Beck Depression–Style Inventory (BDI-II–Aligned)

Purpose: In-depth depression severity screening
Time frame: *Past 2 weeks (including today)*
Length: 21 items
Use case: After PHQ-9 or clinician referral

Instruction to user:

Each group of statements describes a common emotional or physical experience. Please choose **one statement in each group** that best describes how you have felt over the **past two weeks**.

Scoring Rule (Applies to ALL items)

Each question has **4 sentence-based options**, only **one selectable**:

- **0** → No symptom
- **1** → Mild symptom
- **2** → Moderate symptom
- **3** → Severe symptom

21-Item Questionnaire

Q1. Sadness

- **0** – I did not feel sad.
- **1** – I felt sad occasionally.
- **2** – I felt sad most of the time.
- **3** – I felt sad almost all the time and couldn't shake it off.

Q2. Pessimism about the future

- **0** – I felt hopeful about my future.
- **1** – I felt uncertain about my future.
- **2** – I felt the future held little to look forward to.
- **3** – I felt the future was completely hopeless.

Q3. Sense of failure

- **0** – I did not feel like a failure.
- **1** – I felt I had failed more than others.
- **2** – I felt I had failed repeatedly.
- **3** – I felt like a complete failure as a person.

Q4. Loss of pleasure

- **0** – I enjoyed things as much as before.
- **1** – I enjoyed things less than before.
- **2** – I got very little pleasure from activities.
- **3** – I could not enjoy anything at all.

Q5. Guilt

- **0** – I did not feel guilty.
- **1** – I felt guilty about small things.
- **2** – I felt guilty most of the time.
- **3** – I felt overwhelming guilt constantly.

Q6. Sense of punishment

- **0** – I did not feel I was being punished.
- **1** – I felt I might be punished.
- **2** – I expected punishment.
- **3** – I felt I was already being punished.

Q7. Self-dislike

- **0** – I felt neutral about myself.
- **1** – I disliked myself sometimes.
- **2** – I disliked myself most of the time.
- **3** – I hated myself.

Q8. Self-criticalness

- **0** – I was not overly critical of myself.
- **1** – I blamed myself more than usual.
- **2** – I criticized myself for many things.
- **3** – I blamed myself for everything that went wrong.

Q9. Suicidal thoughts ⚠️ HIGH-RISK

- **0** – I did not have thoughts of harming myself.
- **1** – I had thoughts of harming myself but would not act on them.
- **2** – I thought about harming myself seriously.
- **3** – I would harm myself if given the chance.

Immediate escalation if score ≥ 1

Q10. Crying

- **0** – I cried no more than usual.
- **1** – I cried more than usual.
- **2** – I cried frequently.
- **3** – I felt like crying but could not.

Q11. Agitation

- **0** – I felt calm.
- **1** – I felt slightly restless.
- **2** – I felt very restless.
- **3** – I felt so restless I couldn't stay still.

Q12. Loss of interest in people or activities

- **0** – I maintained interest in people and activities.
- **1** – I felt less interested than before.
- **2** – I lost most of my interest.
- **3** – I lost all interest.

Q13. Indecisiveness

- **0** – I made decisions normally.
- **1** – I found decision-making harder.
- **2** – I struggled greatly with decisions.
- **3** – I could not make decisions at all.

Q14. Worthlessness

- **0** – I felt worthwhile.
- **1** – I felt less worthwhile than others.
- **2** – I felt mostly worthless.
- **3** – I felt completely worthless.

Q15. Loss of energy

- **0** – I had normal energy.
- **1** – I felt tired more easily.
- **2** – I had very little energy.
- **3** – I had no energy at all.

Q16. Sleep disturbance

- **0** – My sleep was normal.
- **1** – I slept slightly more or less than usual.
- **2** – I slept much more or less than usual.
- **3** – My sleep was severely disrupted.

Q17. Irritability

- **0** – I was no more irritable than usual.
- **1** – I was more irritable than usual.
- **2** – I was irritated most of the time.
- **3** – I was constantly irritated.

Q18. Appetite change

- **0** – My appetite was unchanged.
- **1** – My appetite changed slightly.
- **2** – My appetite changed significantly.
- **3** – I had almost no appetite or was overeating constantly.

Q19. Concentration difficulty

- **0** – I could concentrate normally.
- **1** – I had mild concentration problems.
- **2** – I struggled significantly to concentrate.
- **3** – I could not concentrate at all.

Q20. Fatigue

- **0** – I was not more fatigued than usual.
- **1** – I became tired more easily.
- **2** – I felt exhausted most of the time.
- **3** – I was too exhausted to do anything.

Q21. Loss of interest in sex

- **0** – My interest was unchanged.
- **1** – My interest decreased slightly.
- **2** – My interest decreased greatly.
- **3** – I lost all interest.

Scoring Logic

Total Score = Sum of all 21 items

Range = 0 – 63

Severity Interpretation (BDI-II Standard)

Score	Depression Level
0–13	Minimal
14–19	Mild
20–28	Moderate
29–63	Severe

Mandatory Safety Rule

If **Q9 ≥ 1 →**

- Immediate suicide-risk protocol
- Pause assessment
- Show empathetic support
- Human escalation required

When to Use This (Mentamind Stack)

- ❌ Not for onboarding
- ✅ After PHQ-9 ≥ 10
- ✅ During therapy tracking
- ✅ Research-grade assessments