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The Experience of Receiving a Diagnosis of Depression in Adolescence:

A Pilot Qualitative Study in Brazil

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Abstract

Receiving a diagnosis of depression can have an important impact on the lives of adolescents. However, there is limited information about how youth tackle, attribute meaning to, and understand mental health diagnoses. The aim of this study was to explore adolescents' initial reactions after receiving a clinical diagnosis of Major Depressive Disorder in the context of a neurobiological study of depression in Brazil. Using a qualitative design, eight Brazilian adolescents were interviewed twice: immediately after a psychiatric assessment and neuroimaging study, in which they were given a diagnosis of depression, and in a follow-up visit two weeks later. Interviews were designed to explore the subjective experience of receiving the diagnosis and the impacts of depression on the adolescents' lives. Framework Analysis was used to analyze the accounts. Diagnosis was perceived as a reification of an abnormal status, highlighting the role of stigma and the process of disclosing the diagnosis to others. Adolescents reported the multiple sensemaking processes that occurred when they received a diagnosis of depression, and most struggled with the idea that negative emotions would equate their experience with a disorder. The results show that future efforts could enhance clinical assessment processes with adolescents by exploring adolescents' reactions to diagnosis, as well as the support networks available to them, resulting in increased help-seeking behaviors, and diminished social and personal stigma.

Keywords: Major Depressive Disorder; Adolescence; Qualitative Methodology; Lived Experience; Psychiatric Diagnosis.

Introduction

Receiving a diagnosis of a mental health condition can have a major impact on the lives of patients (Perkins et al., 2018), as it “marks the point when formal status of psychiatric patient is conferred” (Rose & Thornicroft, 2010, p. 140). It can also be an important part of the illness experience - especially since it is embedded in the social and cultural context, but also connected to the biography of a person and to the disease process (Kleinman & Seeman, 1999). Therefore, it is important to understand how people tackle, attach meaning to, and understand symptoms and diagnoses (Petersen et al., 1993).

There is a modest body of literature on the experience of receiving a diagnosis of a mental health condition. Most of the studies are conducted with adults from western, educated, industrialized, rich and democratic countries and focus on the contradictory nature of the experience of receiving a diagnosis (Pitt et al., 2009). The positive side of this is described as giving patients something to focus on and a way to think about their difficulties, and as giving a sense of relief (Rose & Thornicroft, 2010). The negative side, however, is more focused on the idea of a diagnosis as a label for not fitting in or as a negative judgment (Hayne, 2003), and the concern of being stigmatized and discriminated against by others (Hamilton et al., 2014). Among adolescents, studies show similar results, highlighting the impacts of making sense of a diagnosis (Bluhm et al., 2014; Wisdom & Green, 2004).

During adolescence, however, there is a heightened focus on the impacts of accepting depression as congruent with their previous experiences on self-image and identity, therefore engaging in different ways of integrating the information of the diagnosis into their self-image (Wisdom & Green, 2004). In these cases, diagnoses can give adolescents a sense of insight and validation of previous experiences and feelings, acting as a gateway to intervention and self-management (O'Connor et al., 2018), as well as having a role in

integrating past and present experiences considering the diagnosis (Jones & Hesse, 2018). Receiving a diagnosis involves interpersonal relations, social identity and stigma experiences, being therefore a key point in mental health trajectories of youth (O'Connor & McNicholas, 2020).

However, there are still important gaps in the literature: we need to further investigate how adolescents experience receiving a diagnosis. This approach is highly relevant since adolescence is the phase of development when the prevalence of depression rises sharply (Thapar et al., 2012). Moreover, depression often has a chronic course across the lifespan, and thus the first onset of symptoms during adolescence may be the best opportunity for early intervention to prevent chronicity (Davey & McGorry, 2019). Therefore, understanding how adolescents feel when they are diagnosed and how they make sense of it can provide insights into how to enhance this process, facilitate it, or even contribute to address the gaps in identification and management of mental health disorders.

In this sense, it is important to explore this experience from the perspective of Brazilian adolescents. By contrasting and exploring the experience of Brazilian teens, we can also shed light on the differences and similarities from similar studies in high-income countries, which is particularly important since 90% of the world's adolescents live in low- and middle-income countries (Kieling et al., 2011). We here present the results of a qualitative study with adolescents' who received a clinical diagnosis of Major Depressive Disorder (MDD) during a research assessment in an urban hospital setting in southern Brazil. We also report on how adolescents perceive and experience depressive symptoms and the ways they manage and cope with depression and depressive feelings.

Materials and Methods

Study Design and Sampling

The Identifying Depression Early in Adolescence Risk Stratified Cohort (IDEA RiSCo) study (Kieling et al., 2021) included a sample of 150 adolescents aged 14 to 16 years from schools in Porto Alegre, Rio Grande do Sul, Brazil, who had undergone screening for risk factors associated with MDD (see Table 1 for the list of factors). Additional information on the study setting is provided in Appendix A. As part of the IDEA RiSCo study protocol, participants and their primary caregivers were invited to a clinical assessment (see Appendix B) by a child and adolescent psychiatrist using the DSM-5 Brazilian Portuguese version of Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and Lifetime Version (K-SADS-PL) (Caye et al., 2017).

Recruitment for this qualitative study began during the final stages of the IDEA-RiSCo baseline assessment, focusing on the last 10 included adolescents who met criteria for a formal DSM-5 diagnosis of MDD and were in a current depressive episode. Participants were approached immediately after receiving the diagnosis by the clinician at the end of the clinical assessment and invited to participate in two semi-structured interviews: one immediately after initial recruitment and the second two weeks later. After the first interview, participants also underwent an fMRI protocol and had their blood taken. The final analysis included 8 adolescents, as two were excluded due to incompleteness of the second interview.

Data Collection

To capture both immediate and subsequent reactions to receiving a diagnosis of MDD, we divided the interview process into two stages. In the first, immediately after the adolescent received feedback from the psychiatrist, the adolescents were asked about their experience of depression. Two weeks later, they returned for a follow-up interview which focused on understanding the adolescents' reaction to the diagnosis (see Figure 1 for detailed timeline of

events). The questions included explored the experience of depression and its symptoms, and the experiences of receiving and disclosing diagnosis. For the complete interview guide, see Appendix C.

Data collection took place at the Clinical Research Center, Hospital de Clínicas de Porto Alegre, where the IDEA RiSCo study was being performed. Individual interviews were conducted in Brazilian Portuguese by AV and SB and were audio-recorded and transcribed. Interviews were carried out by a master's student (AV, female) and a Doctor in Psychology (SB, female), both with a background in Psychology and qualitative research.

Data Analysis

Interviews were analyzed using Framework Analysis (FA) (Ritchie & Spencer, 1994). The creation of the codes was inductive - we used line-by-line coding of two initial interviews to create a framework of codes that was subsequently adapted and expanded until no new codes emerged (Thomas, 2016). Additionally, constant comparison - comparing newly coded sections to previous coded data (Glaser & Strauss, 1967) - and discussions with the research team were used to refine and create the final codebook. The final codebook was used to code the full dataset using NVivo version 12 (Richards, 1999). Coding was conducted in Portuguese by two researchers (AV and SB), under the supervision of a senior researcher (CK). We assessed inter-rater reliability (IRR) using Cohen's Kappa, and considered an IRR of 0.7 as indicating adequate agreement (McHugh, 2012). Afterwards, code queries were generated in NVivo and code summaries were written to capture adolescents' perspectives and experiences. All stages of analysis and reporting were executed according to the Consolidated Criteria for Reporting Qualitative Research (Tong et al., 2007) (Appendix D). In preparing the manuscript for publication, the original quotes were translated into English by one of the researchers (AV, Brazilian researcher with advanced proficiency in English),

and reviewed by two of the other authors who speak fluent Portuguese and English (SB and CK).

Ethics

This study was approved by the Hospital de Clínicas de Porto Alegre Ethics Committee (CAAE: 03220818.0.0000.5327) All adolescents and their caregivers provided written consent to participate in the study. All adolescents were provided feedback on their clinical evaluation by a child and adolescent psychiatrist prior to their inclusion in the present study and were referred for care within the Brazilian public health system. No adolescents presenting with imminent risk were included. Participants and primary caregivers were informed that the refusal to take part in this component of the research would not interfere with the overall participation and referral process. To ensure protection of confidentiality and anonymization of the data, all identifiable details given by participants during their interviews were omitted from interview transcripts.

Results

Eight adolescents had full data available - two girls and six boys (mean age of 15.3 years). This sample was equally composed of white and non-white adolescents. Given the IDEA RiSCo study ascertainment design, included adolescents exhibited a high load of social risk factors for developing depression. Additionally, adolescents had a mean score of 49 on the Children's Depression Rating Scale–Revised (CDRS-R), indicating moderate depression (Plener et al., 2012) (for additional information, see Table 1 and Appendix E). Interview duration ranged from 32 to 54 minutes, with an average of 42 minutes per respondent. The two themes and three subthemes were generated in a way that represented the overarching narrative across all respondents.

Theme 1: Reaction to Diagnosis: does having a diagnosis mean it is real?

All adolescents included in the study received a formal diagnosis of depression by a child and adolescent psychiatrist. For most of them (six of eight), this was their first contact with a mental health specialist and the diagnosis was undisclosed until that moment. Adolescents were grouped into two types of reaction to the diagnosis: half of them said it was no surprise, and the other half struggled with the diagnosis.

To those for whom the diagnosis did not come as a surprise, the possibility of having depression was something they were already considering prior to taking part in the research project. They mentioned either searching for the symptoms online and relating to them or comparing their feelings to others' who were diagnosed with MDD.

“It wasn't a surprise, so I took it well. I already imagined it could have something to do with my heritage - my mom has [depression], my grandmother...” (Boy 3, age 15)

To those who were surprised to be diagnosed with depression, the reaction was of disbelief.

“I was surprised and... I think that it made me tense, because I had never thought about something like this, so maybe I don't have it. Having a diagnosis does not mean that this is real.” (Boy 1, age 15)

This disbelief about the diagnosis of depression also expressed the adolescents' concerns about the weight of a diagnosis of depression. They seemed to link the idea of having a diagnosis with being a “depressed person”, which was seen as something negative. The diagnosis, to them, was a powerful label that defines someone.

In Portuguese, as in many languages, ‘depressive’ [Brazilian Portuguese: ‘depressivo’] is a common way of referring to both feelings of sadness and to define someone who has a formal

psychiatric diagnosis. This creates a difference between the idea of *being* depressed and *having* depression - the first as an indicator of a state and the latter as a trait - that adolescents reflected upon:

“I don’t feel like a depressed person. Or I could be one, but right now. The psychiatrist said that, but... [Said] That I have to take medication. But I don’t see myself as a depressive person. Do I have depression? This can be something of this moment. (...) I’m not a depressed person.” (Boy 4, 16)

Subtheme: Stigma as a Barrier to Disclosing the Diagnosis

The beliefs about depression and its diagnosis also seemed to be linked to stigma. Adolescents stressed common shared beliefs of depression as a personal weakness. The idea of depression as something experienced by "crazy people" ["gente louca"] was also a component mentioned by half of the participants.

In the first two weeks after receiving the diagnosis, five adolescents chose to disclose their diagnosis to people outside their families, limiting it to one or two close friends and/or significant others. They reported mixed reactions, but most of them being negative - only one adolescent mentioned a positive and supportive reaction. Most times, adolescents reported that this disclosure led to arguments:

“[Talking about a friend] She was really upset [...] She told me I never tell her things, I never open up to her [...] she was mad at me because I’m not happy.” (Boy 1, 15)

As for the reaction of family members, adolescents also reported mostly negative reactions:

“It wasn’t very good. [...] My dad says things like ‘I didn’t raise you to be sad, I raised you to be strong, because this is something from a weak person’.” (Boy 1, 15)

Those who did not disclose the diagnosis expressed concerns about the stigma that still surrounds a depression diagnosis:

“[I did not tell anyone because] they will call me crazy. [...] They already called me crazy because you invited me to this research. Imagine if I told someone I have depression?” (Girl 1, 16)

Subtheme: Trusting Relations as a Facilitator for Disclosing the Diagnosis

While distraction techniques were most often mentioned by the adolescents to forget negative feelings, for four of the adolescents, distraction techniques involved relying on meaningful relations with friends or family members.

“I think that talking to my friend or... Some of my friends, people that are really important to me. Sometimes they distract me with jokes, our way of being together... The jokes, the playing, it totally changes my mood.” (Boy 1, 15)

From these four adolescents, only one chose not to disclose their diagnosis. Close relations with family, peers, and significant others were often cited as a reason to disclosing the diagnosis:

“I told only a friend of mine. Just her. Because she is a person who is always with me. She is very especial to me, she is always with me and I trust her a lot.” (Boy 1, 15)

While relationships, especially those with friends, were mentioned by all adolescents as being an important part of their lives, the idea of trust was prominent in all respondents who chose to disclose the diagnosis:

“I told my friend about it [the diagnosis] because I trust him very much” (Boy 3, 15)

Subtheme: Biological perspectives on depression

Two weeks after receiving the diagnosis, providing blood samples, and undergoing a magnetic resonance imaging exam, adolescents were interviewed regarding their diagnosis. For most adolescents, depression was like a “*very strong emotion that someone can’t deal with properly*” (Boy 1, 15), and they struggled with the idea of these emotions as indicators of a formal disorder – which made it harder for them to accept the diagnosis.

“You are talking that this [depression] is a disorder, but it is also a kind of emotion. And knowing emotions from blood or other exams is... Different.” (Boy 1, 15)

When talking about the exams they underwent and possible results that could arise from neurobiological markers, adolescents pondered whether feelings were something from “the brain” or “the organism” not only from “the mind.”:

“Maybe I would think that sometimes some of the things I feel are not from my mind, but of how my organism works.” (Boy 5, 15)

This separation of bodily functions and emotions – where depression lies – was often a point of discussion in interviews:

“I’ve never seen finding anything in the blood that caused something I have – like sadness. One thing is feelings and other is what there’s on the blood.” (Girl 1, 16)

While for four adolescents finding neurobiological causes for depression could be a relief, two adolescents were also concerned about the implications of this. Interestingly, these concerns were strictly related to neuroimaging results that could reflect the cultural idea of “madness” [“*loucura*”] as something that comes from a “damaged” brain:

“If it were something from the head [“alguma coisa da cabeça”] then I would be terrified.”

(Girl 2, 16)

Theme 2: Experience of Depression

All adolescents were asked about their personal interpretation and experience of depression. Depression was predominantly described based on the emotions they felt and was associated with an inability to deal with these feelings:

“I think... It’s an emotion so strong someone can’t deal with it properly; can’t deal with it alone. It’s a disease, right? I think it’s very hard, I don’t know why people treat it like it’s a disease, but I know it is. Because I think it is much more like an emotion, but stronger.

Sadness, but the deepest summit. The person loses will, changes who they are. Change completely their life patterns and ways.” (Boy 1, 15)

Adolescents referred to difficulty in understanding why their emotional experience was labeled as a “disease”. At the same time, they expressed willingness to establish a meaning for what they were experiencing. It was clear that depression marked their lives, creating a division between the *before* and *after* the symptoms started. Not all adolescents were able to name actions and feelings that changed after they started experiencing depression-like symptoms, but all agreed that the idea of change was a big part of the experience.

“Things weren’t like this before. I didn’t feel like this.” (Boy 3, 15)

Descriptions of concrete experiences were also mentioned.

“Sadness and boredom... When depression comes in certain people, like my brother, it is this sadness and this boredom.... He didn’t want to go out to work, to go to school, he was very

bored. [He] only wanted to be inside the house, so I see depression a lot like boredom, like sadness.” (Boy 4, 16)

Participants reported that depression had changed their lives in two complementary ways: a *decrease* in their will and ability to do different things, meet new people, and engage in interests that they previously considered to be gratifying; and an *increased* importance was given to their own thoughts and beliefs. They described it as “being stuck” in their own heads: there is added value to thoughts and beliefs and less focus on external situations. The escape through isolation and the difficulty to share depressive feelings made it harder breaking this cycle:

“Sometimes I don’t go out with my friends so I can stay home, you know? Be alone, in my room. On my phone, on the computer. Just being quiet.” (Boy 6, 16)

The negative feelings and words that were most used to express what depression meant to them were: sadness, discomfort, loneliness. One participant said his depression:

“Is like a water jar with a leak... It just empties little by little. It fades, but not at once. But then it is also like someone grabs it and turns it over because they can’t stand this slow leak [...] So it’s just empty and they can start over, buy a new one.” (Boy 1, 15)

Discussion

The present pilot study generated data on Brazilian adolescents’ experiences and processes of constructing and attributing meaning to the diagnosis of depression by conducting interviews with adolescents at two time-points – immediately after receiving the diagnosis and then

again two weeks later. Participants' reports point towards an experience of depression marked by intense emotional features.

Most adolescents, however, struggled with the idea of these emotions as indicators of a formal disorder - which made it harder for them to accept the diagnosis. There was separation of body and mind expressed by adolescents when they pondered whether these feelings were something from "the brain" or "the organism" not only from "the mind." However, IDEA RiSCo was a study designed to investigate neurobiological features associated with the risk of developing and the presence of depression in adolescence (Kieling et al., 2019, 2021), and accounts on the separation of body and mind were cited in the second interview, after providing blood samples and undergoing a magnetic resonance imaging exam. Therefore, they could have been influenced by the study design. However, this fracture was already documented in other studies, notably by Bluhm and colleagues (Bluhm et al., 2014), where adolescents perceive "the mind" as separate from the biological processes that constitute the brain. This entails the belief that there are different forces acting upon behaviors and emotions and can impact the treatment adherence.

This initial struggle has also been described in other studies, where participants expressed an "initial sense of disbelief" following a diagnosis (Loughland et al., 2015). By drawing on the conceptual separation of illness and disease (Kleinman, 1978), it could be argued that, by putting these feelings in "the mind", adolescents were in the realm of experience, and the diagnosis marks the introduction of technical terminology, accompanied by a specific healing system, by explaining these emotions and introducing the idea of disease. By providing the name of Major Depressive Disorder, the diagnosis also acts in a way of 'containing' something previously without meaning (Rose & Thornicroft, 2010).

However, not all adolescents responded like this. Adolescents who were not surprised by the diagnosis were, at least to some extent, familiar with the idea of depression as a disease. To these adolescents, the diagnosis itself was a recognition of previous suspicions. They cited their prior knowledge about depression as an important aspect of this reaction - they knew the symptoms of depression by either searching for them online or by having someone close to them diagnosed with it. The importance of reaching out to those people identified as having suffered from depression was also congruent with previous studies on the topic and was often linked with increased help-seeking behaviors (Wisdom & Green, 2004). This importance of information about the diagnosis in the process of understanding is consistent with prior literature involving adults. Patients frequently find it empowering learning about the diagnosis and its associated symptoms (Perkins et al., 2018), which can facilitate access to treatment and support (Milton & Mullan, 2015). This is often linked to the positive aspect of receiving a diagnosis, but participants here also attributed importance to the negative aspects of it.

Some adolescents see the diagnosis as a negative, fixed label, and acknowledge the difficulty of disclosing the diagnosis to others. This engulfment of the self by the diagnosis – rendering teens feeling unable to manifest other parts of their selves that were not affected by the diagnosis – seems an experience common to teens who are diagnosed with other mental health conditions (Jones & Hesse, 2018). Concerns about the diagnosis seemed to be similar to what has previously been described as the idea of diagnosis as a “master status” - something that becomes an adjective that describes the person and ordains their whole life (Rose & Thornicroft, 2010). This idea of stagnation of their lives was a common concern to adolescents, who seem to struggle with the polarization of their self-identities. Moreover, many adolescents reported seeing the diagnosis as the reification of an abnormal status – which is similar to reports from adolescents suffering from different conditions, such as

ADHD (Jones & Hesse, 2018). Stigma apparently also plays an important role in this scenario, affecting especially the non-disclosure of the diagnosis to others. The interviewed adolescents reported both personal and perceived stigma (Barney et al., 2006) as influencing their diagnosis acceptance and help-seeking behaviors (Schomerus et al., 2019). They also highlighted the pivotal role of caregivers' and peers' perceptions in this process - these may be the people that hold the greatest influence on making sense of the diagnosis. Therefore, further investigation of the role of perceived and personal stigma and its implications on the diagnostic process and search for help are required among adolescents.

One important aspect of this study needs to be contextualized. Given the fact that participants were originally recruited for another study (IDEA RiSCo), they had to meet several inclusion and exclusion criteria (including, but not limited to, meeting diagnostic criteria for other disorders such as post-traumatic stress disorder, or substance use; as well as other factors that could interfere with the biological data collection, such as wearing braces or using anti-inflammatory medication) (Kieling et al., 2021), and therefore are not representative of the general population. Considering that the IDEA RiSCo sample was recruited from a school setting, adolescents were not actively seeking mental health care, so that the context and setting in which we collected data is different from most initial clinical encounters. Therefore, we cannot extrapolate that the experience reported by these participants can be generalized to adolescents receiving the diagnosis within the healthcare system.

Moreover, the limited number of interviewed adolescents must be recognized as an important limitation of this pilot study. The fact that two girls did not return for the second interview and were therefore excluded from the analyses is another limitation both in terms of sample size, but also in terms of unbalancing the gender distribution in the opposite direction of what

is observed in terms of prevalence estimates of depression in community-based samples (Salk et al., 2017).

Despite these limitations, it is worth noting that, in Brazil, most adolescents face important limitations in accessing specialized care, such as long queues, and generally seek help elsewhere, like other medical specialties, friends and religious leaders for advice and referrals (Amaral et al., 2018). Therefore, among the strengths of this study are the focus on an infrequently studied population (community sample of adolescents with depression in a middle-income country), as well as the careful diagnostic procedures and two-staged interview process. The investigation of the reaction to receiving an MDD diagnosis in this age group, though very particular in its needs and characteristics, has been overlooked by researchers. We understand that enhancing the clinical assessment process beyond formal symptom-based diagnostic procedures is a vital component of addressing the mental health needs of this population, and this can only happen by also acknowledging the voice and experiences of adolescents. This study, therefore, investigated some aspects through which adolescents perceive and understand a mental health diagnostic process.

Their reports help to corroborate the importance of understanding adolescents' uncertainties and questions about depression. This could be done in clinical settings through understanding common doubts and misconceptions about it by exploring adolescents' reactions to the diagnosis. Moreover, this approach could strengthen awareness and increase help-seeking behaviors, diminishing stigma and negative perceptions about people with mental health problems. By actively engaging adolescents and exploring their process of assimilating the diagnosis, clinicians also may motivate and facilitate disclosure to others by understanding the adolescents' support network. This may be important since perceived stigma and concerns

about family response are often cited as significant barriers to treatment for adolescent depression (Meredith et al., 2009).

Additionally, it is worth noting that, even with the pilot nature of the present study, results reflect some specificities of the experience of adolescent depression in LMICs. The role of relationships emerges as a defining factor: it is in relations that adolescents can explore and differentiate the meaning of sadness and depression, and disclosure becomes a central discussion regarding stigma, family and peer relationships and help-seeking. This finding is consistent with previous research in LMICs that put social relations and social experiences as central in the experience of adolescent depression (i.e., (Rose-Clarke et al., 2020), and point to culturally-relevant directions regarding receiving a diagnosis in LMICs.

Conclusions

The present study investigated the aspects through which adolescents perceive and understand a mental health diagnostic process. The participants' reports corroborate the importance of understanding and taking into account the voice and experiences of adolescents in clinical and research settings – which is often overlooked by researchers. Moreover, the interviews show the importance of understanding adolescents' concepts of depression, as well as highlight the role of stigma in the process of attributing meaning to the diagnosis. By acknowledging difficulties in disclosing their diagnosis, but also the many doubts that emerge from the diagnosis itself, adolescents indicate relevant directions for enhancing this process.

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Table 1 - Characteristics of the Sample

ID	Gender	Age	Skin Color*	Meet friends to talk, play, do anything else?*	Failed a school grade?*	Ran away from home?*	Lifetime use of alcohol/ other drugs?*	In the last 12 months, got into any fight in which somebody got hurt?*	Relation ship with father*	Relation ship with mother*	Relation ship between father and mother*	History of maltreatment *	CDRS-R score
1	Female	16	Non-white	No	Yes	No	Yes	No	Regular	Regular	Regular	Severe	56
2	Female	16	White	No	Yes	No	Yes	No	Very Good	Regular	Good	Severe	34
3	Male	15	Non-white	Yes	Yes	Yes	Yes	Yes	Very Good	Good	Great	Severe	66
4	Male	14	White	Yes	Yes	Yes	Yes	Yes	Bad	Great	Bad	Severe	60
5	Male	15	Non-white	Yes	No	No	Yes	Yes	Regular	Very Good	Bad	Probable	43
6	Male	16	Non-white	No	Yes	Yes	Yes	No	Very Good	Very Good	Good	Severe	40
7	Male	15	White	No	Yes	Yes	Yes	No	Regular	Regular	Regular	Severe	43
8	Male	16	White	Yes	Yes	Yes	No	Yes	Bad	Great	Bad	Severe	50

CDRS-R = Children’s Depression Rating Scale

*Variables from the Identifying Depression Early in Adolescence Risk Score (IDEA-RS). For additional information on IDEA-RS, see Appendix E.