

Prevalence and Predictors of Depressive Symptoms Among Information Technology Professionals in Work from Home Settings: A Cross-Sectional Study

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ABSTRACT

The widespread adoption of Work from Home (WFH) arrangements in the Information Technology (IT) sector during and after the COVID-19 pandemic has raised substantive concerns regarding the mental health of professionals navigating the convergence of occupational and domestic environments. Depression — a leading contributor to global disability burden — has been identified as a particularly salient risk in remote work contexts, where social isolation, boundary erosion, and reduced access to organizational support may compound individual vulnerabilities. This study investigated the prevalence of depressive symptoms and their key predictors among IT professionals engaged in WFH in Kochi, Kerala. A cross-sectional survey was conducted with 240 IT professionals (120 WFH, 120 Work from Office [WFO] as comparison group), stratified by gender (120 men, 120 women). Depression was assessed using the Patient Health Questionnaire-9 (PHQ-9), a validated nine-item instrument yielding scores across five severity categories. Predictor variables included work hours, social support, role ambiguity, workspace ergonomics, and perceived work-life conflict. Findings indicate that WFH professionals recorded significantly higher mean PHQ-9 scores ($M = 9.84$, $SD = 4.12$) than WFO professionals ($M = 6.21$, $SD = 3.78$), corresponding to mild-to-moderate and minimal depression classifications respectively. Female WFH professionals exhibited higher depression severity than male WFH counterparts. Logistic regression identified social isolation, work-hour extension, and inadequate ergonomic environment as the strongest predictors of clinically significant depressive symptoms. These findings underscore the urgent need for organizational mental health strategies specifically tailored to the remote IT workforce.

Keywords: *Depression, Work from Home, Remote Work, Information Technology Professionals, PHQ-9, Mental Health, COVID-19, Occupational Well-being, Gender Differences*

The intersection of occupational demands and mental health has become one of the most pressing concerns in contemporary organizational psychology. The COVID-19 pandemic, which forced rapid and large-scale transitions to remote work beginning in 2020, acted as a natural experiment of unprecedented scale — exposing the psychological

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Received: May 13, 2026; Revision Received: May 19, 2026; Accepted: May 23, 2026

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costs and benefits of work arrangement changes with a clarity that pre-pandemic voluntary telework research could not provide. For Information Technology (IT) professionals, who represent one of the largest segments of the remote workforce globally, these changes have carried particularly significant implications.

Depression, classified by the World Health Organization (WHO) as the leading cause of disability worldwide, is a pervasive and often underdiagnosed condition in occupational settings. Its hallmark features — persistent low mood, anhedonia, cognitive impairment, sleep disruption, and fatigue — are not merely personal afflictions but organisational liabilities that impair productivity, innovation, and workforce retention (Lerner & Henke, 2008). Despite growing awareness of workplace mental health, research specifically examining depression among WFH IT professionals in the Indian context remains sparse, creating a significant evidence gap for practitioners and policymakers.

Work from Home presents a paradox for mental health. On one hand, the elimination of commuting, increased schedule flexibility, and proximity to family have been proposed as protective factors. On the other, the dissolution of spatial and temporal boundaries between work and home, reduced social contact with colleagues, heightened workload demands, and inadequate ergonomic conditions may collectively elevate depressive risk. The experience of 'techno-isolation' — a state of professional loneliness arising from the absence of informal workplace interactions — has been specifically identified as a pathway through which WFH erodes emotional well-being (Hadar-Shoval et al., 2022).

Gender adds a critical dimension to this analysis. Women in WFH settings frequently navigate a dual burden: managing professional responsibilities while absorbing disproportionate domestic and caregiving labour. This compounded load, documented extensively in pandemic-era literature (Collins et al., 2021; Yildirim & Eslen-Ziya, 2021), positions female IT professionals as a particularly vulnerable subgroup warranting dedicated empirical attention. At the same time, men in WFH contexts are not immune — cultural expectations around professional identity and social withdrawal from male-dominated workplace cultures may produce distinct but equally significant depressive pathways.

The present study was conducted among IT professionals at Infopark, Kochi — one of South India's premier technology clusters — with three primary objectives: to establish the prevalence of depressive symptoms in WFH versus WFO populations; to examine gender-based differences in depression severity within each work arrangement; and to identify the key organizational and psychosocial predictors of clinically significant depression among WFH professionals. Findings are intended to inform evidence-based mental health policy and intervention design within the IT sector.

LITERATURE REVIEW

Depression in Occupational Contexts

Occupational depression has long been recognized as distinct from but continuous with clinical depression, sharing diagnostic criteria while being precipitated or exacerbated by work-specific stressors such as job demands, lack of control, poor social support, and effort-reward imbalance (Siegrist, 1996; Karasek & Theorell, 1990). In the IT sector, the combination of high cognitive demands, project-based pressure, irregular hours, and client-facing responsibilities creates a particularly fertile environment for depressive symptom development. Ng and Burke (2010) noted that IT professionals report higher rates of burnout

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and psychological strain than comparable knowledge workers, attributing this in part to an organizational culture that valorizes overwork.

The PHQ-9 has emerged as the gold standard for depression screening in occupational research, demonstrating robust sensitivity (88%) and specificity (88%) for major depressive disorder at a threshold score of 10 or above (Kroenke et al., 2001). Its brevity, validated psychometric properties across cultural contexts, and dimensional scoring — which allows both categorical diagnosis and continuous severity measurement — make it ideally suited to large-sample occupational surveys.

Remote Work and Depressive Symptoms

Prior to the pandemic, evidence on telework and mental health was mixed. Whilst some studies reported enhanced autonomy and reduced work-family conflict as protective mechanisms (Gajendran & Harrison, 2007), others highlighted professional isolation and the 'always-on' culture of remote work as significant risk factors (Allen et al., 2015). The pandemic context transformed this calculus: WFH was no longer a chosen flexibility but an imposed condition, often executed in suboptimal home environments and without the infrastructural support that characterizes organizational workplaces.

Xiao et al. (2021) in a large-scale Chinese study found that WFH workers reported PHQ-9 scores approximately 2.3 points higher than office-based counterparts during the pandemic, with work-hour extension and social disconnection as primary mediators. Similarly, Srivastava et al. (2022), studying Indian IT workers, identified significant elevation in depressive symptoms following transition to WFH, particularly among employees residing in joint family arrangements — an important cultural variable in the Kerala context. Conversely, Schifano et al. (2021) found that WFH professionals with high perceived job autonomy showed no significant depression elevation, suggesting that organizational trust and control mediate the WFH-depression relationship.

Gender Differences in WFH-Related Depression

Gender differences in depression prevalence are well established, with women demonstrating approximately twice the population-level depression rates of men (WHO, 2021). In WFH contexts, these disparities may be amplified or attenuated depending on the degree to which domestic responsibilities are equitably distributed. Collins et al. (2021) demonstrated that mothers in dual-income households experienced significantly greater mental health deterioration during pandemic WFH than fathers, a pattern attributed to asymmetric increases in childcare and household management burdens. Yildirim and Eslen-Ziya (2021) replicated this finding in a European context, emphasizing that gender ideology — rather than WFH per se — moderated the mental health impact.

In India, where patriarchal household structures remain influential even among educated urban professionals, the intersection of WFH, caregiving expectations, and gender is expected to exert particularly pronounced effects on depressive outcomes for women. The present study tests this expectation in the Kerala IT sector, which, while demographically progressive relative to many Indian regions, is not immune to such structural dynamics.

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Objectives and Hypotheses

Objectives

- To assess and compare the prevalence and severity of depressive symptoms between IT professionals in WFH and WFO arrangements.
- To examine gender differences in PHQ-9 scores within both WFH and WFO groups.
- To identify the significant psychosocial and organizational predictors of clinically significant depression ($\text{PHQ-9} \geq 10$) among WFH IT professionals.

Hypotheses

- **H₁:** IT professionals working from home will report significantly higher PHQ-9 depression scores than those working from office.
- **H₂:** Female IT professionals in the WFH group will report significantly higher PHQ-9 scores than male IT professionals in the same group.
- **H₃:** Social isolation, extended working hours, and inadequate ergonomic environment will be significant predictors of clinically significant depression ($\text{PHQ-9} \geq 10$) among WFH professionals.

METHODOLOGY

Research Design

A quantitative cross-sectional survey design was employed to assess depressive symptom prevalence and identify organizational and psychosocial predictors. Data were collected between January and April 2023, capturing a post-acute pandemic period during which hybrid and full-time WFH arrangements had stabilized as organizational norms rather than emergency measures. This temporal framing is methodologically important: post-acute assessments are less susceptible to acute crisis reactivity and more indicative of the structural, long-term mental health implications of WFH.

Participants and Sampling

Participants were recruited from technology firms operating within Infopark, Kochi. Stratified random sampling was employed to ensure balanced representation across work modality (WFH/WFO) and gender (male/female). The final sample comprised 240 IT professionals, distributed as: 60 WFH women, 60 WFH men, 60 WFO women, and 60 WFO men. Eligibility criteria required active employment in a technical IT or ITES role for a minimum of twelve months, current engagement in the stated work arrangement for at least six continuous months, age between 22 and 45 years, and provision of written informed consent. Participants with a prior diagnosed psychiatric disorder were not excluded, as their inclusion was considered ecologically valid for a prevalence study; however, current treatment status was recorded as a covariate.

Instruments

- **Personal Datasheet:** A researcher-designed instrument collected demographic and occupational data including age, gender, marital status, living arrangement, work arrangement, daily working hours, years of experience, job role, and home workspace characteristics (dedicated room vs. shared space).
- **Patient Health Questionnaire-9 (PHQ-9; Kroenke et al., 2001):** The PHQ-9 is a nine-item self-report scale assessing the frequency of depressive symptoms over the preceding two weeks, rated on a four-point scale (0 = Not at all to 3 = Nearly every day). Total scores range from 0 to 27 and are classified as: Minimal (0–4), Mild (5–9),

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Moderate (10–14), Moderately Severe (15–19), and Severe (20–27). The PHQ-9 has demonstrated strong psychometric properties in Indian samples (Cronbach's $\alpha = .86$; Ganguli et al., 2010) and is widely used in occupational mental health research.

- **Work Environment and Psychosocial Stressor Inventory (WEPSI):** A researcher-constructed 20-item supplementary scale assessed five predictor domains: perceived social isolation at work (4 items), daily work-hour extension beyond contracted hours (4 items), role ambiguity (4 items), workspace ergonomic quality (4 items), and work-life conflict (4 items). Each domain yields a sub-score from 0 to 12; higher scores reflect greater adversity. Content validity was established through expert review by two occupational psychologists.

Procedure

Institutional ethical clearance was obtained prior to data collection. WFO participants completed paper questionnaires administered during designated break periods at company premises. WFH participants were reached via secure online survey links distributed through HR contacts and professional WhatsApp groups associated with Infopark companies. All participants received a written debrief explaining study objectives and directing those with PHQ-9 scores ≥ 10 to available mental health resources. Data were screened for completeness; questionnaires with more than two missing items were excluded. The final response rate was 87.3% (240 usable responses from 275 distributed questionnaires).

Statistical Analysis

Data were analysed using IBM SPSS v.26. Descriptive statistics, frequency distributions of PHQ-9 severity categories, and independent samples t-tests were used to address H₁ and H₂. Chi-square tests examined categorical severity distribution differences between groups. Binary logistic regression (dependent variable: PHQ-9 ≥ 10 vs. < 10) was employed to test H₃, with WEPSI sub-scores entered as predictors alongside demographic covariates. Statistical significance was set at $p < .05$ (two-tailed); effect sizes were reported as Cohen's d (t-tests) and Nagelkerke R^2 (logistic regression).

RESULTS

Sample Characteristics

The mean age of participants was 29.6 years (SD = 4.82; range: 22–45). The WFH group comprised 68.3% who reported working beyond contracted hours daily, compared to 41.7% of the WFO group. Among WFH participants, 54.2% worked from a shared domestic space rather than a dedicated home office. Marital status was comparable across groups (WFH: 48.3% married; WFO: 51.7% married). Table 1 summarizes key demographic characteristics.

Table 1. Demographic and Occupational Characteristics of the Sample (N = 240)

Variable	WFH Group (n=120)	WFO Group (n=120)
Mean Age (SD)	29.4 (4.71)	29.8 (4.94)
Women (%)	50.0%	50.0%
Married (%)	48.3%	51.7%
Mean Experience in Years (SD)	5.2 (2.84)	5.6 (3.01)
Working >8 hrs/day (%)	68.3%	41.7%
Dedicated Workspace at Home (%)	45.8%	N/A

Note. WFH = Work from Home; WFO = Work from Office; N/A = Not Applicable.

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PHQ-9 Scores: Descriptive Statistics and Group Comparisons

Table 2 presents the mean PHQ-9 scores and severity distributions for all four sub-groups. WFH professionals recorded a mean PHQ-9 score of 9.84 (SD = 4.12), falling within the Mild depression range, while WFO professionals recorded a mean of 6.21 (SD = 3.78), within the Minimal range. An independent samples t-test confirmed this difference was statistically significant: $t(238) = 6.87, p < .001$, Cohen's $d = 0.89$ (large effect). H_1 is supported.

Within the WFH group, women ($M = 11.42, SD = 4.05$) scored significantly higher than men ($M = 8.27, SD = 3.74$), $t(118) = 4.31, p < .001, d = 0.79$ (medium-to-large effect), supporting H_2 . Within the WFO group, the gender difference was non-significant: women ($M = 6.58, SD = 3.92$) vs. men ($M = 5.84, SD = 3.61$), $t(118) = 1.09, p = .28, d = 0.20$.

Table 2. PHQ-9 Descriptive Statistics by Work Modality and Gender

Group	N	Mean PHQ-9 (SD)	Severity Category	% Scoring ≥ 10 (Moderate+)
WFH – Women	60	11.42 (4.05)	Moderate	61.7%
WFH – Men	60	8.27 (3.74)	Mild	35.0%
WFH – Total	120	9.84 (4.12)	Mild–Moderate	48.3%
WFO – Women	60	6.58 (3.92)	Mild	18.3%
WFO – Men	60	5.84 (3.61)	Minimal	13.3%
WFO – Total	120	6.21 (3.78)	Minimal–Mild	15.8%

Note. PHQ-9 severity: Minimal = 0–4; Mild = 5–9; Moderate = 10–14; Moderately Severe = 15–19; Severe = 20–27.

PHQ-9 Severity Category Distribution

Chi-square analysis of severity category distributions revealed a significant association between work modality and depression severity category, $\chi^2(4, N = 240) = 38.74, p < .001$, Cramér's $V = 0.40$. Table 3 presents the full severity distribution. Nearly half (48.3%) of WFH professionals scored in the Moderate or above range, compared to only 15.8% of WFO professionals. At the severe end, 7.5% of WFH professionals met criteria for Moderately Severe depression versus 1.7% in the WFO group.

Table 3. PHQ-9 Severity Category Distribution by Work Modality (%)

Severity Category	PHQ-9 Score	WFH (n=120)	WFO (n=120)
Minimal	0–4	12.5%	39.2%
Mild	5–9	39.2%	45.0%
Moderate	10–14	30.8%	11.7%
Moderately Severe	15–19	10.8%	3.3%
Severe	20–27	6.7%	0.8%

Note. Percentages may not sum to 100 due to rounding. $\chi^2(4) = 38.74, p < .001$, Cramér's $V = 0.40$.

Logistic Regression: Predictors of Clinically Significant Depression

Binary logistic regression was conducted with clinically significant depression ($PHQ-9 \geq 10$) as the dependent variable, restricted to the WFH subsample ($n = 120$). Five WEPSI subscores (social isolation, work-hour extension, role ambiguity, ergonomic quality, work-life conflict) were entered simultaneously alongside gender and marital status as covariates. The model was statistically significant, $\chi^2(7) = 52.34, p < .001$, and explained 48.7% of variance

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in depression classification (Nagelkerke $R^2 = .487$). Overall classification accuracy was 76.7%.

As shown in Table 4, social isolation (OR = 2.84, 95% CI [1.63, 4.95], $p < .001$), daily work-hour extension (OR = 2.31, 95% CI [1.38, 3.87], $p = .001$), and inadequate ergonomic environment (OR = 1.97, 95% CI [1.14, 3.40], $p = .015$) emerged as significant predictors, supporting H_3 . Work-life conflict trended toward significance (OR = 1.58, $p = .067$). Gender (female) was a significant covariate (OR = 2.42, $p = .003$), while role ambiguity and marital status did not reach significance.

Table 4. Logistic Regression Predictors of PHQ-9 ≥ 10 Among WFH Professionals ($n = 120$)

Predictor	B	SE	Wald χ^2	OR	95% CI	p
Social Isolation	1.04	0.28	13.81	2.84	[1.63, 4.95]	< .001
Work-Hour Extension	0.84	0.26	10.39	2.31	[1.38, 3.87]	.001
Ergonomic Quality	0.68	0.28	5.87	1.97	[1.14, 3.40]	.015
Work-Life Conflict	0.46	0.25	3.38	1.58	[0.97, 2.58]	.067
Role Ambiguity	0.31	0.27	1.31	1.36	[0.80, 2.31]	.251
Gender (Female)	0.88	0.30	8.65	2.42	[1.34, 4.36]	.003
Marital Status	0.19	0.28	0.46	1.21	[0.70, 2.09]	.499

Note. OR = Odds Ratio; CI = Confidence Interval. Nagelkerke $R^2 = .487$; overall classification accuracy = 76.7%.

DISCUSSION

This study provides robust evidence that WFH is associated with significantly elevated depressive symptoms among IT professionals at Infopark, Kochi. The mean PHQ-9 score for WFH professionals ($M = 9.84$) fell at the upper boundary of the Mild depression range — clinically meaningful in its own right — and 48.3% of WFH professionals scored at or above the clinically significant threshold of 10, compared to 15.8% of WFO professionals. The large effect size ($d = 0.89$) indicates that work modality is not merely a statistical moderator but a substantively important predictor of depressive risk in this population.

The finding that social isolation emerged as the strongest predictor of clinically significant depression (OR = 2.84) is consistent with the broader literature on loneliness and mental health (Cacioppo & Hawkey, 2009) and specifically with Hadar-Shoval et al.'s (2022) documentation of 'techno-isolation' in remote knowledge workers. Informal workplace interactions — corridor conversations, shared lunches, spontaneous collaborative moments — are not mere organizational pleasantries; they constitute a form of social sustenance whose removal from the daily professional experience carries measurable psychological cost. The findings suggest that organizations must actively engineer social connection opportunities for remote employees rather than assuming that digital communication tools adequately substitute for embodied collegiality.

Extended working hours as a significant predictor (OR = 2.31) reflects a well-documented phenomenon in WFH research: the absence of physical workplace boundaries correlates with the psychological inability to disengage from work. The present finding that 68.3% of WFH participants reported working beyond contracted hours daily — compared to 41.7% of WFO participants — is consistent with Mehta and Sharma's (2021) documentation of boundary erosion in Indian IT WFH contexts. The implication for organizational policy is direct: clear

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right-to-disconnect policies, enforced through managerial modelling, are a mental health intervention as much as a work-life balance measure.

The significant gender effect — with female WFH professionals recording PHQ-9 scores 3.15 points higher than male WFH counterparts ($d = 0.79$) and showing an OR of 2.42 for clinically significant depression — confirms and extends prior literature on the disproportionate mental health burden borne by women in remote work settings. The absence of a significant gender difference in the WFO group ($d = 0.20$, $p = .28$) is particularly informative: it suggests that the office environment serves as an equalizer, providing structural scaffolding — managerial visibility, peer support, physical separation from domestic demands — that partially mitigates the gender-specific vulnerabilities that WFH exposes. Intervention designs must therefore be gender-sensitive, addressing not only individual coping resources but the household and organizational structural conditions that shape them.

The finding that ergonomic inadequacy predicted depression (OR = 1.97) adds an underappreciated dimension to the WFH mental health discourse. While ergonomics is typically framed as a physical health concern, the present findings align with evidence that chronic physical discomfort — headaches, musculoskeletal pain, eye strain — impairs mood regulation, elevates irritability, and depletes the cognitive and emotional resources needed to maintain psychological equilibrium. Organizational provision of ergonomic equipment and allowances for WFH professionals is therefore not a luxury but a mental health investment.

Several limitations warrant acknowledgement. The cross-sectional design precludes causal inference; longitudinal data would be necessary to establish whether WFH causes depression or whether individuals with pre-existing vulnerabilities are more likely to remain in WFH roles. The sample, while drawn from a premier IT hub, is geographically restricted to Kerala and may not generalize to IT professionals in Tier-1 cities such as Bengaluru or Hyderabad, where workplace cultures, compensation structures, and housing conditions differ substantially. Self-report measures are subject to social desirability effects, though the anonymity of online administration partially mitigates this. The WEPSI, while content-validated, is a researcher-constructed instrument whose psychometric properties require further investigation. Future research should employ ecological momentary assessment, clinical diagnostic interviews, and multi-site sampling to build upon the present findings.

CONCLUSION

This study demonstrates that IT professionals working from home carry a substantially higher burden of depressive symptoms than their office-based counterparts, with nearly half meeting criteria for clinically significant depression. Social isolation, extended working hours, and inadequate ergonomic environments are the primary organizational drivers of this risk, while female gender confers additional vulnerability. These findings call for an urgent reorientation of organizational mental health strategy in the IT sector — one that recognizes WFH not as a monolithic benefit but as a heterogeneous condition whose mental health implications depend critically on how it is structured, supported, and gendered.

Practical recommendations include: mandatory ergonomic support allowances for remote employees; structured virtual social interaction programmes (beyond task-focused meetings); enforceable right-to-disconnect policies; regular PHQ-9 screening embedded within employee wellness programmes; and gender-sensitive support resources that address the

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intersection of remote work and domestic burden. Mental health in the remote IT workforce is not an individual responsibility — it is an organizational and policy imperative.

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Acknowledgment

The authors extend sincere gratitude to the IT professionals at Infopark, Kochi, who generously contributed their time and candid responses. Appreciation is also extended to the HR departments of participating companies and to the occupational psychology colleagues whose expert review strengthened the WEPSI instrument.

Conflict of Interest

The authors declare no conflict of interest in relation to this research, authorship, or publication.

How to cite this article: Vattapparambath, P. & Sayed, S. (2026). Prevalence and Predictors of Depressive Symptoms Among Information Technology Professionals in Work from Home Settings: A Cross-Sectional Study. *International Journal of Social Impact*, 11(2), 313-322. DIP: 18.02.029/20261102, DOI: 10.25215/2455/1102029