anything	2	24	24%
I can't do any work at all	3	01	1%

Above table shows that 25(25%) of students can work about as well as before,50(50%) of students takes extra efforts to get started at doing something, 24(24%) of students have to push themselves very hard to do anything, whereas (1%) of students can't do any work at all.

Table 17: Frequency and percentage distribution of students regarding Question no 16.

Options	Score	Frequency	Percentage
I can sleep as well as usual	0	65	65%
I don't sleep as well as I used to	1	20	20%
I wake up 1-2hrs earlier than usual and find it hard to get back to sleep	2	08	8%
I wake up several hours earlier than I used to and cannot get back to sleep	3	07	7%

Above table shows that 65(65%) of students can sleep as well as usual, 20(20%) of students don't sleep as well as they used to,8(8%) of students wake up 1-2 hrs earlier than usual and find it hard to get back to sleep, whereas 7(7%) of students wake up several hours earlier than they used to and cannotget back to sleep**.**

Table 18: Frequency and percentage distribution of students regarding Question no 17.

Options	Score	Frequency	Percentage
I don't get more tired than usual	0	40	40%
I get tired more easily than I used to	1	46	46%
I get tired from doing almost anything	2	09	9%
I am too tired to do anything	3	05	3%

Above table shows that 40(40%) of students don't get more tired than usual,46(46%) of students get tired more easily than they used to,9(9%) of students get tired from doing almost anything, whereas(5%) of students are too tired to do anything.

Table 19: Frequency and percentage distribution of students regarding Question no 18.

Options	Score	Frequency	Percentage
My appetite is no worse than usual	0	48	48%
My appetite is not as good as it used to be	1	40	40%
My appetite is much worse now	2	07	7%
I have no appetite at all any more	3	05	5%

Above table shows that 48(48%) of students have no worse appetite than usual,40(40%) of students have appetite not as good as it used to be,7(7%) of students have appetite worse now, whereas 5(5%) of students have noappetite at all anymore.

Table 20: Frequency and percentage distribution of students regarding Question no 19.

Options	Score	Frequency	Percentage
I haven't lost much weight if any lately	0	77	77%
I have lost more than 5pounds	1	18	18%
I have lost more than 10 pounds	2	03	3%
I have lost more than 15 pounds	3	02	2%

Above table shows that 77(77%) of students haven't lost much weight if anylately,18(18%) of students have lost more than 5 pounds,3(3%) of students have lost more than 10 pounds, whereas 2(2%) of students have lost more than 15 pounds.

Table 21: Frequency and percentage distribution of students regarding Question no 20.

Options	Score	Frequency	Percentage
I am no more worried about my health than usual	0	50	50%
I am worried about physicalproblems like aches, pains, upset stomach or constipation	1	31	31%
I am very worried about physical problems and it's hard to think of much else	2	12	12%
I am so worried about myphysical problem that I cannot think of anything else	3	07	7%

Above table shows that 50(50%) of students are no more worried about theirhealth than usual,31(31%) of students are worried about physical problems like aches, pains, upset stomach or constipation,12(12%) of students are very worried about physical problems and it's hard to think of much else, whereas 7(7%) of students are so worried about their physical problems that they cannot think of anything else.

Table 22: Frequency and percentage distribution of students regarding Question no 21.

Options	Score	Frequency	Percentage
I have not noticed anyrecent changes in my interest in sex	0	67	67%
I am less interested in sex than I used to be	1	18	18%
I have almost no interest in sex	2	14	14%
I have lost interest in sex completely	3	01	1%

Above table shows that 67(67%) of students have not noticed any recent changes in their interest in sex,18(18%) of students are less interested in sex than they used to be,14(14%) of students have almost no interest in sex, whereas 1(1%) of students have lost interest in sex completely.

Below graph shows overall score of 21 questions present in standardized Beck's depression scale of 100 students regarding sign and symptoms of depression.
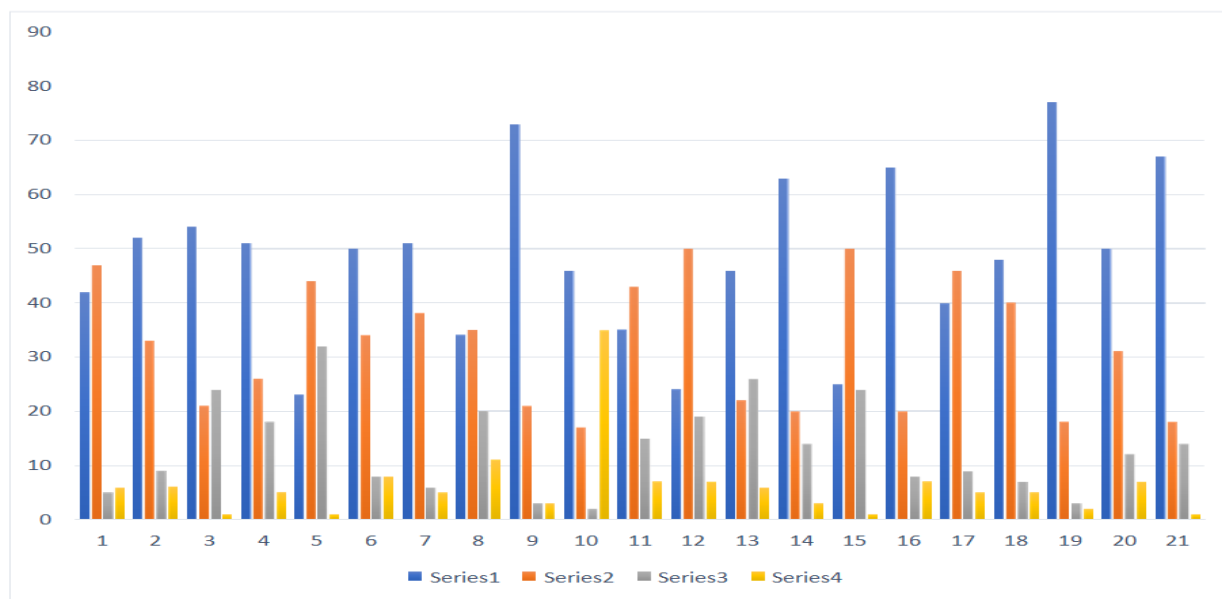
Part 3-Findings based on age group in relation to becks depressionscale.

Age	Frequency	Percentage Distribution
17-18 years	09	9%
19-20 years	32	32%
21-22 years	26	26%
Above 22 years	03	3%

Above table shows that 9(9%) of students have sign and symptoms of depression whose age is in between 17-18yQears, 32(32%) of students have sign and symptoms of depression whose age is in between 19-20 years and 26(26%) of students have sign and symptoms of depression whose age is in between 21-22years, whereas 3(3%) of students have sign and symptoms of depression whose age is above 22 years.

Chapter V
Summary, Findings, Conclusion And Reccomendation
The present study was undertaken to asses the prevalence of sign and symptoms of depression among college students in selected urban community of metropolitan city.

The objectives of study were
1. To identify sign and symptoms of depression among college students
2. To find out number of suffering from sign and symptoms of depression in selected community in metropolitan city.
3. To assess the prevalence of depression among college students at different levels of education and find about their stressors.

Depression is a common psychiatric condition that negatively affects feeling, thinking and acting.

Depression causes feeling of sadness and or a loss of interest in activities once enjoyed. As college students have stress due to various reasons such as exams, submissions etc. Depression can leads to multiple emotional and physical problem and can decrease a person's ability to function at work and at home. Therefore investigator felt the need to find out number of suffering fromsign and symptoms of depression and need to help with the support of family, friends and health professionals to those who suffering from depression and also identify those who are under risk of depression.
Investigators used descriptive evaluator study approach for the study questionnaire was used for data collection . Sample consist of 100 college students between age group of (17- 22 and above 22)years . Formal permission was taken from the respective authorities to conduct the pilot study. The pilot study was conducted on 5 samples and data collection was done.

Findings of study
Part 1 Demographic dataAGE:
- 13 samples were in the age group between 17-18 years
- 47 samples were in the age group between 19-20 years
- 36 samples were in the age group between 21-22 years
- 4 samples were in the age group above 22
- Majority of samples were in the age group 19-20

years i.e. 47

Educational status
- 56 of the samples were first year Basic Bsc nursing students
- 44 of samples were second year Basic Bsc nursing students Part 2- Finding based on becks depression

Question No 1:42(42%) of students do not feel sad, 47(47%) of students feel sad,5(5%) of students feels sad all the time and can't snap out of it, whereas 6(6%) of students feel sad, unhappy and can't stand it.

Question No 2: 52(52%) of students feels that they are not particularly discouraged about the future,33(33%) of students feel discouraged about the future,9(9%) of students feel they have nothing to look forward to, whereas 6(6%) of students feels that future is hopeless and that things cannot improve.

Question No 3: 54(54%) of students do not feel like a failure,21(21%) students feels that they have failed more than an average person,24(24%) of students feels that as they look back on their life all they can see is a lot of failures, whereas 1(1%) of students feels that they are complete failure as a person.

Question No 4: 51(51%) of students I get as much satisfaction out of things as they used to,26(26%) of students don't enjoy things the way they used to be,18(18%) of students don't get real satisfaction out of anything anymore, whereas 5(5%) of students are dissatisfied or bored with everything.

Question No 5:23(23%) of students don't feel particularly guilty,44(44%) of students feels guilty a good part of time,32(32%) of students feel guilty most of time, whereas 1(1%) of student feels guilty all of the time.

Question No 6:50(50%) of students don't feel that they are being punished,34(34%) of students feel that they may be punished,8(8%) of students expect to be punished,8(8%) of students feels that they are being punished.

Question No 7:51(51%) of students don't feel disappointed with themselves,38(38%) of students feels disappointed with themselves,6(6%) of students feels disgusted with themselves, whereas 5(5%) of students hate themselves.

Question No 8:34(34%) of students don't feel that they are any worse than anybody else,35(35%) of students that they are critical of themselves for their weaknesses or mistakes,20(20%) of students blame themselves all the time for their faults,11(11%) of students blame themselves for everything bad that happens.

Question No 9: 73(73%) of students don't have any

thoughts of killing themselves,21(21%) of students have thoughts of killing themselves but they would not carry them out,3(3%) of students would like to kill themselves, whereas 3(3%) of students would kill themselves if they had a chance.

Question No 10: 46(46%) of students don't cry anymore than usual,17(17%) of students cry more than they used to,2(2%) of students cry all the time now, whereas 35(35%) of students used to be able to cry but now they can't cry even though they want to.

Question No 11: 35(35%) of students feel no more irritated by things than they ever was,43(43%) of students feel slightly more irritated now than usual,15(15%) of students feels quite annoyed a good deal of the time, whereas 7(7%) of students feel irritated all the time.

Question No 12: 24(24%) of students have not lost interest in other people,50(50%) of students are less interested in other people than they used to be,19(19%) of students have lost most of their interest in other people, whereas 7(7%) of students have lost all of their interest in other people.

Question No 13: 46(46%) of students make decisions as well as they ever could,22(22%) of students put of making decisions more than they used to,26(26%) of students have greater difficulty in making decisions more than they used to, whereas 6(6%) of students can't make decision at all anymore.

Question No 14: 63(63%) of students don't feel that they look any worse than they used to,20(20%) of students are worried that they are looking old and unattractive,14(14%) of students feel that there are permanent changes in their appearance that make them look unattractive, whereas 3(3%) of students believe that they look ugly.

Question No 15: 25(25%) of students can work about as well as before, 50(50%) of students takes extra efforts to get started at doing something,24(24%) of students have to push themselves very hard to do anything, whereas (1%) of students can't do any work at all.

Question No 16: 65(65%) of students can sleep as well as usual, 20(20%) of students don't sleep as well as they used to,8(8%) of students wake up 1-2 hrs earlier than usual and find it hard to get back to sleep, whereas 7(7%) of students wake up several hours earlier than they used to and cannot get back to sleep.

Question No 17: (40%) of students don't get more tired than usual,46(46%) of students get tired more easily than they used to,9(9%) of students get tired from doing almost anything, whereas(5%) of students are too tired to do anything.

Question No 18: 48(48%) of students have no worse

appetite than usual,40(40%) of students have appetite not as good as it used to be,7(7%) of students have appetite worse now, whereas 5(5%) of students have no appetite at all anymore.

Question No 19: 77(77%) of students haven't lost much weight if any lately,18(18%) of students have lost more than 5 pounds,3(3%) of students have lost more than 10 pounds, whereas 2(2%) of students have lost more than 15 pounds.

Question No 20: 50(50%) of students are no more worried about their health than usual,31(31%) of

students are worried about physical problems like aches, pains, upset stomach or constipation,12(12%) of students are very worried about physical problems and it's hard to think of much else, whereas 7(7%) of students are so worried about their physical problems that they cannot think of anything else.

Question No 21: 67(67%) of students have not noticed any recent changes in their interest in sex,18(18%) of students are less interested in sex than they used to be,14(14%) of students have almost no interest in sex, whereas 1(1%) of students have lost interest in sex completely.

CONCLUSION

Findings based on Becks Depression scale.

	Frequency	Percentage Distribution
Mild	38	38%
Moderate	25	25%
Severe	07	7%

Above table shows the frequency and percentage distribution of mild, moderate and severe depression among college students 38(38%) of students have mild depression, 25(25%) of students have moderate depression, whereas 7(7%) of students have severe depression.

Recommendation
On the basis of the study following recommendation have been drawn:
- The same study could be replied on the larger sample.
- To include the entire topic of depression

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