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DEPPRESION AND ANXIENTY COMMON MENTAL HEALTH DISORDERS IN PUPILS

Havva Şaban, page 9-40

ABSTRACT

Human life, its phases, difficulties, obstacles, and solutions that can prevent or eliminate these obstacles and facilitate them have always been the subject of psychology and psychiatry. Many factors in life can lead to depression, anxiety, and stress. Depression and anxiety are two of the most common mental disorders. Many individuals with anxiety also experience depression, and vice versa.

The dynamics of modern life are increasingly complicating our mental, emotional, and social well-being. In recent years, levels of depression and anxiety, which negatively affect societal peace, have been on the rise. This situation is particularly critical for university students, who are dynamic members of society. Anxiety and depression are more prevalent among university students than the general population.

The purpose of this study was to explore the relationship between depression and anxiety among university students.

Keywords: Depression, Anxiety, Stress, University Students

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Introduction

Human life, life stages, difficulties, obstacles, and solutions to prevent or eliminate these obstacles have consistently been the subject of psychology and psychiatry. It has been observed that negative life events that may occur in a person's life can lead to anxiety and depression. In some cases, negative things in the life of an individual can assist them in coping with their issues and strengthened them.

Psychological diseases are the foremost common psychiatric health problem worldwide (Syed, Ali, & Khan, 2018). Depression is a globally very dominant and widespread issue and is projected to be the leading disease by 2030 (Syed, Ali, & Khan, 2018). Depression is a common mental illness, as stated by the World Health Organization (WHO) marked by lack of interest or enjoyment, feelings of depression and remorse, low self-worth, disrupted sleep or appetite, low energy and lose of apatite (Syed, Ali, & Khan, 2018)". Anxiety is taken in to account a state of uneasiness and it is a way of bodily response to a perceived danger that could be real or imaginary and triggered by an individual's thoughts, beliefs, and feelings. (Annosha , Shazad Ali, & Khan, 2018).

Barlow provides a model of psychopathological disorders based on advances in emotion theory. He suggests that disorders of anxiety and depression are fundamentally emotional disorders and that they have their origins in the inappropriate and spontaneous firing of certain primitive, basic, negative emotions such as fear and sadness, respectively, in individuals who are biologically over-reactive to stressful life events. In this way, those people who have an overreactive neurobiological reaction to upsetting life occasions, as well as early encounters with the need for control, will be likely to create clinically critical scenes of uneasiness or misery when activated by these negative feelings.(Alloy, 1991). However, an issue presented here is where does depression and anxiety start, and the distressed human nature beings that require treatment. The ladder is the reason why treatment and early detection are crucial and must be considered.

Depression and anxiety are two of the foremost common mental disorders. (Duivis, Vogelzangs, Kupper, de Jonge, & Penninx, 2013) Patients with depression regularly have highlights of uneasiness disorders, and those

with anxiety disorders commonly have depression as well. Both disorders may happen together, assembly the criteria for both (Tiller J. W., 2013). This may display, especially difficult circumstances for the patient, and the illness is thus amplified. It can be difficult to distinguish between them, but it is important to identify and treat both illnesses, as they are associated with significant morbidity and mortality. (Tiller J. W., 2013).

General practitioners are well placed to identify and take a primary role in the treatment of these illnesses, to facilitate better mental health outcomes (Tiller J. W., 2013).They can take place in all age groups — almost 50% of older adults with a 12-month history of GAD met the criteria for lifetime major depressive disorder, while only 7.4% of those without GAD met these criteria. (Gonçalves, Pachana, & Byrne, 2011) Considering the fact that virtually anyone can be a target, especially sensitive groups exposed to traumatic events, it is clear how it presents a threat to the entire population. However, differing among sexes, men suffered from depression and anxiety at half the rate of women (Rosenfield, 2010). Among the 7516 individuals in the experiment, the average age was 47.9, with 62% being female. (Oshiyama, et al., 2018) The mean age of premenopausal and menopausal women was 42.6 and 55.2 respectively (Oshiyama, et al., 2018). The number of individuals with no or minimal, mild, moderate, and severe depression symptoms were 4671 (62.2%), 1309 (17.4%), 992 (13.2%), and 544 (7.2%). (Oshiyama, et al., 2018).

This means that more than 50% of the population in the experiment has some sort of depression, which differs in severity. This is particularly concerning considering the fact that, the research is contemporary meaning that the general state of the world is not going towards progress and treatment, however, the self-awareness and information seem to be working in a positive way.

There are many consequences and symptoms of depression and anxiety. General symptoms include fatigue and loss of energy, feeling slowed up or agitated, and restless (Tiller J. W., 2013) Cognitive symptoms include poor attention and concentration, slow thinking, distractibility, impaired memory, and indecisiveness (Tiller J. W., 2013). Psychological symptoms are apprehension, derealization, depersonalization, irritability, and atypical anger. (Tiller J. W., 2013) There are even somatic symptoms, which include the effect on the muscle system such as muscle aches and

pain, tension, and headaches; gastrointestinal systems with the effects such as dryness of mouth, choking sensation, nausea, vomiting, and diarrhea; a cardiovascular system with symptoms such as palpitations, tachycardia, chest pain, and flushing; respiratory system in the form of shortness of breath or hyperventilation; a neurological system with issues such as dizziness, vertigo, blurred vision; and genitourinary system with the effect of loss of sex drive and difficulties with micturition (Tiller J. W., 2013). All these symptoms can occur as a result of another illness, which makes the right treatment of depression and anxiety hard and it takes an experienced physician who can recognize the symptoms and provide proper treatment.

The most prevalent anxiety disorders are post-traumatic stress disorder (6.4%), social phobia (social anxiety disorder; 4.7%), agoraphobia (2.8%), GAD (2.7%), panic disorder, (2.6%) and obsessive-compulsive disorder (1.9%) (Tiller J. W., 2013). Of the population aged 16–85 years, 14.4% have an anxiety disorder (Tiller J. W., 2013). The prevalence of depression is 6.2%, with the prevalence of unipolar depressive episodes being 4.1%, dysthymia, 1.3%, and bipolar disorder, 1.8% (Tiller J. W., 2013).

1.1 History of Anxiety

Anxiety is a biological stimulus that prepares it to take action to do what it should, in case of a potential threat to the individual. This threat, as will be explained in later chapters, is sometimes caused by a loss and sometimes from spiritual conflicts. Conflict may be between internal stops and internal or external barriers. Freud distinguished fear as a real threat and anxiety as a reaction against an internal threat. Anxiety is a reaction against a threat, and it is for the future. On the contrary, depression develops as a dull reaction to the past due to lost things.

The word anxiety, which gained its medical meaning at the end of the 19th century, was from the "angh" word with an Indo-Germanic origin. It means "pressing hard, tightening throat, trouble and worry".

It was used by linguists in the 17th century for severe unrest, pause, and anxiety. For similar situations, the French used Angoisse, Almanlae

Angst, and the Spanish Angustia, although there were some significant differences between them. (Berrios, 1996)

Anxiety symptoms have attracted the attention of many doctors and authors since ancient times and have been expressed in various articles in different social or medical contexts. According to Hippocrates, who has brought terms such as mania, hysteria, and paranoia to psychiatry, the source of any psychiatric symptom is the brain. (Stone & Young, 1997).

Until the first half of the 1800s, the physical symptoms of anxiety were each considered as separate diseases of some organs or systems such as the heart, ear, gastrointestinal, or central nervous system. On the other hand, the psychological symptoms of anxiety were evaluated as a part of melancholic situations.

For example, Westphal has argued that the platzscwindel (not to be able to get to open areas alone), which is called agoraphobia, is mistakenly due to an abnormal sense of balance caused by inner ear pathology. (Nutt P. , Making Strategic Choices, 2002).

Feuchtersleben observed the symptoms of anxiety caused by organic diseases for the first time in 1847; Morel said in 1866 that changes in the autonomic nervous system led to promotional signs. (Nutt P. C., 1988) Although the symptoms of anxiety were seen in many other diseases in the 1890s, it was gradually developed that the physical and mental symptoms - called anxiety, on behalf of the same - were the elements of a single clinical condition. (Berrios, 1996)

In 1894, Freud defined the "anxiety neurosis" by combining the physical and spiritual symptoms of anxiety and brought anxiety out of the scope of neurasthenia. During this period, Freud, in his writings, said that traditional neuroses such as hysteria and hypochondriasis are of psychological origin, whereas anxiety neurosis and obsessional conditions are organic origins. (Nutt P. C., 1988).

Despite these developments, the various clinical conditions that were included in the anxiety were separated from each other and had different characteristics, they were included in different classifications as a different disease, but it could be realized with DSM-III in 1980 as a result of the data obtained after the 1960s. (APA, DSM History, 1980).

When addressing anxiety disorders, the importance of two basic emotions is emphasized. These are feelings of anxiety and fear. Fear initiates the functions of the autonomic nervous system by activating the individual in case of real danger. Anxiety is different from fear. Fear means feeling scared, or threatened by external stimuli, clearly identifiable, that represent danger to the person. Problematic anxiety, compared to normal anxiety, is more intense and more difficult to control, it becomes crippling, or in other words unproductive, an obstacle in daily activity.

1.2 Types of Anxiety Disorders

1.3.1 General Anxiety Disorder

GAD is a discomfort associated with significant tension, inspiration, anxiety about everyday events and problems, often with a chronic course and occasional flares, leading to significant deterioration in quality of life.

In 1986, Kraepelin divided all psychiatric disorders into 13 categories and became one of the first attempts to classify "psychogenic neurosis" anxiety disorders. Freud's concept of "anxiety neurosis" was the first attempt to address a severe and chronic anxiety condition as a true and independent medical nosologically entity. DSM-I (Diagnostic and Statistical Manual of Mental Disorders), published in the early 1950s, was heavily influenced by Freud's views and divided anxiety disorders into two groups as "Anxious reaction" and phobic reaction. (Bayraktar, 2006) With the separation of anxiety disorders as separate clinical entities in 1980, GAD was first described as a separate disorder in DSM III. (APA, Diagnostic and Statistical Manual of Mental Disorder, 1980).

In this classification, GAD was a low-confidence, uncertain, and residual diagnostic group. Diagnosis problems related to GAD are largely resolved in DSM III-R. The time required for diagnosis was increased from 1 month to 6 months to be able to distinguish from adjustment disorders and short-term anxiety states. (APA, Diagnostic and Statistical Manual of Mental Disorder, 1987)

It was emphasized in DSM IV that the anxiety was uncontrollable and it was stated that at least 3 of 6 somatic symptoms should accompany anxiety and anxiety (APA, Diagnostic and Statistical Manual of Mental Disorder, 1994). The World Health Organization, on the other hand, gave

GAD as a separate diagnosis in 1990, only in the 10th edition of the International Classification of Diseases.

GAD is characterized by frequent, ongoing fear and anxiety. It is a disease characterized by excessive anxiety and sadness about many events or activities almost every day, difficult to control sadness, anxiety, and sadness, accompanied by irritability, muscle tension and sleep disturbance. Patients with GAD may not inform that their fears are too high, but they experience difficulties with the level of their fears. (Kaplan & Freedman, 1967).

These patients are saddened by the small things, are in constant fear, and expect the worst of all they can be, they are constantly anxious.

A- For at least 6 months, almost every day, over anxiety and delusions about many events or activities (business success, school success, etc.)

B- One cannot prevent himself from getting caught in delusions

C- Anxiety and delusion accompany three (or more) of the following 6 symptoms (almost always at least some symptoms over the past 6 months)

1. Restlessness, excessive excitement or anxiety

2. Easy fatigue

3. Not being able to focus his thoughts or if the mind seems to have stopped

4. Irritability

5. Muscle tension

6. Asleep disorder (difficulty in falling asleep and maintaining, restless or restless sleep)

D- The focus of anxiety and delusion is not limited to the features of an axis I disorder.

E- Anxiety, delusion and physical complaints cause clinically apparent stress or impairment in social, professional or other important functional areas.

F- This disorder is not directly related to the physiological effects of a substance (e.g. a drug that can be abused, a drug used for treatment) or a general medical condition (e.g. hyperthyroidism) and is not only a Mood Disorder, a Psychotic Disorder, or a Common Developmental Disorder. (APA, Diagnostic and Statistical Manual of Mental Disorder, 2000).

1.3.2 Panic Disorder

Recurring unexpected panic attacks are a disease that progresses with persistent anxiety that other attacks will occur, feelings of sadness about the attack's consequences or (e.g. losing control, having a heart attack, going crazy), showing significant behavioral changes related to attacks (Kaplan & Freedman, 1967). PD is a common disease among anxiety disorders, chronic or recurrent, causing familial, social and functional disability. (Eaton, Magee, Kessler, & Wittchen, 1994).

1.3.2.1 History of Panic Disorder

The word panic is derived from Pan, a god in Greek mythology. Pan is known for living alone, closing in a cave where he is angry, scare living creatures by screaming. Although PB first appeared as a separate diagnostic category in DSM-III in 1980, the symptoms and phobic avoidance of panic attacks have been described by people since ancient times. In 1871, Da Costa first described the "Irritable Heart Syndrome", which was accompanied by palpitations, chest pain, worsening and fainting in the soldiers.

Later, names such as “neurocirculatory asthenia” and “effort syndrome” were used for similar tables. Westphal in 1872 and Legrand in 1877 identified similar tables that meet today's agoraphobia criteria. (Kaplan & Freedman, 1967)

Kraepelin, in 1909, in the 8th edition of his book, described the “fear neurosis” by describing the physico-autonomic and behavioral appearance of anxiety. Francis Heckel, on the other hand, described the “paroxysmal anxiety attack” in his book, which he wrote before World War I but published in 1917, classified the symptoms and discussed their causes.

In his study in the 1960s, Klein reported that although imipramine was good for panic attacks, it was not effective on general anxiety, against it,

it was ineffective on low dose Benzodiazepine panic attacks, but it corrected general anxiety.

He claimed that it was a disease, thus contributing greatly to the presence of PD and GAD as a separate disease in DSM-III. Klein's trilogy as "recurring unexpected panic attacks", "expectation anxiety" and "agoraphobia" is still the most valid PD model today. (Alkin & Türkel, 2000).

Diagnosis

PD is a common anxiety disorder in medical settings. The main feature of this disorder is the recurrence of panic attacks that cannot be predicted when to begin. The restlessness and anxiety accompanied by strong physical sensations such as shortness of breath, palpitation chest pain, additionally, temporary loss the abilities such as planning and thinking, and the intense desire to escape from the environment are the characteristics of the panic attack. Panic attacks typically start suddenly, with intense fear, anxiety, and anticipation of something bad, and reach their peak within 2-10 minutes. Attacks that leave the patient weak and depleted usually take 10–30 minutes, rarely extends up to hours. The main feature of the disease is recurrent anxiety or panic attacks (Alkin & Türkel, 2000)ç

Diagnostic Criteria for Panic Attack

There is a separate period of intense fear or discomfort when all four (or more) of the following symptoms begin and reach their peak within 10 minutes:

1. Palpitations, heartbeat sensations, or increased heart rate

2. Sweating

3. Tremors or shaking

4. The feeling of shortness of breath or choking

5. Breathlessness

6. Chest pain or feeling of chest distress

7. Nausea or abdominal pain

8. Dizziness, feeling light-headed, being like falling or fainting

9. Derealization (feelings of unreality) or depersonalization

(leaving yourself)

10. Fear of losing control or going crazy

11. Fear of death

12. Paresthesia (numbness or tingling sensations)

13. Chills, chills or hot flashes

Attacks that meet all other diagnostic criteria but have fewer than four somatic or cognitive symptoms are called “limited symptom attacks” (American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorder, Washington DC, 2000). There are three different panic attacks in DSM-IV: situational predisposition, situational, and unexpected. People seeking treatment for unexpected panic attacks often describe their fear very intensely. They say they think they are as if they are going to die as if they are losing control, like they are having a heart attack or stroke, or they are going crazy. These people regularly state that they have a incredible crave to elude wherever the attack occurs. Recurrent unexpected panic attacks should occur to diagnose PD (with or without agoraphobia).

Situational panic attacks are mostly specific to social and specific phobias. Situationally predisposed panic attacks are especially common in PD, but specific phobia or Social Phobia sometimes occurs. While PB requires, by definition, at least some panic attacks to be unexpected, some people with PB report that they have condition-related attacks, especially in later stages of the disorder. (APA, Diagnostic and Statistical Manual of Mental Disorder, 2000).

1.3.3 Specific phobia

The term phobia can be generally described as being overly afraid of an object, event, or situation. In specific phobia, there is an intense and stubborn fear of panic against a particular object or situation. When someone with a fear of a dog sees a dog, for instance, he expects to be attacked and bitten, and panics. Anyone who is afraid of an elevator will

be afraid that when the doors are locked, the elevator will not go outside and may faint inside.

Studies in the United States found that specific phobia is the most common mental disorder in women and second in men. It is obvious that the specific phobia, which is found around 15% in women and 7% in men, affects about 5-10% of the society. Specific phobias are about two times higher in women than in men. The only exception here is fear of blood, injection, or injury, this type of phobia is equally common in men and women. Common comorbid disorders in specific phobia are anxiety, mood, and substance-related use disorders.

There are two basic theories in explaining phobias:

Behavioral factors

Here, Watson's experience with Little Albert, a baby afraid of mice and rabbits, is described in detail in the conditional emotional reactions article. Based on the stimulus-response model in the traditional Pavlovian conditional reflex, anxiety was stimulated by a natural frightening stimulus associated with a second innate stimulus, and as a result of the successful couple of two stimuli, it was found that a neutral stimulus alone could create anxiety alone. That is, the neutral stimulus can become a conditional stimulus in the formation of anxiety.

In the classical stimulus-response theory, if the conditional stimulus is not reinforced with the unconditional stimulus, and the periodic repetition, the power of reaction stimulation gradually decreases. In phobias, the response to the stimulus does not weaken, and the symptom may persist for years even if no obvious feeding is made. The operant conditioning theory explains this situation. Anxiety is an impulse that motivates the organism in whatever it can to prevent painful affection. With coincidental behaviors, the organism develops attitudes that will avoid anxiety-producing stimuli, and these are reinforced, even if unrealistic, and permanent. Because the sole purpose of the organism is to protect itself. Improved avoidance behavior continues phobia. For example, not getting on the elevator to avoid fainting.

Although these behavioral learning theories give basic data about phobias, they only explain the parts on the surface and remain inadequate. At the bottom are very complex psychic processes.

Psychoanalytic factors

Sigmund Freud is still psychoanalytic in the explanation of the specific phobia and social phobia. Accordingly, a phobia is an anxiety hysteresis and is the result of conflicts in the room of unresolved childhood edema. Sexual impulses persist in adults with the appearance of strong incest, and sexual arousal can stimulate anxiety-like castration fear. We recommend printing this. There are ego auxiliary defense mechanisms available that suppression fails. In phobias, a displacement mechanism is used, and sexual conflict is replaced by the conflict against unrelated objects or situations. Sometimes it works with the symbolization defense mechanism. It opens in the story of Little Hans.

Today, the presence of separation anxiety in agoraphobia and the shame element (fear of red, flushing of the face) in blood phobia is associated with superego anxiety. As in these examples, anxiety accompanying phobias can be based on several sources. In psychodynamic theory, traumatic events such as parental death, parental discrimination, criticism, or humiliation by older siblings, domestic violence, and abuse can activate the child's sensitivity.

To understand phobia and specific phobias, it is necessary to know the definition of an anti-phobia attitude. This definition, defined by Otto Fenichel, states that opposite attitudes and behaviors can be exhibited to deny the object or situation that is feared. This may be the cause of dangerous sports enthusiasm such as mountaineering, parachuting, bungee jumping. The individual is a slave to his fears, and instead of being a passive victim, he can engage in activities to face and overcome fear. In children's games, roles such as doctors, police, thieves can also show anti-phobia items.

Specific phobia diagnostic criteria are as follows according to DSM-5 classification:

1) There should be a specific fear or fear of a specific object or situation, such as boarding, height, seeing blood, seeing any animal.

2) A Phobia source should always cause fear and anxiety.

3) Effectively moving away from the phobia source or enduring with intense fear and anxiety.

4) The fear felt must be disproportionately higher than the actual danger posed by the object or situation.

5) Fear, anxiety, or avoidance must have existed for at least 6 months.

6) Because of fear, the person should have a clinically apparent problem, or there should be a significant loss of functionality in social or work-related areas.

7) Symptoms should not be explained with another mental disorder such as panic disorder, OCD, posttraumatic stress disorder.

In the classification of specific phobias, animal type (such as spider, insect, dog, snake phobias), natural environment type (height, storm, lightning, thunder phobias), blood-injection-injury type, situational type (aircraft phobia, elevator phobia, closed 5 different groups have been defined, such as floor phobia) and other types (such as fear of situations that can cause breathing or vomiting, loud noise in children, or special clothing).

Blood-injection-injury phobias are distinct from all other phobias. It is likely to be seen in many members of the family and affect other generations. Clinically, the initial palpitation is often followed by bradycardia and hypotension.

When the patient with phobia encounters a specific situation or object or expects to encounter it, he experiences severe anxiety, which can progress to the panic attack table. These people endure great troubles to avoid phobic stimuli. It is a common avoidance behavior for someone with a plane phobia to spend their days preferring the road or avoiding long journeys. Phobic people may show alcohol and substance use disorders to avoid the stress of the phobic stimulus. Major depression is also observed in one-third of patients, especially in patients with social phobia.

The differential diagnosis of the phobic disorder, panic disorder, agoraphobia, and shy personality disorder should be considered. Hypochondriasis, OCD, and paranoid personality disorders are also

important in the differential diagnosis. It should also be remembered that schizophrenic patients may have phobic symptoms as part of their psychosis. Animal phobias, natural environmental phobias, and blood-injection-injury phobias reach their peak in childhood, while situational phobias peak in early adulthood.

1.6 History of Depression

Depression is known as a mental disorder that has a negative effect on our mood, emotions and behavior. As a common mental disorder, is one of the oldest known psychiatric disorders.

Today this psychiatric disorder, in history occurs to be defined by physicians since before the time of ancient Greek in different ways.

In the medical literature, Greek physician Hippocrates appears to be the first one to describe depression who called it melancholia. Hippocrates says four basic phenomena make our body, such: black bile, yellow bile, blood, and phlegm. Hippocrates linked each of these to an element in the universe and atmospheric conditions:

- Black bile: related to earth, with cold and dry properties.
- Yellow bile: related to fire, with dry and warm properties.
- Blood: related to air, with moist and warm qualities.
- Phlegm: related to water, with moist and cold qualities.

According to this theory, these phenomena's must be in perfect balance to have and ideal health. When this balance is lost, it leads to sickness. (Exploring your mind, 2020)

Physical and mental health is based on the balance of moods and the qualities that accompany them. Any minor imbalance causes "mood swings", any major imbalance threatens health. By example, autumn, dry and cold, promotes black bile and melancholy. (Bourin, 2020)

Among these four phenomena for Hippocrates the black bile was equivalent and causes of melancholy. So the word "melancholy" consists of the Greek words molasses (black) and khole (bile).

Hippocrates by using the name melancholy for some mental disorders revealed a similar picture to today's depression. Hippocrates attributed the definition of depression to an increase in the number of black bile. (Türkçapar, 2018)

Depression: it is known to be depicted in stories and legends in ancient Egypt and ancient times. The first historical idea of depression was that depression was a spiritual illness rather than a physical one and that was caused by demons and evil spirits that have existed in many cultures such as Ancients, Greeks, Romans, Egyptians, and Chinese.

According to these beliefs in an attempt to drive the demons out of the afflicted person's body, was often applied methods such as physical violence, beatings, and starvation.

There were several Ancient Greek and Roman doctors who believed that depression was a biological and psychological illness, while many believe that demons were the root cause of depression. Roman and Greek doctors used therapeutic methods to treat depressive symptoms such as music, gymnastics, massage, bath, donkeys milk, and a mixture of poppy extract. (Nemade & Patricelli, Historical Understandings of Depression)

1.6.1 What is Depression?

The term depression comes from the Latin root “deprimere” which means to ‘press down. In medical terminology depression, is defined as being collapsed or feeling low.

It presents with loss of interest, motivation, low energy, poor concentration, feeling of being sad, guilty, and lack of pleasure in life. Depression, also referred to as "clinical depression" or "depressive disorder," is a mood disorder that causes distressing symptoms, such as sleeping, eating, or working, that affect how you feel, think, and manage everyday activities. (NIH, 2016) Depression is more than just feeling sad and affects people in many aspects of their life. Everyone may experience difficulties from time to time in life. They may feel lonely, sad, or mourn when they lose something or someone they love. But these feelings are the natural part of life and usually pass by themselves or with a little time.

It can be considered a passing case of the blues" when these feelings last for a brief period of time. But it is likely to be a depressive condition when they last for more than two weeks and interfere with normal everyday activities. (ADAA)

These symptoms should appear most of the day, almost every day for at least 2 weeks to be diagnosed with depression. If symptoms such as mood disturbance, reluctance, significant weight loss or gain, loss of interest, attention difficulties and guilt continue and begin to affect our daily behavior, we can speak of a depressive disorder.

1.6.3 What are the signs and symptoms of depression?

Sadness is just a small aspect of depression and may not experience sadness at all for some people with depression. Different individuals have varying symptoms. Such depression signs include:

Persistent mood of sad, nervous, or "empty"

Feelings of urgency or pessimism

Feelings of remorse, loss of worth, or helplessness

Loss of interest in interests or sports or of enjoyment

"Decreased energy, exhaustion, or "slowed down

Difficulty focusing, recalling, or making choices

Without a specific physical cause and/or which does not ease even with medication, aches or pains, headaches, cramps, or digestive problems (NIH, 2016).

1.6.4 Types of Depression

Depression is the most common psychiatric disorder. Psychiatric disorders are classified with different classification systems. The most accepted classification system in the world is DSM IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition), which is the classification system of the American Psychiatric Association. According to DSM IV, depression was evaluated within the following subgroups: (Köroğlu, 1994)

1. Major depressive disorder.
2. Dysthymic disorder.
3. Depression in bipolar disorder.
4. Depression due to a general medical condition.
5. Depressed adjustment disorder.
6. Depressive disorder not otherwise specified:
   a-premenstrual dysphoric disorder.
   b- minor depressive disorder
   c- recurrent brief depressive disorder

1.7 Depression and anxiety in pupils

In the case of school pupils, emotional and behavioral problems are the main causes of low school achievement pupils (Davor, 2012). Attention problems, somatic complaints, thought problems, withdrawal, anxiety, and depression, aggressive behavior, internalizing and externalizing problems have the most significant influence on school achievement of girls (Davor, 2012). School achievement of boys is basically influenced by attention problems, anxiety/depression, withdrawal, delinquent behavior, externalizing, and internalizing problems (Davor, 2012).Pupils who have multiple emotional and behavioral problems mainly achieve poor school results (Davor, 2012).Teachers have been proven to be the best and the most reliable evaluators of school achievement about other evaluators (parents and pupils) their estimations have a significant prognostic value (Davor, 2012).This means that aggressive, unattended behavior can result in behavioral issues in the future and potentially causes serious disorders accompanied by depression and anxiety. As previously said, the most important link, in this case, are the teachers who present the only correspondent who can sport this sort of behavior and alert those responsibilities. However, the main issue among pupils is the stigma and the peer pressure where pupils tend to tease those who are different, even though it means being diagnosed for treatment. This could cause pupils to shy away from beginning treatment, which could result in worsening of the behavior and spiraling into more serious conditions in the future. That is the reason why the teacher and practitioners included must be careful while approaching pupils with behavioral issues.

Another dimension of depression and anxiety in youth, most dangerous for pupils, is the one triggered by cyber bullying. Children and adolescents

today are involved in cyberspace, which may lead to adverse consequences. They rely on the Internet for many things, including interactions and social connections. It is essential to understand the psychological outcomes of cyber-violence for children and adolescents in order to provide guidance and prevent negative outcomes (Šincek, Duvnjak , & M, 2017). Based on the results of extensive research, we can conclude that the group of perpetrators/victims has the most negative psychological outcomes and low academic achievement (Šincek, Duvnjak , & M, 2017).Therefore, to effectively plan preventive activities for children and adolescents, we should take account of the characteristics of perpetrators/ victims, perpetrators, and victims, as well as the outcomes that arise from cyber-violent behaviors (Šincek, Duvnjak , & M, 2017).Results suggest that perpetrators/victims should be included in selective or even indicated prevention programs focused on reducing involvement in cyber-violence and its known outcomes, especially depression, anxiety, and stress (Šincek, Duvnjak , & M, 2017). Shown anticipation programs for culprits ought to likely be custom-made in an unexpected way, such as by problematizing the need of blame and advancing sympathy for casualties, whereas diminishing the positive results of cyber-violence. (Šincek, Duvnjak , & M, 2017).

Cyber-violence presents a great threat for pupils in their early stages of life. Not only does it harm the social surrounding of the moment and affects their emotions, but it also creates stressors at a very early age that can later trigger depression and anxiety. However, the most prominent issue, in this case, is the fact that it is very hard to monitor. Teachers have virtually no possibility to know about it, while parents want to ensure their offspring's privacy and, in the desire, to do so, they tend to neglect obvious signs of bullying. It is important to establish honest communication with children and make them differentiate good and bad actions due to their consequences. This cannot be done on an individual level, but it must be a systematic change, which should include schools and parents.

1.8 Depression and anxiety in youth

Many different triggers can cause depression and anxiety in youth, as well as in adult life. However, one of the most interesting phenomena is the causal link between physical and psychological health, meaning, the effect of the lack of physical activity on psychological health.

The health-promotion benefits of regular physical activity and sports to the human body are well-documented (Donaldson & Morris, 2000,1994). Physical activity (PA) is associated with a lower risk of heart disease, type 2 diabetes, high blood pressure, and osteoporosis (Vuori, 2004,2010).Different contemporary studies confirmed that overall bodily fitness and physical/sporting activity have an important role in mental health preservation and promotion (Landers, Arent, Singer, Hausenblas, & Janelle, 2001) they contribute to the reduction of depressive and anxiety symptoms (Arent, Landers, Matt, & Etnier, 2005) enhance resistance to stress (Alderman, Rogers, Johnson, & Landers, 2003)and provide the formation of positive physical self-concept and self-esteem (Ekeland, Heian, Hagen, Abbott, & Nordheim, 2004)

However, it can be challenging to include activity in everyday life. Numerous research studies have shown that the physiological and psychological changes, which occur following a prolonged period of bed rest, are similarly to the changes observed in astronauts on their return from space travel (Krasnoff & Painter, 1999).

Even though it would be generally difficult to determine the exact cause of any psychological change, some probable explanations are viable (Pišot & Dolenc, 2011). Extreme and prolonged confinement to bed and immobility resulting from the simulated weightlessness might contribute to psychological changes like, for example, tension, elevated stress, alteration of mood status, and behavior outbursts (Pišot & Dolenc, 2011). The research described above was done on young people from age 20 to 30 to see the effect of bed rest, meaning constant inactivity, on mental health in general.

A big public health concern has been physical inactivity. In the last decade, the authors have noticed an increased research interest in clarifying the relationship between physical activity and some indicators of mental health and psychological adaptation (Biddle & Mutrie, 2001). Although the causality of this relationship is not clear, the pattern of evidence suggests that exercise programs recruit a process, which confers enduring resilience to stress (Pišot & Dolenc, 2011). However, it is also important to study the psychological and socio-psychological aspects of acute physical inactivity, using the bed rest model (Pišot & Dolenc, 2011). Research findings have applicative value in the areas of health, sport, and

rehabilitation (Pišot & Dolenc, 2011). Namely, the results explain the effects of physical inactivity on human mental health under diverse living conditions like post-operative period requiring a long-term recovery; health indications requiring physical inactivity or bed rest, or lifestyles in which extreme physical inactivity prevails. Also, the results anticipate the use of appropriate psychological interventions to prevent psychological stress thus increasing the quality of life under conditions of prolonged physical inactivity (Pišot & Dolenc, 2011).

Therefore, the conclusion that can be drawn relates to the fact that extreme inactivity for the research can cause severe psychological issues that can potentially result in depression and anxiety, after which treatment is necessary. Even though it is not covered by the research, the most probable outcome of that situation cannot be to simply start with the activity again but to first heal the emotional damage as a result for the young person to develop into a healthy individual who can cope with its emotions.

1.9 Depression and anxiety in students

The following research among students of undergraduate studies of psychotherapy was conducted by Syed, Ali, and Khan (2018) who present the fact of the finding in a theoretical form that can be applied to students' profiles of the world. A descriptive observational study was conducted among undergraduate physiotherapy students. Students were selected from various institutes located in different cities of Sindh, Pakistan. The total duration of this study was four months from September 5, 2016, to January 5, 2017. A total of 267 participants was included in the study. The sample was selected through non-probability purposeful sampling technique. The inclusion criteria were only undergraduate physiotherapy students. The 42 items of the questionnaire are culturally free and that makes the test feasible to adapt to any culture.

This study is like other studies conducted earlier in Pakistan and other countries. In contrast, the present study was conducted on undergraduate physiotherapy students precisely. Depression in the past as well as in the present has been accredited with the highest morbidity rate likewise anxiety and stress in medical education all over the globe. Thus, it has been a subject of interest to the researchers. The present study highlights

psychological morbidities including depression, anxiety, and stress among physiotherapy students in Sindh, Pakistan. As well as the participant's response was 100% thus validating the study results. The prevalence of depression is 48.0%, anxiety 68.54%, and stress 53.2% which is greater than that 24.4% of depression, 52% of anxiety, and 16.9% of stress respectively among preclinical medical students reported by Faud et al.

More than half of the undergraduate physiotherapy students were found to be affected by depression, anxiety, and stress. There is an urgent need to establish prevention programs and to bring out evidence-based psychological health promotion for physiotherapy students in Pakistan, as well as the world. This indicates how most students in any part of the world, regardless of the cultural background, are oppressed by the burden of depression and anxiety due to the modern way of life. This can have a negative future effect on a whole generation of intellectuals, as well as their offspring. Due to the global state of depression and anxiety, it is important to bring even more awareness to the proper treatment of the condition without creating a stigma around it.

1.10 Depression and Anxiety in Elderly

Depression among the elderly is one of the most serious public health problems that modern societies face (Daniel & Geraldine, 2008). The appearance of depression tends to be associated with high levels of suicide in adults. In the elderly, depression is associated with a marked reduction in their cognitive abilities which, in turn, is commonly accompanied by a decrease in social and physical activities (Amy, Wetherell, & Gatz, 2009). Some have argued that physical activity has therapeutic effects concerning depression, while Nelson et al. (Nelson, Adger, & Brown, 2007)recommended that all seniors should be physically active and that given the relevance and strength of evidence, physical activity should be one of the leading areas of focus for the prevention and treatment of diseases associated with any form of disability. According to Cardoso et al. (Pedro Cardoso, Erwin, Borges, & New, 2011), once involved, elderly people once adhere to a physical activity program, they only tend to abandon the practice for reasons such as health problems of the spouse, or because the programs are not properly suited to their psychomotor capabilities.

Physical activity contributes to the reduction of psychological distress among the elderly because it promotes psychosocial interaction, improves self-esteem, helps maintenance and improvement of cognitive functions, and serves to reduce the frequency of relapses of depression and anxiety (Stella, Gobbi, Corazza, & Costa, 2012)

To establish a visible link between depression and anxiety in the elderly, (Teixeira C. , Raposo, Fernande, & Brustad, 2012) conducted research (2013). The study was a cross-sectional, descriptive, and correlational study (Teixeira C. , Raposo, Fernande, & Brustad, 2013) The sample was comprised of 140 elderly individuals (70 women and 70 men) recruited from the region of Três-os-Montes e Alto Douro in northern Portugal and lived in dential homes or attended daily care centers for the elderly regularly. Their age span ranged from 62 and 93 years (Teixeira C. , Raposo, Fernande, & Brustad, 2013). The questionnaires were administered by research assistants specifically trained for this project and in the use of these questionnaires (Teixeira C. , Raposo, Fernande, & Brustad, 2013).This study examined patterns of relationships among physical activity, depression, anxiety, and trait anxiety in a sample of 140 elderly subjects with lower levels of institutional attainment in the north of Portugal (Teixeira C. , Raposo, Fernande, & Brustad, 2013). The results provided some support for the expectation that physical activity would be associated with a more favorable profile across the depression and anxiety variables (Teixeira C. , Raposo, Fernande, & Brustad, 2013). The results provided additional support to the existing theory that women present higher depression scores than men (Teixeira C. , Raposo, Fernande, & Brustad, 2013). In the case of women in physical activity, there are other benefits such as a proactive means of depression (Ayala, 2011)as well as to reduce the incidence of osteoporosis and the physical condition (Kenny & Baron, 2010) This outcome may attribute in part to cultural tradition, however, on the other hand, considering that all participants are retired, it could be anticipated that men would be expected to present higher values of depression as they were the ones allowed to work and do physical activity (Teixeira C. , Raposo, Fernande, & Brustad, 2013)The appearance of depressive states, according to Parker and Parker (2005) may be related to fears associated with concerns about disease and death and loss of meaning in life, to the extent that the elderly can develop a sense that it is no longer worthwhile to set goals for life, and because upon retirement,

they lose money and resources such as social support, among other considerations.

The size of the effects of these associations, in some way, reinforced the arguments of those who advocate for the need to rethink the existing diagnoses in which depression and anxiety are presented as separate entities (Das-Munshi et al. 2008). Given the results, we conclude that regular physical activity has a beneficial effect on the mental health of older adults ((Teixeira C. , Raposo, Fernande, & Brustad, 2013)). Individuals who engage in regular physical activity presented lower levels of depression, state, and trait anxiety (Teixeira C. , Raposo, Fernande, & Brustad, 2013)Comparisons by sex revealed that women have higher levels of depression, state anxiety, and trait anxiety (Teixeira C. , Raposo, Fernande, & Brustad, 2013)The data obtained showed that active individuals had lower depression and anxiety levels when compared to older adults (Teixeira C. , Raposo, Fernande, & Brustad, 2013). This proves how the elderly, due to sudden loss of purpose in life, have to be attended to in a way where they will be occupied with activities and content to maintain mental health. In this study, the elderly subject to research was from Portugal. However, these implications can be applied anywhere except for the results that women are in turn more depressed and anxious than men even though it is the current state as well. The authors associate these activities with physical activity, which has, as mentioned above, had a positive effect on human mental health in youth. Therefore, it is important to notice that the creation of these sorts of programs for the elderly creates a positive impact on the mental health of the population as even adults gain the perspective that aging doesn't mean losing the purpose in life, making them in turn less anxious about the future. In addition to that, the suicide rate is lowered, and the population is more balanced.

1.11 Diagnosis

Symptomatology may initially seem vague and non-specific and there is often a treatment gap, with patients undertreated for either or both disorders (Jameson & Blank, 2010) A careful history and examination with relevant investigations should be used to make the diagnosis. About 85% of patients with depression have significant anxiety, while 90% of

patients with anxiety disorder have depression so there are significant chances of these two disorders coming in pair. (Gorman, 1996/1997)

Among emotional problems, depression and depressive symptoms are well recognized and treated with success usually. (Lançon, Auquier , Reine, Bernard , & Addington , 2001) Many people do not seek treatment for anxiety and depression and, when they do, treatments are not always used effectively. Only 40% of people with current disorders did not seek treatment in the previous year and, of those who did, only 45% were offered a treatment that could be beneficial (Andrews, Sanderson, Slade, & Issakidis , 2000). Only 35% of people with a mental disorder had consulted a health professional for a mental health problem during the previous year, but most had seen a general practitioner for that disorder or some other health reason (Andrews et al., 2001). In this setting, barriers to effective care were stated to be patient knowledge and physician competence (Tiller J. , 2012)

The treatment of the patient and the diagnosis itself include much more than just one visit – it is usually a set of visits used to track and monitor the patient and the overall progress. If features of anxiety or depression are identified, features of the other disorder should always be sought (Tiller J. , 2012). For example, if a patient is depressed, a clinician should ask: With this illness, have you had symptoms like restlessness, irritability, impulsivity, palpitations or (other anxiety symptoms)? (Tiller J. W., 2013). If a patient is anxious, the practitioner should ask something along the lines of “With this illness, have you had symptoms like feeling sad or numb, slowed up, loss of energy, a sense of hopelessness (or other depressive symptoms)?

Although no one knows what exactly causes it, biological, psychological, and social factors are effective in the emergence and persistence of depression. None of these factors can be said to cause depression alone. Depression occurs as a result of many factors intertwining and interacting. Admittedly depressed patients are not the same and each is unique. (Torun, 2018, s. 80) People can experience depression in many ways and reasons. Some of them experience it during the unexpected death of a loved one or in a break-up and some of them during the loss of a job or serious medical illness.

According to Williams and Neighbors, the prevalence of depression increased noticeably in the second half of the twentieth century. (Williams and Neighbors 2007)

Depression (major depressive disorder) is characterized by the American Psychiatric Association as a widespread and severe medical condition that adversely affects how you feel, how you think, and how you act. Fortunately, it is also treatable. When enjoyed, depression triggers feelings of distress and/or a lack of interest in hobbies. This may contribute to a number of emotional and physical issues and can affect the ability of an individual to function at work and at home. (APA).

Besides, depression causes feelings of anxiety, restlessness, worthlessness, feeling of guiltiness, also loss of energy, hopeless feelings of self-harm, or suicidal thoughts.

Universities, besides providing diplomas and future careers for young people also are institutions that offer many social and cultural opportunities. During the adaptation process, being apart from the family, making new friends, a decrease of the social support, economic difficulties and responsibilities provides a basis for the development of mental health disorders.

When depression and anxiety are evaluated in students who are new to university or studying at university, socio-economic problems, education process, it can be seen that it can affect students' mental development and mental health negatively.

University years are one of the most important transition stages of students' lives, but it also brings with it the adaptation process. Many students leave their homes, families, and safe environments for the first time and find themselves in a city and social environment where they are completely foreign. Besides, this process is necessary to make many decisions alone and take responsibility alone.

Also, this process can be a very disturbing and stressful process for the students who are in the period of finding his / her identity and transition to adulthood and can have significant behavioral and adaptive problems. New changes in life and adaptation to it involves the transformation of

human relationships with the environment and surroundings, changes in attitude to the content, and organization of one’s activities.

The optimal adjustment to the demands of the environment is the essence of human adaptation. If the individual deals with the unfamiliar living conditions, and faces changes in the environment, this undermines stability. Adaptive situations emerge when the system or its individual elements restore balance. This situation, in modern psychology is considered as an active, purposeful process of conflict resolution originating from interaction with the new natural or social environment and its typical for all kinds of human adaptation.

In such a period of change, the individual may experience mental symptoms such as depression, anxiety and stress.

According to World Health Organization, more than 264 million people are affected, and number of women affected by depression is more than man. (WHO, 2020)

According to the Eisenberg and his friends, mental health problems represent a potentially important but relatively unexplored factor in explaining human capital accumulation during college. (Eisenberg & Hunt, Mental Health and Academic Success in College, 2009). In younger population, one of the key concerns is that mental health issues can affect the accumulation of human resources, especially the amount and efficiency of education, which can, in turn, have lifelong implications for jobs, wages, and other outcomes. Therefore, recognizing the connection between mental health and academic achievement is a critical step in determining the return of young people to the prevention, diagnosis, and treatment of mental health problems.Higher education institutions, scholars, and administrators have given less attention to student mental health than to other comparable factors known to affect college student retention, including financial stress, social connectedness, sense of belonging, and academic preparedness. (Eisenberg, Golberstein, & Hunt, 2009).

According to “*The annual Healthy Minds Study” the research has shown that there was the relationship between student mental health and academic outcomes. Results have shown that across all types of campuses,*

students having mental health problems were twice as likely to quit their studies. A longitudinal study made among students with low GPAs has revealed that quarter of (25 percent) who exhibited symptoms of a mental health problem dropped out. (Eisenberg, Golberstein, & Hunt, 2009).

On the other hand the research that was conducted and known as largest epidemiological studies, regarding mental health status among university students, "The Prevalence and Socioeconomic Correlates of Depressive and Anxiety Symptoms in a Group of 1,940 Serbian University Students" (Vukomanic, et al., 2016), has shown that the prevalence of depressive symptoms among university students were 23.6%,while the prevalence of anxiety symptoms were 33.5%. The depressive symptoms were significantly related to the study year (p = 0.002), type of faculty (p = 0.014), satisfaction with college major choice (p < 0.001), satisfaction with grade point average (p < 0.001). Female students (odds ratio – OR = 1.791, 95% confidence interval – CI = 1.351–2.374), older students (OR = 1.110, 95% CI = 1.051-1.172), students who reported low family economic situation (OR = 2.091, 95%) CI = 1.383–3.162), not owning the room (OR = 1.512, 95% CI = 1.103–2.074), dissatisfaction with graduate education (OR = 1.537, 95% CI = 1.165–2.027) were more likely to show depressive symptoms. The anxiety symptoms were significantly related to study year (p = 0.034), type of faculty (p < 0.001), family economic situation (p = 0.011), college residence (p = 0.001) satisfaction with the college major choice (p = 0.001), and satisfaction with graduate education (p < 0.001). Female students (OR = 1.901, 95% CI = 1.490–2.425), and students who reported parents' high expectations of academic success (OR = 1.290, 95% CI = 1.022–1.630) were more likely to show anxiety symptoms. (Vukomanic, et al., 2016).

Meaning that confirmed a *significantly increased rate of depression in college students, previously reported from the U.S. and Western Europe studies.* (Vukomanović, et al., 2016)

A cross- sectional study was carried out about depression, anxiety stress and associated factors among university students in France.

A total of 1.202 student participated to the study, were the sex ratio (M: F) was of 0.42 with a mean age of 20.0 years. Prevalence of depression, anxiety and stress were respectively 16.4%, 26.4% and 16.0%. After

multivariate analysis, female gender was associated with presence of stress (AOR=1,41 IC 95% [1,03-1,93]). Based on results there was a significant prevalence of depression, anxiety and stress symptoms among students. (ADAA)

Depression, anxiety and stress symptoms among students was associated with high level of perceived academic pressure, financial difficulties and presence of eating disorders. (Herrmann, Déchelotte, Lander, & Tavalocci, 2019)

Another study that was conducted in 2015 "*Anxiety and self-esteem among university students: comparison between Albania and Kosovo" was measured the level of anxiety and self-esteem among university students and determine links between. Participant were* 125 students, aged 18 - 44 years old from Albania and Kosovo. (Mustafa, Melanoshi, Shkembi, Besimi, & Fanaj, 2015). The measures used included the Albanian versions of Zung Self-Rating Anxiety Scale and the Rosenberg Self-Esteem Scale. Based on the study 14.3% (Albania) and 32.3 % (Kosovo) of participants reported mild to moderate levels of anxiety. Only 12.9 % Kosovo sample had marked to severe level of anxiety; 6.3 % (Albania) and 1.6 % (Kosovo) reported low self-esteem. Self-esteem and gender were significantly negatively correlated with anxiety only in Albanian sample. No significant differences in self-esteem levels based on country, but students from Kosovo had significantly higher anxiety. (Mustafa, Melanoshi, Shkembi, Besimi, & Fanaj, 2015)

Another study that was done in 2014 in Republic of Macedonia to "determine the prevalence of high anxiety and substance use among university students in the Republic of Macedonia".

The sample contained 742 students, aged 18-22 years, who attended the first (188 students) and second year studies at the Medical Faculty (257), Faculty of Dentistry (242), and Faculty of Law (55) within Ss. Cyril and Methodius University in Skopje. (Manchevska & Gligoroska, 2014). Results has shown that the highest mean BAI scores were obtained by first year medical students (16.8 ± 9.8). Fifteen percent of all students and 20% of first year medical students showed high levels of anxiety. Law students showed the highest prevalence of substance use and abuse. Survey showed that students demonstrate these types of unhealthy reactions, regardless of

the curriculum of education and that more attention should be paid to students in the early stages of their education. (Manchevska & Gligoroska, 2014).

Acorrding to the reseraches mentioned above results has has shown that depression and axiety are the most important mental disorder among university students in many regions of the world and impact on quality of life and academic attainment.

*Depression and anxiety are medical condition that can affect a student's ability to work, study, on social interaction and can be the biggest barriers to doing well at university. Beside this student that are facing depression and anxiety most of the time can have lack of interest around the world. C*ommon causes that can sometimes contribute to symptoms of depression among university students could be homesickness and loneliness, financial stress, academic stress, poor body image, drug and alcohol use.

Discussion and Conclusion

The dynamics of modern life are increasingly complicating our mental, emotional and social lives. By committing to others appreciating and liking us as well as focusing on what others think of us, as if we forget to associate with ourselves and know our inner self, so sometimes unconsciously prevent ourselves from living happily and healthily. To get out of this situation overloaded with unnecessary preoccupations, of course, it is necessary to have self-respect, so to know ourselves, personal values and needs and to be aware of personal abilities and weaknesses. Self-esteem and loneliness are related to each other, when we do not have self-esteem we feel lonely, avoiding various activities of daily life, and associating with different people, thus presenting us with the feeling that something is not going in and out of us.

The presented concerns turn out to be related to anxiety and depression as two psychic disorders which in the period of studies have the possibility to appear among the student age groups. Sometimes happens that we do not feel self-respect because we perceive ourselves as not being accepted by society, this affects us to feel lonely, and then this loneliness turns into anxiety or leads to even greater deterioration as if is depression (Promoter:

Luc Goossens en Rutger, CME Engels Co-promoter: Koen Luyckx en Ron HJ Scholte, 2012). Loneliness is sometimes positive in adolescents and young adults because they have enough time to get to know themselves and their abilities, so they manage to feel balanced with personal feelings, thoughts, behaviors, and beliefs.

Students who are living on college campuses are often away from home for the first time. Those who are facing depression may not have immediate access to the same types of mental health resources that were available at home. Student organizations that focus on mental health and wellness can help these students in addressing their health concerns. College campuses should provide offices and mental health resources, such as counseling sessions. Also, students should be educated about depression and anxiety to improve recognition and diagnosis.

Students can avoid depression while studying abroad by seeking proper information about their place of study and have little knowledge about their new study place. Providing international students with efficient services, for instance having get together parties with other students, also having some special events like camping and this could help to introduce the culture of their new study environment this kind of event can be done by the multicultural trained students this can help international students to feel at home. Studying environment is impressive and students feel relax when the atmosphere is friendly. Using different ways or styles while teaching international students is important, it makes the class interesting, and students are willing to learn more.

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