Title

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ABSTRACT

Maternal mental health is a critical component of overall well-being for mothers and their families, yet it is often influenced by a complex array of factors beyond biological and psychological considerations. Among these, sociocultural influences play a significant role in shaping maternal mental health outcomes. These sociocultural influences, which manifest into cultural norms, social expectations, family dynamics, and community support systems, can profoundly impact a mother's mental health during pregnancy, childbirth, and the postpartum period. For many women, navigating motherhood is deeply intertwined with cultural values, identity, and societal pressures, which can either enhance or undermine their emotional and psychological well-being.

Research has shown that maternal mental health disorders, such as postpartum depression and anxiety, are prevalent across all demographic groups. However, the experience and expression of these conditions often vary across cultural contexts, highlighting the need for a more nuanced understanding of how sociocultural factors affect mental health outcomes. For instance, stigma surrounding mental illness, expectations of motherhood, and access to culturally appropriate healthcare can create barriers for mothers seeking help. In addition, immigrant, minority, and low-income women may face unique stressors related to acculturation, discrimination, and socioeconomic challenges, further complicating their maternal mental health experiences.
This paper explores the impact of sociocultural factors on maternal mental health, with a focus on how cultural values, societal expectations, and access to support systems shape the mental well-being of mothers. By examining these influences, this study aims to better understand the diverse experiences of motherhood and to identify culturally sensitive interventions that can improve maternal mental health outcomes across different populations.

We collaborated with Harvest Home, a residential program that supports unhoused pregnant women in Los Angeles (LA), to conduct a study on maternal mental health. A standardized survey incorporating the Cultural Values Conflict Scale and the Beck Depression Inventory was administered to 21 mothers who had graduated from the Harvest Home program. Our findings revealed a significant correlation: mothers who identified as belonging to minority communities, such as Black or Latinx, reported more severe symptoms of depression compared to those from overrepresented communities. While this study highlights a link between race and mental health, it is limited to the homeless population. Thus, future research should extend the survey to include mothers from a broader range of backgrounds to ensure the findings are more generalizable to the wider population of mothers.

LITERATURE REVIEW

The relationship between sociocultural factors and maternal mental health has been increasingly recognized in recent literature. Sociocultural influences—including cultural norms, social support, socioeconomic status, and systemic inequities—can significantly shape maternal mental health outcomes. This literature review synthesizes key findings from existing studies to explore how these sociocultural determinants impact the mental health of mothers during pregnancy and postpartum.

Cultural Norms and Expectations

Cultural values and norms shape how motherhood is perceived and experienced. According to Davies (2021), cultural beliefs about motherhood, including idealized roles and expectations, can create pressure that contributes to mental health challenges such as postpartum depression. In many cultures, motherhood is romanticized, leading to feelings of inadequacy and shame when mothers struggle to meet these expectations. In many societies, traditional gender roles dictate

that women are naturally nurturing and caregiving, positioning motherhood as the pinnacle of female identity and fulfillment. These expectations are rooted in the belief that women are biologically predisposed to maternal instincts, making caregiving not just a role but an obligation. As a result, women often feel pressure to meet these idealized standards, which can leave them struggling when the realities of motherhood don't align with societal portrayals. Studies have also shown that mothers in cultures with strict gender roles or where women are expected to shoulder caregiving responsibilities with little support are more prone to developing depressive symptoms (Rajadhyaksha and Aycan, 2015). Cultural norms often frame motherhood as a role that requires complete self-sacrifice. Mothers are expected to prioritize the needs of their children and family over their own, often neglecting their own mental and physical health. The demands of caregiving, coupled with sleep deprivation and little time for self-care, can result in chronic exhaustion and burnout. When these needs go unmet, it can wear down a mother's emotional resilience, making her more vulnerable to depression. Thus, the combination of high sociocultural expectations and the stigma around maternal mental health creates an environment where mothers may struggle silently with their emotional well-being.

Social Support and Community Networks

Social support is widely documented as a protective factor for maternal mental health. However, the availability and quality of support can vary significantly across cultural and socioeconomic contexts. A meta-analysis by Míguez and Vázquez (2021) highlights that women who lack adequate support from partners, family members, and community networks are at higher risk for anxiety and depression. In many minority communities, extended family and community networks serve as crucial sources of emotional and practical support. Mothers who feel they must manage everything on their own may struggle to reach out for the support they need from

their partners, family, or friends. This lack of social and emotional support, especially during challenging times like postpartum, is a well-documented risk factor for postpartum depression and anxiety.

Conversely, mothers who are isolated from these networks due to migration, acculturation, or displacement may experience heightened mental health challenges (Anderson et al., 2017). Societal expectations discourage open discussion of the struggles of motherhood. Many women feel they must hide their difficulties because admitting to stress or negative feelings may be seen as an admission that they are not good mothers. This can lead to social isolation, as they may fear judgment from family, friends, or society. The lack of emotional outlets and support can intensify feelings of loneliness and helplessness, both of which are associated with depressive symptoms.

Socioeconomic Status and Structural Inequities

Socioeconomic status (SES) is a critical sociocultural determinant of maternal mental health, with low SES consistently linked to higher rates of depression, anxiety, and stress among mothers. Studies by Martin et al. (2011) and Radey and McWey (2021) found that mothers living in poverty face multiple stressors, including financial instability, housing insecurity, and limited access to healthcare, all of which contribute to poorer mental health outcomes. These stressors create environments of chronic stress, insecurity, and deprivation. Thus, the cumulative effects of these stressors increase the likelihood of developing anxiety, depression, and other mental health disorders, particularly in vulnerable populations like mothers.

Moreover, mothers from low-income and minority backgrounds often face structural inequities, such as systemic racism and healthcare disparities, that can exacerbate stress and hinder access to mental health services (Shenassa et al., 2021). These systemic barriers are embedded in social,

economic, and healthcare structures, disproportionately affecting marginalized communities and perpetuating cycles of inequality. Systemic racism contributes to economic disparities, including unequal access to well-paying jobs, education, and housing opportunities. Minority mothers are more likely to be concentrated in low-income jobs, face job insecurity, and experience higher rates of unemployment. These financial challenges exacerbate stress and create additional barriers to accessing mental health services, as out-of-pocket costs for care may be unaffordable.

The Impact of Race and Ethnicity

For minority mothers who also face financial instability, the intersection of race, gender, and class creates unique stressors that compound their mental health challenges. Intersectionality, a concept that acknowledges the overlapping systems of discrimination and disadvantage, highlights how mothers who are both racial minorities and economically disadvantaged face heightened barriers. Race and ethnicity play a significant role in shaping maternal mental health experiences. Studies consistently show that women from minority racial and ethnic groups, particularly Black and Latinx mothers, are at higher risk for maternal mental health disorders due to a combination of sociocultural stressors. A study by Burton (2023) found that Black mothers are more likely to experience postpartum depression and anxiety than their white counterparts, often due to the cumulative stress of racial discrimination, socioeconomic disadvantage, and inadequate healthcare access. Similarly, Latinx mothers, especially those who are immigrants, may experience additional stressors such as acculturation challenges, language barriers, and fears related to immigration status, which can negatively affect their mental health (Romero and Piña-Watson, 2017). The trauma experienced by mothers due to structural inequities often gets passed down to their children, perpetuating a cycle of stress, poor mental health, and disadvantage. For example, children raised in environments marked by poverty, discrimination,

and housing instability are more likely to experience toxic stress themselves, making them vulnerable to mental health challenges later in life.

Healthcare Disparities and Culturally Informed Care

Access to culturally competent healthcare is another critical factor in maternal mental health. A study by Nadeem et al. (2008) emphasizes that healthcare systems often fail to provide adequate support to mothers from diverse cultural backgrounds. Language barriers, lack of trust in healthcare providers, and insufficient cultural awareness among healthcare professionals can all limit access to mental health services. For mothers from immigrant or non-English-speaking communities, language barriers and a lack of culturally competent care hinder access to mental health services. Without translators or providers who understand cultural nuances, these mothers may not feel comfortable or understood during their interactions with mental health professionals, leading to inadequate or ineffective care. Interventions that incorporate cultural sensitivity and address the specific needs of minority mothers have been shown to improve mental health outcomes (Valdez et al., 2018). For example, group-based interventions that allow women to share their experiences in culturally safe spaces can reduce isolation and promote better mental health (Valdez et al., 2018). The chronic stress caused by economic hardship, discrimination, and lack of healthcare access increases vulnerability to mental health disorders, including anxiety, depression, and trauma-related conditions. Addressing these structural issues requires systemic changes in healthcare, housing, and social policies to ensure that minority mothers receive equitable care and support for their mental well-being.

METHODS

To investigate how sociocultural influences affect maternal mental health, a mixed-method survey incorporating two standardized psychological scales: the Cultural Values Conflict Scale

(CVCS) and the Beck Depression Inventory (BDI) were used. This study aimed to explore the relationship between cultural expectations and depression in mothers, particularly those from minority communities, and to assess the extent to which cultural values may contribute to mental health outcomes.

The survey was divided into several sections, each designed to gather comprehensive information regarding participants' cultural background, familial expectations, and mental health status. In the initial section, participants were asked to provide demographic information, including race, ethnicity, and the presence of familial expectations related to their role as daughters or females within their cultural framework. Additionally, participants were asked whether they intended to pass down these cultural values to their children. To account for the possible effects of postpartum depression on mental health, participants were also asked to report the time since the birth of their most recent child. To maintain participant confidentiality, sharing contact information to expand on cultural background was optional.

The CVCS was used to measure conflicts between an individual's cultural values and the dominant societal values they experience (Inman et al., 2001). A modified version of the CVCS, which included two distinct sections, was administered. The first section consisted of 11 items that explored participants' beliefs regarding intimate relationships within the context of their cultural background. The second section contained 13 items focused on participants' sex-role expectations and how these are influenced by their cultural heritage. Responses were collected using a 5-point Likert scale, ranging from 1 ("strongly disagree") to 5 ("strongly agree"). Questions from the CVCS may be viewed in Appendix A.

To assess the severity of depressive symptoms, the study used a shortened version of the BDI, a widely recognized tool for measuring depression in individuals aged 13 and older (Chibnall and Tait, 1994). This version included 13 items, asking participants to reflect on their current emotions, behaviors, and self-perception. Given the sensitive nature of the population and the lack of on-site clinical support, the item relating to suicidal ideation was omitted from the questionnaire to avoid potential distress or the inability to provide immediate support. Questions from the BDI may be viewed in Appendix B.

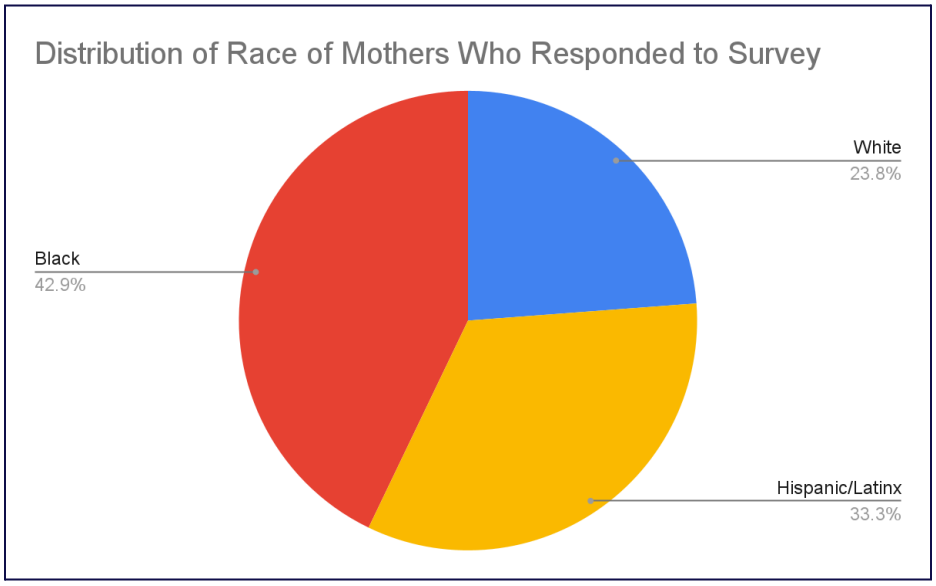
The study population comprised of alumni of the Harvest Home program, a residential service supporting unhoused pregnant women in LA. By focusing on program alumni—mothers who had secured stable housing after leaving the program—we aimed to mitigate the potential confounding effect of acute housing instability on the study's findings. The survey was distributed via email to these participants, with a recruitment flyer outlining the study's purpose and confidentiality assurances. In recognition of their time and effort, participants were compensated $10 upon completing the survey. This study was made possible through funding from the UCLA Center for the Study of Women | Barbra Streisand Center and the UCLA Spark Campaign, which supported participant compensation and data collection efforts.

RESULTS

A total of 21 alumni mothers from the Harvest Home program participated in the study. Among them, 9 identified as Black, 7 as Hispanic/Latinx, and 5 as White. No participants identified as Asian, Middle Eastern, or other racial/ethnic backgrounds. Two responses, one from a Black-identifying participant and one from a White-identifying participant, were excluded from the analysis due to inconsistencies and outlier responses. Therefore, the final sample consisted of 19 participants. Notably, all mothers in the study reported having given birth at least one year

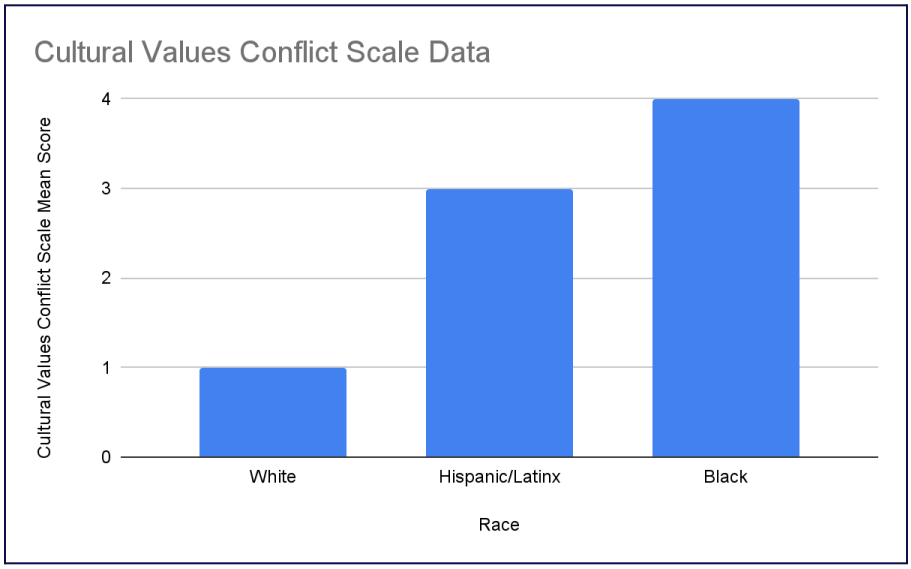
prior to the survey, thereby reducing the potential confounding effect of postpartum depression. Figure 1 displays the racial demographic breakdown of the survey participants.

Figure 1: Distribution of Race of Mothers Who Responded to Survey



The participants' responses to the Cultural Values Conflict Scale (CVCS) were analyzed by calculating the mean score for each participant. This was done by summing the individual scores from the 5-point Likert scale for each question and dividing by the total number of questions. Higher mean scores reflected greater levels of conflict between the participant's cultural values and the dominant societal values. Figure 2 illustrates the mean CVCS scores by racial group.

Figure 2: Cultural Values Conflict Scale Data



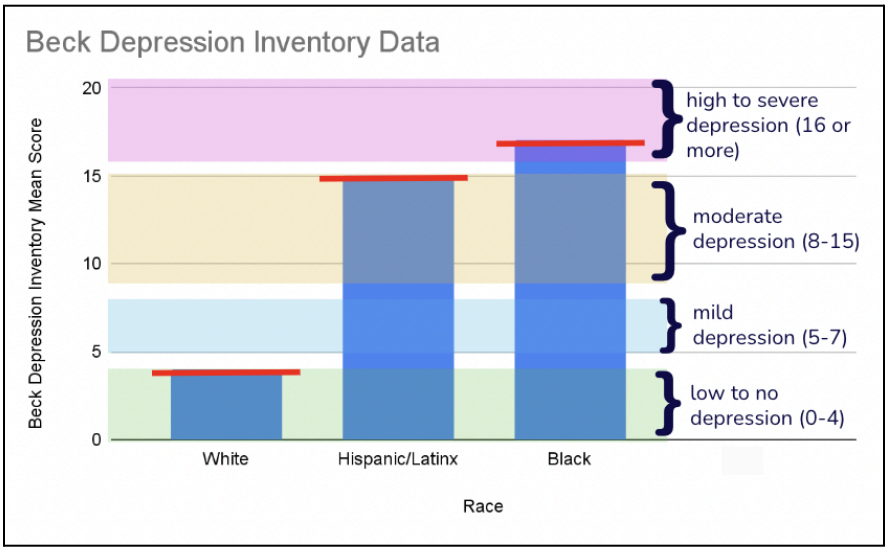
The results indicated that Black-identifying mothers reported the highest levels of cultural conflict, followed by Hispanic/Latinx mothers, and White-identifying mothers, respectively. Specifically, Black mothers had the highest mean score, suggesting they experienced the greatest tension between their personal and cultural values and societal norms. Hispanic/Latinx mothers reported the second-highest level of cultural conflict, while White mothers reported the lowest levels of conflict, indicating less dissonance between their cultural and societal values.

The CVCS results support the theoretical framework of the study, which posits that sociocultural influences—such as cultural values, societal norms, and family expectations—play a significant role in shaping maternal mental health outcomes. By demonstrating a correlation between high cultural conflict and increased depressive symptoms, the CVCS results validate the study's hypothesis that sociocultural factors are key contributors to maternal mental health disparities.

The BDI scores were calculated similarly, with responses on the 4-point Likert scale summed and averaged for each participant. The severity of depression was then categorized based on

standardized scoring criteria: a mean score of 0–5 (green range) indicated low to no depression, 6–7 (blue range) indicated mild depression, 8–15 (yellow range) indicated moderate depression, and scores of 16 or higher (pink range) indicated severe depression. Figure 3 presents the mean depression scores for each racial group.

Figure 3: Beck Depression Inventory Data



The data revealed significant disparities in depression severity among racial groups. Black-identifying mothers had the highest mean depression score of 17, indicating severe depression symptoms. Hispanic/Latinx mothers reported moderate depression, with a mean score of 15. In contrast, White-identifying mothers reported low to no depression, with a mean score of 4.

The results of the BDI are essential for this study because they provide a standardized, objective measure of the severity of depressive symptoms experienced by the participating mothers. As a widely recognized tool in psychological research, the BDI offers a reliable way to quantify participants' mental health status, allowing the study to draw connections between sociocultural

influences—such as cultural conflict measured by the CVCS—and actual mental health outcomes. By assessing depressive symptoms directly, the BDI results offer critical data on the emotional and psychological well-being of the mothers involved, making it possible to determine the extent to which cultural pressures and conflict contribute to maternal depression.

Moreover, the BDI results are crucial for identifying disparities in mental health across different racial and ethnic groups within the study. The data revealed significant differences in depression severity, with Black-identifying mothers showing the highest levels of depressive symptoms, followed by Hispanic/Latinx mothers, and White-identifying mothers experiencing the least. These findings highlight how systemic factors, including cultural dissonance, racism, and healthcare inequities, can disproportionately affect the mental health of minority mothers. By linking the BDI results to the sociocultural context, the study emphasizes the need for targeted mental health interventions that consider the unique challenges faced by mothers from minority communities, further validating the importance of addressing sociocultural influences in maternal mental health research.

These findings demonstrate a correlation between race, cultural conflict, and mental health outcomes. Black-identifying mothers experienced the highest levels of both cultural conflict and depression, suggesting that the stress associated with navigating conflicting cultural values may exacerbate depressive symptoms. Hispanic/Latinx mothers, who reported moderate levels of cultural conflict, also experienced moderate levels of depression. White-identifying mothers, who reported the lowest levels of cultural conflict, demonstrated the lowest levels of depressive symptoms.

This pattern aligns with existing literature on the effects of sociocultural influences on mental health, particularly for mothers from minority backgrounds. Thus, the findings underscore the need for culturally sensitive mental health interventions that account for the unique stressors faced by Black and Hispanic/Latinx mothers.

DISCUSSION

The findings from this study provide critical insights into the impact of sociocultural influences on maternal mental health, particularly in relation to cultural conflict and depressive symptoms among mothers from different racial and ethnic backgrounds. The results of the CVCS and BDI; demonstrate a clear correlation between cultural conflict and depression, highlighting how mothers from minority communities, particularly Black and Hispanic/Latinx mothers, are more vulnerable to experiencing mental health challenges due to sociocultural pressures.

Sociocultural Conflict and Maternal Depression

The CVCS results show that Black-identifying mothers reported the highest levels of cultural conflict, followed by Hispanic/Latinx mothers, with White-identifying mothers experiencing the least conflict. This indicates that minority mothers face greater challenges in navigating the tension between their cultural values and societal expectations. The significant cultural dissonance experienced by Black and Hispanic/Latinx mothers could stem from a variety of factors, including conflicting gender role expectations, familial obligations, and societal pressures around motherhood. For these mothers, the clash between their cultural background and dominant societal norms likely adds additional stress, which in turn can negatively impact their mental health.

This is further supported by the BDI results, which revealed that Black-identifying mothers demonstrated the highest levels of depressive symptoms, with an average score of 17, indicating severe depression. These findings underscore the detrimental effects of cultural conflict on mental health and suggest that the stress of navigating cultural and societal expectations may be a key factor driving depression among minority mothers.

The disparities in mental health outcomes across racial and ethnic groups observed in this study align with existing research on the intersection of race, cultural identity, and mental health. The higher depression scores among Black and Hispanic/Latinx mothers may be explained, in part, by systemic factors such as racism, discrimination, and socioeconomic inequities that disproportionately affect these communities. Black mothers, in particular, are often subject to both overt and covert forms of racial discrimination, which can exacerbate the stress of cultural conflict and contribute to mental health deterioration. Additionally, limited access to culturally competent mental health services, compounded by structural barriers like financial instability and healthcare disparities, may further hinder minority mothers' ability to seek help and cope with the emotional challenges of motherhood.

The lower depression scores among White-identifying mothers suggest that they experience less cultural dissonance and fewer external stressors related to race or ethnicity. This highlights the importance of considering not only individual-level factors but also the broader social and structural contexts in which mothers from different racial and ethnic backgrounds live. For White-identifying mothers, the alignment between their cultural values and dominant societal norms may act as a protective factor, reducing the risk of depression and other mental health issues.

Implications for Maternal Mental Health Interventions

The findings of this study have important implications for mental health interventions aimed at supporting mothers from diverse sociocultural backgrounds. The significant cultural conflict and depressive symptoms observed among Black and Hispanic/Latinx mothers suggest that mental health services need to be tailored to address the unique cultural pressures and systemic barriers these mothers face. Culturally competent interventions that account for the intersection of race, culture, and mental health are crucial in helping minority mothers navigate cultural conflict, reduce stress, and improve their psychological well-being.

Furthermore, this study underscores the need for mental health professionals to be aware of the impact of systemic inequities, including racism and healthcare disparities, on maternal mental health. Providing equitable access to mental health care and fostering culturally sensitive environments that recognize the sociocultural realities of minority mothers is essential for reducing the mental health disparities observed in this study.

Limitations and Future Directions

While this study offers valuable insights, there are limitations that should be considered. The sample size, though informative, was relatively small, and the study focused solely on mothers who graduated from the Harvest Home program, which may limit the generalizability of the results. Future studies should aim to include a larger and more diverse sample of mothers from different socioeconomic backgrounds and geographic locations. Additionally, exploring the influence of other factors, such as socioeconomic status, educational background, and access to mental health services, would provide a more comprehensive understanding of how sociocultural influences interact with other determinants of maternal mental health.

Another limitation of this study is the reliance on self-reported data, which can introduce biases such as social desirability bias or recall bias. Participants may not fully disclose their true feelings or may provide responses they believe are socially acceptable rather than accurate reflections of their experiences. This can potentially skew the results, particularly in a study focusing on sensitive topics like mental health and cultural conflict.

For future research, incorporating qualitative methods, such as in-depth interviews or focus groups, could provide richer context and a deeper understanding of how sociocultural influences affect maternal mental health. These methods could capture more nuanced personal experiences, explore the complexities of cultural conflict in greater detail, and reveal factors that may not be fully expressed through standardized surveys alone. Integrating qualitative data could also help validate and complement the quantitative findings, offering a more comprehensive view of how cultural, social, and systemic factors intersect to shape maternal mental health outcomes.

CONCLUSION

This study highlights the significant role that sociocultural influences, particularly cultural conflict, play in shaping maternal mental health outcomes. Black and Hispanic/Latinx mothers, who experience higher levels of cultural conflict, are more vulnerable to severe depressive symptoms, likely due to the intersection of cultural pressures, systemic racism, and healthcare disparities. These findings call for the development of culturally sensitive mental health interventions that address the unique challenges faced by minority mothers and the broader societal factors contributing to their mental health disparities.

In conclusion, the results of this study provide a compelling case for the importance of considering sociocultural influences in the study of maternal mental health. The significant

cultural conflict experienced by Black and Hispanic/Latinx mothers, coupled with their higher levels of depression, demonstrates the need for mental health research and interventions to be tailored to the specific cultural and social realities of minority mothers. Additionally, the role of structural inequities in exacerbating these mental health challenges cannot be ignored. Addressing both the cultural and systemic factors that contribute to maternal mental health disparities is critical for improving the well-being of all mothers, particularly those from marginalized communities.

A key takeaway from this research is the critical importance of identifying and understanding cultural differences when addressing maternal mental health. Cultural values, gender role expectations, and family dynamics vary significantly across racial and ethnic groups, and these differences can deeply influence how mothers experience and manage stress, societal expectations, and mental health challenges. For example, cultural expectations around motherhood and gender roles in Black and Hispanic/Latinx communities may create additional layers of pressure that exacerbate mental health struggles, particularly when these expectations clash with dominant societal norms. Recognizing and accounting for these cultural differences is essential for designing effective mental health interventions that are sensitive to the unique challenges faced by mothers from diverse backgrounds.

Understanding cultural differences also allows healthcare providers to offer more personalized and culturally competent care, which can improve treatment outcomes. By addressing the cultural context of maternal mental health, researchers and practitioners can develop more inclusive approaches that not only mitigate mental health disparities but also foster resilience and empowerment within diverse communities. Moving forward, a holistic approach that

incorporates cultural, social, and institutional considerations will be key to fostering mental health equity and supporting the mental health needs of diverse maternal populations.

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Appendix A - Cultural Values Conflict Scale (CVCS) Questions

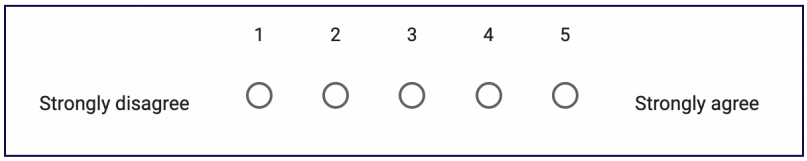
Intimate Relations:

1) I believe dating is acceptable only in a mutually exclusive relationship leading to marriage.
2) I would experience anxiety if I decided to marry someone from another racial/cultural/ethnic group.
3) I feel guilty when my personal actions and decisions go against my family's expectations.
4) I would feel guilty if I were dating someone from another cultural/ethnic group.
5) Despite cultural expectations, I would not experience anxiety if I engaged in premarital sex with someone I was in love with.
6) I would not experience discomfort if I were to engage in premarital sexual relations with someone I was physically attracted to.
7) I would experience guilt engaging in premarital sexual relations due to the social stigma attached to it within my culture.
8) Marrying within my own ethnic group would be less stressful than marrying outside of my racial/ethnic group.
9) The idea of living with a partner prior to marriage does not create anxiety for me.
10) I believe that premarital sexual relations are acceptable only after being engaged to the person.
11) An interracial marriage would be stressful to me.

Sex-Role Expectations:

1) I feel that I do not belong to either my culture nor the American culture when it relates to my role as a woman.
2) I experience anxiety at the thought of having an arranged marriage.
3) I feel like a pendulum in my role as a woman, wherein within my ethnic culture, I am expected to be dependent, submissive, and putting others needs before mine, but in the American culture, I am encouraged to be independent, autonomous, and self-asserting of my needs.
4) I struggle with the value attached to needing to be married by age 25.
5) I feel guilty for desiring privacy from my family.
6) I feel conflicted about my behaviors and options as a woman within my culture.
7) I feel frustrated in going back and forth in my role as a woman within my community and within the American community.
8) I often find it stressful balancing what I consider private and what my family considers to be public and vice versa.
9) I struggle with the double standard within my ethnic culture, wherein women more so than men are expected to be equally attentive to both their professional roles (e.g., maintaining career) as well as their home lives (e.g., household chores, parenting).
10) I struggle with the pressure to be married and the lack of option to remain single within my culture.
11) My family worries about me becoming too Americanized in my thoughts and behaviors.
12) I am bothered by the fact that in my ethnic culture, marriage for a woman is considered to be more important than having a career.
13) I struggle with my family's need to be involved in my day-to-day activities.

Likert Scale



Appendix B - Beck Depression Inventory (BDI) Questions

1.	0	I do not feel sad.
	1	I feel sad.
	2	I am sad all the time and I can't snap out of it.
	3	I am so sad or unhappy that I can't stand it.
2.	0	I am not particularly discouraged about the future.
	1	I feel discouraged about the future.
	2	I feel I have nothing to look forward to.
	3	I feel that the future is hopeless and that things cannot improve.
3.	0	I do not feel like a failure.
	1	I feel I have failed more than the average person.
	2	As I look back on my life, all I can see is a lot of failure.
	3	I feel I am a complete failure as a person.
4.	0	I get as much satisfaction out of things as I used to.
	1	I don't enjoy things the way I used to.
	2	I don't get real satisfaction out of anything anymore.
	3	I am dissatisfied or bored with everything.
5.	0	I don't feel particularly guilty.
	1	I feel guilty a good part of the time.
	2	I feel quite guilty most of the time.
	3	I feel guilty all of the time.
6.	0	I don't feel disappointed in myself.
	1	I am disappointed in myself.
	2	I am disgusted with myself.
	3	I hate myself.
7.	0	I don't have any thoughts of killing myself.
	1	I have thoughts of killing myself, but I would not carry them out.
	2	I would like to kill myself.
	3	I would kill myself if I had the chance.
8.	0	I have not lost interest in other people.
	1	I am less interested in other people than I used to be.
	2	I have lost most of my interest in other people.
	3	I have lost all of my interest in other people.
9.	0	I make decisions about as well as I ever could.
	1	I put off making decisions more than I used to.
	2	I have greater difficulty in making decisions than before.
	3	I can't make decisions at all anymore.
10.	0	I don't feel I look any worse than I used to.
	1	I am worried that I am looking old or unattractive.
	2	I feel that there are permanent changes in my appearance that make me look unattractive.
	3	I believe that I look ugly.
11.	0	I can work about as well as before.
	1	It takes an extra effort to get started at doing something.
	2	I have to push myself very hard to do anything.
	3	I can't do any work at all.
12.	0	I don't get more tired than usual.
	1	I get tired more easily than I used to.
	2	I get tired from doing almost anything.
	3	I am too tired to do anything.
13.	0	My appetite is no worse than usual.
	1	My appetite is not as good as it used to be.
	2	My appetitie is much worse now.
	3	I have no appetite at all anymore.

Scoring:

Low to no depression: 0-4

Mild depression: 5-7

Moderate depression: 8-15

High to severe depression: 16 or higher